Proposed Code of Ethics for Treating Osteopathic Manipulation Demonstration Models in Front of Groups

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Introduction
Generally, the purpose of osteopathic manipulative medicine (OMM) demonstrations is to show a screening or treatment approach or technique with a demonstration model, who is usually a volunteer. By showing this in front of a group of learners, this maximizes the learning experience. It is also helpful for the demonstration model since many kinesthetic learners learn best by tactile experience. It is important to keep medical ethics in mind for all professional interactions, including for physician instructors who are treating demonstration models, especially medical students, with OMM in group settings. Medical students are considered a vulnerable population in the language of medical research.¹ In a group setting, they may feel coerced to be a treatment model, and student-teacher relationships may be affected as a result.

The American Osteopathic Association (AOA) Code of Ethics² outlines an ethical approach for osteopathic medical students, residents, and physicians in clinical and educational settings. It incorporates aspects of the 4 principles of medical ethics: respect for autonomy, beneficence, non-maleficence, and justice.³ Demonstration models do not fall under a patient-physician legal relationship. However, because these models are volunteering the use of their bodies in a professional setting, it is advisable to keep the Code of Ethics and principles in mind.

This paper will explore the 4 principles and the relevant sections in the AOA Code of Ethics and briefly address other resources in regards to treating demonstration models with OMM in group settings. This paper will also address generational differences in millennials and how these might affect participation in or perception of OMM demonstrations. A literature search revealed no articles written on a principled approach to OMM demonstrations so this will hopefully elicit interest and conversation on how best to approach this topic.

The 4 Principles of Medical Ethics

Autonomy
Autonomy describes the importance of the physician respecting the right of the competent patient to make decisions for his or her medical care. For treating demonstration models in front of groups, it is imperative to keep this principle in mind. The demonstration model should be given an explanation of the procedure. The procedure, risks, benefits, and side effects should be discussed especially before doing potentially traumatic techniques, such as high-velocity, low-amplitude or a somatoemotional release.⁴ If the demonstration is not meant to show a comprehensive diagnosis and treatment, this should be explained to the model and the group. The demonstration model should be made aware that he or she does not need to agree to be treated and that this right of the model is respected. This also helps to model positive physician communication skills and ethics for the observers and explains to them what they might be witnessing.

Beneficence and non-maleficence
Beneficence and non-maleficence describe 2 sides of the same concept. Beneficence means to cause a net benefit for the patient; non-maleficence is another way to say “do no harm.” The model should be treated in such a way that offers respect, autonomy, and maybe the benefit of a technique that can help his or her function or well-being. Non-maleficence in this context not only means physical harm but also emotional harm. For example, discussing whether

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the model has experienced physical or emotional abuse in the past in a group setting without his or her consent can result in anxiety, embarrassment, and anger.

**Justice**

Gillon\(^7\) describes *justice* in terms of distributive justice, rights-based justice, and legal justice. On different levels, these ideas may include personal, organizational, professional, and societal justice.

**Relevant Sections of the AOA Code of Ethics**

The AOA’s Code of Ethics is a document that describes medical ethics for the osteopathic physician, resident, or medical student. It can and should be applied to public demonstration as much as to private treatments. The sections on privacy, abandonment and sexual harassment are especially applicable.

**Section 1.** The physician shall keep in confidence whatever she/he may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.\(^2\)

The demonstration model is entitled to privacy. Indicate that he or she might be asked invasive questions and that the model should not feel coerced to go into detail in front of the group. The physician instructor should avoid eliciting sensitive information if the model seems uncomfortable. Remember that medical students are trained to be compliant to attending physicians. Their autonomy needs to be respected.

**Section 4.** A physician is never justified in abandoning a patient. The physician shall give due notice to a patient or to those responsible for the patient’s care when she/he withdraws from the case so that another physician may be engaged.\(^2\)

If a treatment reaction or somatoemotional release does occur, make sure that the demonstration model feels supported physically and emotionally. Observers may feel distressed by this reaction, so explain the process to them. Above all, do not abandon the demonstration model. Make sure to check on them periodically. If necessary, have appropriate follow-up care arranged.

**Section 16.** Sexual harassment by a physician is considered unethical. Sexual harassment is defined as physical or verbal intimidation of a sexual nature involving a colleague or subordinate in the workplace or academic setting, when such conduct creates an unreasonable, intimidating, hostile or offensive workplace or academic setting.\(^2\)

Sometimes techniques in potentially sensitive body areas may be appropriate for didactic purposes or for treatment of a demonstration model. Physician instructors demonstrating such techniques on models should use appropriate language and clearly explain to the models and observers what they are doing. Sexual innuendo and joking language are inappropriate and should not be used. As discussed previously, consent should be obtained and autonomy should be respected.

**Other Educational Ethics**

The American Association of Colleges of Osteopathic Medicine formed a Task Force on Ethics and Professionalism in early 2018.\(^5\) At the time of this writing, they have met twice and recommendations are forthcoming.

The Association of American Educators has written a Code of Ethics for Educators that is also relevant to physician instructors.\(^6\) They structure the code around 4 principles: ethical conduct towards students, practices and performance, professional colleagues, and parents and community. Some noteworthy points of intersection are the affirmation to not reveal confidential information, “to protect the student from conditions detrimental to learning, health, or safety,”\(^6\) and to not purposefully encourage the teasing of students.

**Generational Differences**

Today’s medical students are generally millennials (those born between the 1980s and mid-2000s) and have different approaches to classroom learning. They are sensitive to power imbalances and to appearing vulnerable in front of their peers, which can lead to decreased classroom participation.\(^7\) A qualitative analysis by Roehling et al examined barriers to college undergraduate classroom participation and highlighted several concepts that are applicable to OMM demonstrations.\(^7\) One concept was to “work to develop a comfortable classroom atmosphere at the very beginning of the semester while norms for participation are being established.”\(^7\)

In the setting of a demonstration at a workshop, these norms for participation could be established with the group at the beginning of the workshop, which can include clarifying that the demonstration model can withdraw consent for treatment at any time without any adverse judgments. As an example of a situation where these norms were not explicitly discussed beforehand, part of a recent demonstration at a school included drawing landmarks on the demonstration model’s abdomen so that students could visualize their locations. The model’s approval for this had been previously obtained but the observing students were not aware of this. When the physician instructor started drawing landmarks, it elicited several audible gasps and the incident was remarked about on course evaluations. Indicating that the model’s approval had

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been obtained for this would have obviated much of the observers’ concern.

Another concept proposed by Roehling et al was “do not let a student feel isolated or unsupported in a discussion” or, in this setting, a demonstration. If the demonstration model appears to be uncomfortable or having a side effect from the treatment, the observing students are going to be aware of this and also to any perceived lack of concern on the part of the physician instructor. This can adversely affect both the perception of the demonstration as well as the perception of the physician’s ethics. Another approach that could be helpful is to ask the demonstration model if they are uncomfortable or having pain and to encourage them to give feedback about their experience to the group.

Conclusions
Treating demonstration models in front of an audience is a valuable didactic tool for OMM. Although there is no legal patient-physician relationship, physician instructors should keep ethical guidelines in mind for the benefit of modeling good physician behavior and communication, as well as to respect the patient models’ integrity.

Observers who are in the millennial generation are very conscious of perceived power imbalances and unfairness. Making sure that both the models and the observers are clear about the goals and objectives for the demonstrations can help to clarify unclear or potentially uncomfortable situations.

If demonstrating treatment, a physician instructor could consider these questions for guidance: Is this technique necessary or appropriate now for this patient and in this setting? Is there an established protocol for appropriate follow-up care if the model needs further management after this technique or treatment?

There are several directions to take this in the future. A survey of OMM departments’ policies could be instructive. A possible study would be an inquiry into how comfortable the demonstration models feel during the assessment and treatment, how supported they feel in refusing to do certain treatments or to answer certain questions, and if they feel that they have appropriate follow-up. The AACOM task force includes an Educational Council on Osteopathic Principles representative, so its recommendations could be helpful in drawing up a Code of Ethics specific for OMM departments if none already exist. The American Academy of Osteopathy could also include a section in their presenter agreements on ethical OMM demonstrations at courses and at conferences.

Acknowledgements
The author would like to gratefully acknowledge the discussion and contributions of Harriet Shaw, DO, emeritus clinical professor at the Oklahoma State University College of Osteopathic Medicine (OSU-COM), and Amelia McConaghy, DO, clinical assistant professor at OSU-COM.

References