not obliged to participate in teaching even if they are uninsured or are unable to pay for their medical services [3].

In the case scenario, the extent of a house officer’s participation should have been disclosed prior to the start of the procedure. By disclosing the resident’s level of training and competence and reasonable estimates of the potential for additional risks, patients often allow residents to perform invasive procedures under supervision [4].

The variables associated with the willingness to allow residents to learn and practice are poorly understood. A recent survey suggested that 85% of respondents were uncomfortable with the prospect of having a spinal tap performed for the first time by a resident supervised by an attending [5]. A report published 12 years earlier was less pessimistic of the willingness to be a first-time patient undergoing a diagnostic spinal tap [6]. Perhaps altruism of patients has diminished over time.

Consenting to participate in resident teaching is a charitable and altruistic act. The unselfish act of permitting a resident to perform an invasive procedure balances the welfare of the patient (risk for pain or complication) against a potential intended benefit (enhancing a physician’s skill). Altruism and volunteerism are complicated themes when applied to medical care and teaching [7]. Altruism, the performance by physicians of unselfish acts beneficial to others, is another ethical concept embraced by all medical professionals.

Most interventionists feel that epidural steroid instillations are low-risk procedures. The risk of a resident inflicting injury in this scenario is quite rare. Therefore, the dilemma described in the scenario is not strictly an example of a potential breach of nonmaleficence.

When working with residents, teaching physicians must balance the enrichment of a resident’s educational experience against the risk for them to do harm. It is laudable when patients permit residents the opportunity to perform interventions. The clinical teaching of medical students and residents often involves “practicing on patients.” Today’s teaching environment has evolved from “see one, do one, teach one” to formal credentialing and awarding of clinical privileges to physicians in training. Even when residents are clinically competent, patients are not obligated to undergo procedures performed as part of a training curriculum. The patient’s right to choose is protected by the principle of autonomy.

The adequacy of consent disclosures initiates the process of “doing the right thing.” Teaching physicians should assess a resident’s competency in order to ensure that the potential for harm is minimized to an expected standard of care.

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Opinion #2: Ben A. Rich, JD, PhD

Patients’ Rights in the Academic Medical Center

No one can reasonably dispute the essential role that academic medical centers (AMCs) play in the training and enculturation of future physicians, or the need for residents, as well as third and fourth year medical students, to be directly involved in patient care activities. Most patients who receive care at hospitals and clinics affiliated with an AMC understand, appreciate, and accept this fundamental feature of medical education and training and are willing, if not eager, to consent to participate.
in this important aspect of medical education while receiving care. The general consent forms that nonemergent patient’s sign upon admission to an AMC typically contain “boilerplate” language, by which they purportedly acknowledge and provide consent to care and treatment involving physicians and other health care professionals in training. This element of medical education is so ingrained and pervasive that the denizens of AMCs typically assume, without further consideration or reflection, that the vast majority of patients and their families are aware and approve of this phenomenon.

If all the above was true, then one might also assume that those involved in the operation of AMCs would fully embrace this approach to medical education when it came to their own medical care and that of those nearest and dearest to them. Arguably, this should constitute the litmus paper test of the ethical legitimacy of the practice. But anecdotal evidence suggests that such an assumption would, not infrequently, be in error. In a revealing essay, surgical resident and writer Atul Gawande offers a detailed account of his early, unsuccessful efforts as a trainee to place a central line and of the conspiracy of silence surrounding the higher risks posed when a less, rather than a more, experienced person undertakes a procedure, even with supervision [1]. He goes on to describe a health policy expert who, with breathtaking audacity in the context of a single conversation, declares that people should be willing to “take on chances for societal benefit” (by accepting care from a physician-in-training), while at the same time openly admitting that when his child was born a few months previously “[w]e didn’t even allow residents in the room.” Gawande then delivers his own mea culpa, acknowledging that when his very young and seriously ill child was nearing discharge from the AMC, a cardiology fellow offered to provide follow-up outpatient care. Gawande told him forthrightly that he was going with the much more experienced attending faculty member, and then explained to the reader: “This was my child. Given a choice, I will always choose the best care I can for him. How can anybody be expected to do otherwise? Certainly, the future of medicine should not rely on it” [1].

In his further reflections on the inpatient care of his son, Gawande acknowledged that during the major surgical procedure on his infant son, unlike the labor and delivery for the health policy expert’s wife, a resident intubated him, the cardiology fellow placed a central line, and a surgical trainee scrubbed in for the procedure. All of this was done as a matter of course and without explicit informed consent, aptly characterized by Gawande as a form of “bodily eminent domain” that is routinely asserted over the patient by the AMC and its medical staff and to which even he felt constrained to acquiesce. Nevertheless, he declares: “By traditional ethics and public insistence (not to mention court rulings), a patient’s right to the best care possible must trump the objective of training novices.”

One who would argue that disclosure of the identity, qualifications, and experience of the person who will perform all or any significant portion of an invasive procedure on a patient is not an essential element of informed consent bears a heavy, if not insurmountable, burden of proof. Early suits against surgeons, in which a patient was caused to believe that one physician would perform the procedure when in fact a different surgeon actually did with an unfavorable outcome, were actually based upon the cause of action of battery (an intentional tort) rather than negligence. The practice came to be referred to colloquially as “ghost surgery” [2]. Whatever its characterization, the right of patients to restrict their consent to an invasive medical procedure to a particular health care professional, and to refuse consent to its performance by someone else, has been consistently reaffirmed by the courts.

In the past, some AMCs attempted to compel patients without health insurance to execute contracts releasing the AMC and its clinical staff from liability for negligence as a quid pro quo for providing them with uncompensated care. Courts have found such exculpatory clauses to violate public policy [3]. Similar public policy considerations might preclude an AMC from making patient consent to treatment by medical trainees a condition precedent to receiving care, although at least one court decision suggests that there may be some room for negotiation of certain aspects of patient care provided under the auspices of an educational institution [4].

The case under consideration here presents a situation in which the procedure to which the patient had consented was about to be initiated when the identity of the person who would perform it became known to the patient. The case presentation states that “the procedure along with all the possible attendant side effects were thoroughly explained to the patient who readily signed the consent form.” The critical question for purposes of this analysis, however, is whether consent...
to an invasive medical procedure that reveals nothing about the identity, qualifications, or experience of the person who will perform it is a truly informed one. In my opinion it is not. I believe, and repeatedly state whenever addressing the issue of informed consent, that the essential elements of an informed consent to a medical intervention or treatment include the following: the patient’s diagnosis or (in the case of an invasive diagnostic procedure) differential diagnosis; the nature of the procedure as well as its reasonably anticipated risks and benefits; the alternatives and their reasonably anticipated risks and benefits (including, always, doing nothing); the prognosis with and without treatment; the identity of the person performing the procedure or primarily responsible for the treatment and as much information about that person’s training and experience as the patient wishes to know. Another recommended, but perhaps not ethically or legally required, element is the cost of the procedure or treatment and how much of it will be the patient’s personal financial responsibility. If a fully informed consent requires the above disclosures, then the patient’s consent to the lumbar epidural steroid injection was not valid because an important piece of information—the identity of the person performing it—was not disclosed. Any attempt to coerce or otherwise compel the patient, against her will, to submit to the performance of the procedure by the resident would be ethically unacceptable.

There is a tendency on the part of health care professionals to believe that such a disclosure should only be required if the patient is about to undergo some major, high-risk procedure, for example, open-heart surgery or a solid organ transplant. However, discussions about informed consent in the professional literature do not support a tiered approach to disclosure depending upon the relative degree of invasiveness of the procedure. Moreover, the bioethical principle at risk of being compromised in cases such as the one under consideration is not beneficence or non-maleficence, but respect for patient autonomy. There is no countervailing bioethical principle concerning the duty of patients to willingly participate in the education of future physicians. Such participation on the part of patients is supererogatory.

Under the circumstances as presented, the preferred approach would be to seek to reassure the patient of the direct, immediate, and continuous supervision of the procedure by the attending physician. However, if the patient’s concerns and agitation could not be alleviated and a voluntary consent obtained, then the attending should promptly proceed to perform the procedure. Later, the patient’s response can hopefully provide an opportunity for those involved to discuss the ethical aspects of the case, as well as to revisit the appropriateness of the consent process.

References
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Opinion #3: Perry Fine, MD

Patients Have Rights, but Good Manners Help!

A summary of principles around student involvement in patient care is provided by the American Medical Association (AMA)’s Council on Ethical and Judicial Affairs [1,2]. For purposes of this discussion, the term student herein includes individuals in all levels of medical training, undergraduate and postgraduate (i.e., residents, fellows, etc.). The following are currently accepted principles:

1. Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of any individual involved in their care, and all health care professionals share the responsibility for properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students.

2. Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfill this responsibility.