Bedside Teaching and Respecting the Pediatric Patient: A Response to Verpaelst

COMMENTAIRE / COMMENTARY

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Résumé
L'enseignement au chevet, qui implique des patients, des médecins et des étudiants, est une technique omniprésente et utilisée pour la formation médicale. Le respect, le consentement libre et éclairé et la transparence sont des éléments clés d'un enseignement éthique et efficace. Le refus du patient à participer à l'enseignement au chevet doit être respecté. Ceci devrait être appliqué aux patients de tous âges, y compris les enfants qui ne comprennent pas pleinement ou qui ne sont pas aptes à consentir et à participer à l'enseignement.

Mots clés
pédiatrie, bioéthique, consentement, enseignement de chevet, éthique clinique, enseignement médical

Summary
Bedside teaching involving patients, physicians, and students is a ubiquitous technique used for medical training. Respect, valid informed consent, and transparency are key to ethical and effective teaching. Patient refusal in participating in bedside teaching must be respected. These ought to apply to patients of all ages, including children, who may not fully understand or be capable of consenting to participating in teaching.

Keywords
pediatrics, bioethics, consent, bedside teaching, clinical ethics, medical education

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None declared

In a recent creative work entitled "A Very Embarrassing Moment" [1], Frank Verpaelst narrates his childhood experience of being used, by his doctor, as a teaching tool for medical students. Recapping his experience as an adult, he reiterates and emphasizes the embarrassment he felt for being publicly exposed and scrutinized. This left him feeling humiliated, with longstanding emotional, psychological, and social distress. The reification of patients in any setting, whether for teaching purposes (such as Verpaelst's case) or for research, highlights many ethical issues, particularly the disrespect for patient autonomy, neglecting their wellbeing, potential abuse of privacy and patient dignity, denigration of the individual's rights, and ultimately turning the patient into an object.

Yet, using real life patients with unique and interesting presentations, demonstrable signs, and characteristic symptoms of disease or rare conditions is an age-old accepted and ubiquitous technique for teaching medical students [2]. The patient is essential for optimizing the experience and teaching of clinical skills – including observation, communication, examination, and professionalism – for future medical practice. With the voluntary cooperation of patients, rare and interesting cases

make medical history and leave valuable legacies. This should be considered as an important contribution to medical teaching, knowledge, and humanity.
However, as with Verpaelst's case, it is important to consider the very thin line between using a propositus patient as merely a means-to-an-end for the sake of teaching, and having a genuine participation and teaching experience involving respect for all three parties involved: patient, trainee, and teacher.

The practice of Western medicine has changed over the last century. What was once a predominantly paternalistic, reductionist, dictatorial and systematic approach, with researcher-doctors making most decisions, has become a more holistic medical practice; the whole process is aimed at respecting patient autonomy, liberty, providing beneficence, and ensuring justice for all patients. These fundamental ethical principles, based on Beauchamp and Childress's bioethical principles, are fundamental factors; they are the very pillars of ethics delivered to medical students as foundations for their future clinical practices [3].

Yet, some doubt arises regarding the implementation of these principles by physician-teachers when actually *teaching* clinical medicine in a "classroom" setting, or in this case, at the bedside. With all clinical teaching, particularly individual bedside teaching, all principles of respect for patient autonomy, liberty, justice, and providing beneficence should be reinforced by physician-teachers and medical students, just as it would be in any transparent clinical setting or encounter. The art of effective and ethical bedside teaching resides in respecting these fundamental ethical principles, and maintaining excellent standards for teaching skills. Verpaelst's exposure at such a young age for the sake of bedside teaching clearly violated the aforementioned core principles, leaving Verpaelst feeling angry, embarrassed, and distrustful of his medical-healthcare provider for many years after the event, which is most unfortunate.

Just as with any medical procedure or participation in a research study, physician-teachers are required to gain valid informed consent from patients (or their guardians) to be involved in bedside teaching. Informed consent must be free from coercion, manipulation, or persuasion, and extra care must materialize when vulnerable patients who are incapable of giving consent, such as children like the young Verpaelst, are involved. It remains unclear as to whether or not any type of consent was obtained from Verpaelst's guardians/parents prior to his experience. The question of whether consent was obtained, how it was obtained, and whether or not Verpaelst should have been more involved in the process is relevant; profound ethical issues arise from the narrative of his experience. Further, the concern that Verpaelst, the patient, was evidently not well informed nor aware that he was being used for teaching, what it entailed, or how it would consequently affect him is, to say the least, morally disconcerting.

While there is no legal requirement to involve or inform young children about the medical procedures that they may receive (once their guardians consent), the question arises as to whether there is a further *moral* requirement to clarify and explain the expected procedures. The identical moral questions should apply to being involved in clinical teaching. Some may argue that due to Verpaelst's age at the time (seven years old), he was too young to be fully aware and involved in the decision making of being used for teaching. Perhaps his parents consented without full consideration for his sensitivities and sensibilities, and did not realize that the assent was actually of minimal protection to their child from subsequent harm. Yet, this should not and does not justify the use of child-patients (as happened with Verpaelst) at the bedside against their wishes. If any child feels uncomfortable, or shows any sign of dissent regarding being used as a subject for bedside teaching purposes, the child should have the inalienable right to refuse to participate [4,5]. This must be respected. As with medical research, patients of any age have every right to change their mind or refuse to partake in bedside teaching if they so wish. Again, this must be clearly presented, respected, and understood by clinical teachers and trainees.

In contemporary medical education, the ancient exposition-type of bedside teaching that Verpaelst encountered is generally no longer routinely practiced, unless it is well planned, discussed beforehand, and general consensus is obtained by all involved parties. In a world of information technology, rapid dissemination and data retrieval, alternatives to bedside teaching exist, including consented images and videos capturing clinical presentations while ensuring patient anonymity. With this, patient confidentiality is protected, consent is facilitated, and any potential embarrassment is mitigated. Nevertheless, the human element experienced in bedside teaching is often hard to replace, and patient interactions remain central to significant learning experiences and clinical training.

The challenge of bedside teaching is to find the right balance between respecting patient rights, best-interests, and dignity, without compromising or hindering the teaching experience of students. Approaches that disregard patient rights and which replicate Verpaelst's experience should no longer occur. Patients remain central and are key to best bedside teaching experiences, and must be respected in any clinical setting. Physicians and students are in a privileged position to examine patients, and this should never be taken for granted.

Biography

Sarah Touyz is a graduate from McGill University, where she completed a Bachelors of Science in Anatomy and Cell Biology and Environmental Studies, and a Masters of Science in Experimental Medicine specializing in Biomedical Ethics. Her interests are in clinical and research ethics, particularly with regards to animal ethics, paediatrics, and end-of-life care. She is currently studying medicine at the University of Glasgow, and hopes to continue broadening her knowledge by incorporating her bioethical training with future clinical experience.

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