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Women's Health Care Physicians

COMMITTEE OPINION

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Committee on Ethics

This Committee Opinion was developed by the Committee on Ethics of the American College of Obstetricians and Gynecologists as a service to its members and other practicing clinicians. Although this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Professional Responsibilities in Obstetric–Gynecologic Medical Education and Training

ABSTRACT: The education of health care professionals is essential to maintaining standards of medical competence and access to care by patients. Inherent in the education of health care professionals is the problem of disparity in power and authority, including the power of teachers over learners and the power of practitioners over patients. Although there is a continuum of supervision levels and independence from student to resident to fellow, the ethical issues that arise during interactions among all teachers, learners, and their patients are similar. In this Committee Opinion, the Committee on Ethics of the American College of Obstetricians and Gynecologists discusses and offers recommendations regarding the professional conduct and ethical responsibilities of practitioners toward patients and participants in research in educational settings; of learners and teachers toward one another; and of institutions toward patients, learners, and teachers.

Education in obstetrics and gynecology, as in other fields of medicine, carries professional obligations to patients as well as obligations between teachers and students. Students in the context of this Committee Opinion include medical students, residents, and fellows and are referred to as “learners” in the course of this document. In order to help clarify both the professional responsibilities of practitioners and learners to those patients whose care provides educational opportunities and the responsibilities of teachers and learners toward one another, the Committee on Ethics makes the following recommendations and conclusions:

- The education of health care professionals is essential to maintaining standards of medical competence and access to care by patients.
- Disparities of power and authority exist in the relationships between teachers and learners and between practitioners and patients that have an effect on the educational process.
- Respect for patient autonomy requires that patients be allowed to choose not to be cared for or treated by learners when this is feasible.
- Pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery.
- It is the responsibility of the teacher to impart wisdom, experience, and skill for the benefit of the learner, without expectation of personal service by or reward from the learner.
- Amorous relationships between teachers and their current learners are never appropriate.
- Learners should not be placed in situations where they must provide care or perform procedures for which they are not qualified or not adequately supervised.
- Communication between learner and teacher is essential in fostering an atmosphere that will allow, and even encourage, learners to request help and constructive feedback.
- Institutions have ethical obligations to learners, patients, and teachers, including an obligation to provide a work environment that enhances professional competence.

- Institutions have an obligation to protect patients and learners from unprofessional health care providers.
- Medical education and postgraduate training of learners assisting in research with human participants should include a curriculum on research ethics and study design.

Background

The education of health care professionals is essential to maintaining standards of medical competence and access to care by patients. Inherent in the education of health care professionals is the problem of disparity in power and authority, including the power of teachers over learners and the power of practitioners over patients (1). Residents have a dual responsibility as teacher and learner and must understand their ethical responsibilities to both the learners they teach and the patients for whom they provide care. Physicians in postgraduate fellowship programs face the same issues as residents and, for the purposes of this Committee Opinion, are treated identically. Although there is a continuum of supervision levels and independence from student to resident to fellow, the ethical issues that arise during interactions among all teachers, learners, and their patients are similar. It also should be noted that the line between learners and teachers in medicine is fluid and nonlinear. All clinicians learn from and teach each other at every point in their professional development. In this statement, the ethical obligations of teachers apply to all of those in the teaching role, wherever they may be in the educational continuum, and the obligations of learners apply to all of those in the learning role.

Ethical Responsibilities Toward Patients in Educational Settings

At the turn of the 20th century, some medical educators were concerned about the needs of patients in “teaching hospitals,” and they took steps to ensure that patients’ rights would be protected. However, the prevailing opinion was more aptly characterized by this statement from one medical school faculty member: “Patients must clearly understand from the beginning that they are admitted for teaching purposes and that they are to be willing to submit to this when pronounced physically fit” (2). This sentiment persists as an unstated presumption in some contemporary education programs and opposes the respect for patient autonomy that is due to patients in educational settings. Moreover, if the power inherent in the role of medical practitioner is misused in educational settings, this misuse may carry over into attitudes and relationships with future patients as well.

If health care professionals are to benefit society, they must be well educated and experienced. The benefits to society of educating health care professionals provide the justification for exposure of patients to risks

and inconveniences associated with education in clinical medicine. However, although these benefits generally accrue to society at large, the burdens fall primarily on individual patients, especially the economically disadvantaged or the very ill, who are more likely to receive their care at teaching hospitals (3).

Physicians must learn new skills and techniques in a manner consistent with the ethical obligations to benefit the patient, to do no harm, and to respect a patient’s right to make informed decisions about health matters. These obligations must never be subordinated to the need and desire to learn new skills. In consideration of society’s interest in the education of physicians, all patients should be considered “teaching patients.” Patient characteristics such as race, ethnicity, or socioeconomic status should not be the basis for selection of patients for teaching.

Although patients are given the opportunity to consent to or refuse treatment by learners, the obligations of the profession, the institution, and patients should be uniform and explicit. Professional obligations include disclosure of the risks and benefits inherent in the teaching setting and provision of adequate supervision at all levels of training. The patient should be encouraged to participate in the teaching process to contribute her fair share to the development of a new generation of health care providers. A situation may arise in which a patient refuses, for whatever reason, to have a learner involved in her health care. For example, a patient may express concerns about receiving care from an inexperienced learner or a learner of a particular gender or even cultural background. Such refusals should initiate discussion and counseling and should be handled with compassion and respect. Respect for patient autonomy requires that patients be allowed to choose not to be cared for or treated by learners when this is feasible (4, 5).

Some procedures, such as pelvic examinations under anesthesia, require specific consent (6). In women undergoing surgery, the administration of anesthesia results in increased relaxation of the pelvic muscles, which may be beneficial in some educational contexts. However, if any pelvic examination planned for an anesthetized woman offers her no personal benefit and is performed solely for teaching purposes, it should be performed only with her specific informed consent, obtained before her surgery (7, 8). When patients are not making decisions for themselves, as may be the case with minors or those with brain injury or intellectual disability, consent for these pelvic examinations under anesthesia must be obtained from the patient’s surrogate decision maker (eg, a parent, spouse, designated health care proxy, or guardian); however, when possible and clinically appropriate, the health care provider should also obtain the assent of the patient herself for such examinations.

Alternatives to teaching pelvic examinations exist that do not raise the challenges of securing informed consent. Today, many medical schools employ surrogates for patients to teach learners how to perform pelvic examina-

tions. These surrogates are variously referred to as gynecology teaching associates, professional patients, patient surrogates, standardized patients, or patient simulators.

Improvements in technology continue to allow for increased training in the virtual setting for learners. Specifically, technology has allowed surgical training using laparoscopic and hysteroscopic surgery simulation and has improved resident education in these areas. Obstetric simulators also have allowed for teaching emergency techniques, maneuvers, and management strategies without putting patient safety at risk. Although simulation often improves clinical education, simulation cannot completely substitute for educational experiences with real patients.

Learners must hold in confidence any information about patients acquired in the context of a professional relationship. They should discuss specific patient care matters only in appropriate settings, such as teaching conferences or patient care rounds. Conversations in public places, such as hospital corridors or elevators, involving comments about patients, their families, or the care they are receiving are inappropriate (9). Furthermore, as medical records are increasingly kept in electronic form, it is important to ensure patient privacy and security of information in accordance with the Health Insurance Portability and Accountability Act of 1996 regulations. Accordingly, learners should only access charts of patients for whom they are providing care.

Ethical Responsibilities of Learners Assisting in Research

Learners in academic centers may elect to assist in human research studies as collaborators with faculty researchers, as recruiters of research participants, or both. Because of this, medical education and postgraduate training of these learners should include a curriculum on research ethics and study design. In addition, there may be institutional requirements of all researchers (eg, online learning modules or institutional review board certification) that learners of any level must fulfill if they are assisting in such studies.

Ethical Responsibilities of Teachers to Learners

The relationship between teacher and learner in medical education inevitably involves the problem of imbalance of power and the risk of exploitation of a learner for the benefit of the teacher (1). The teacher-learner relationship exists at multiple levels among faculty members, medical students, residents, and fellows. There is a fundamental ethical responsibility at all levels for the teacher to impart wisdom, experience, and skill for the benefit of the learner, without expectation of personal service by or reward from the learner. Because so much of medicine is learned in a preceptor-learner relationship, great care must be taken that the teacher does not exploit the learner. An example is the teacher who expects a learner

to spend time that is out of proportion to the educational value involved on a research project, but gives little or no credit for such a contribution. In this regard, the behavior of teachers toward learners is a powerful example of ethics in action. Learners are likely to model their behavior on that of their teachers (10).

The relationship of a teacher to a learner involves not only trust and confidence but also power and dependency. It is the role of the teacher to foster independence in the learner while nurturing the learner in the learning process. This is a complex relationship, the boundaries of which can become obscured in the intense setting of a clinical preceptorship (11). For example, the long hours spent by teachers and learners in relatively arduous and isolated circumstances may foster amorous (romantic or sexual) relationships. Regardless of the situation, the power imbalance makes an amorous relationship between a teacher and learner ethically suspect. Such relationships between teachers and their current learners are never appropriate. Institutional policies may be more restrictive, and both teachers and learners should be aware of these policies and adhere to them. Occasionally, situations may arise that challenge these proscriptions; for example, the spouse of a professor of obstetrics and gynecology might matriculate at the professor's medical school. These are rare circumstances, however, and should not contravene the general rule of avoiding these relationships.

Adequate and appropriate supervision of learners is of utmost importance. Learners should not be placed in situations where they must provide care or perform procedures for which they are not qualified or not adequately supervised. To do otherwise violates an ethical responsibility to the learner as well as to the patient. A healthy relationship between teachers and learners allows learners to request assistance or supervision without fear of humiliation or retribution. Teaching should take place in an atmosphere that fosters mutual respect. Furthermore, learners should never independently attempt procedures or even counsel patients if they lack the experience, knowledge, or skills to do so without supervision. In rare circumstances, learners should have the right to decline participation in a patient's care when participation in this care creates a clear conflict of conscience for the learner (12).

Both teachers and learners should be aware that the behaviors and attitudes of teachers are being keenly observed by learners and constitute part of the "hidden curriculum" on which the Committee on Ethics has previously commented in Committee Opinion Number 480 *Empathy in Women's Health Care* (13):

The hidden curriculum results from "the processes, pressures, and constraints which fall outside of, or are embedded within, the formal curriculum, and that are often unarticulated or unexplored" (14). This hidden curriculum can have both positive and negative influences.

In most instances this informal curriculum models positive behavior, including empathy. These positive influences include attending physicians, residents, nurses, and other personnel who take time to listen, communicate with patients, and understand what each individual patient is experiencing with her illness. However, negative role models can contribute problematic aspects to the hidden curriculum (15, 16).

Conduct and Responsibilities of Learners Toward Their Teachers

Learners have the obligation to be honest, conscientious, and respectful in their relationships with their teachers. They should act in ways that preserve the dignity of patients and do not undermine relationships between patients and their physicians. It is the learner's responsibility to ask for assistance and supervision when it is needed. Unfettered communication between learner and teacher is essential in fostering an atmosphere that will allow, and even encourage, learners to request help and constructive feedback. When such communication does not occur, both education and patient care are impaired.

Inherent in the teacher-learner relationship is the vulnerability of the learner in dealing with perceived unethical behavior or incompetent conduct of a teacher. If a learner observes such behavior or conduct, the matter should be brought to the attention of the appropriate institutional authority. Mechanisms that are nonjudgmental and without penalty should be clearly defined to encourage an open dialogue about these observed behaviors.

Institutional Responsibilities

Institutions have ethical obligations to learners, patients, and teachers, including an obligation to provide a work environment that enhances professional competence. The health care system often has exploited learners at all levels of education. Learners may be viewed as a source of cheap labor, especially in busy hospitals on a teaching service. However, the goals of providing a broad clinical experience and maintaining continuity of care for patients must be balanced against the neglect of learners' physical health and mental health as well as patient safety (17, 18). Lack of sleep, heavy workloads, and increasing amounts of responsibility without commensurate levels of authority are sources of great stress in medical education, especially during residency (19-21). The potentially negative effect of such an educational experience on the learner's developing attitude toward patients and the profession should be considered. The obligation to provide a good work environment includes ensuring that learners work reasonable hours, establishing a balance between medical education and responsibility for patient care,

providing adequate ancillary and administrative support services, and, in the case of residents and fellows, providing reasonable salaries and benefits (22).

A source of substantial stress for some learners is the conflict between family responsibilities and the demands of medical education (23). For many learners, sleep deprivation caused by long work hours results in fatigue, irritability, and anxiety. The inability to relate with consideration or affection to a partner or spouse or to participate in any effective way with child care or other domestic responsibilities may seriously impair family relationships. Also, because residents and fellows are often at an age when they begin families, the demands of pregnancy, the postpartum period, and child rearing (for both male and female residents and fellows) are often paralleling their ongoing career goals, which can lead to both personal and institutional conflicts requiring special attention. Providing ample time for all residents and fellows to sustain family relationships without adversely affecting the educational experience or imposing excessive burdens on colleagues is a challenging task, but one that must be confronted. Shared positions and more flexible timelines for completing educational requirements can be helpful in solving such problems. Nevertheless, despite the need for institutions to support both learners and teachers in maintaining healthy and fulfilling lives outside of their medical careers, it must be recognized that the decision to pursue the profession of medicine entails a duty to patients that may at times require the subjugation of personal needs.

Institutions have an obligation to protect patients and learners from unprofessional health care providers. Institutions should maintain a well-established reporting and review process for investigating allegations of unethical behavior or incompetent conduct by its teachers and learners. Access to such a process can protect patients and facilitate fair and just relationships between learners and teachers in these scenarios. It is the responsibility of any teacher to address unprofessional behavior in learners because this behavior has been shown to be predictive of unprofessional behavior in the workforce later on in life (24).

Finally, as concerns about cost containment increase, education could become a low priority. The process of medical education may reduce the efficiency of patient care and increase costs. It is the responsibility of all physicians and institutions involved in the education of health care professionals to ensure that cost-reduction efforts do not diminish the opportunities for education in clinical medicine. Institutions have an ethical responsibility to develop policy statements and guidelines for the inclusion of learners in patient care in ways that ensure sound medical education and high-quality medical care.

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