

Peer physical examination: time to revisit?

John E Marley

TO THE EDITOR: The article by Outram and Nair on peer physical examination¹ misses the point that consent by medical students for physical examination by their peers can never be freely given. It always contains elements of coercion.

Ethics committees usually do not allow medical students to enter clinical trials run by staff, who at some point may be their assessors, because there may be subtle duress to participate. Even if consent for peer physical examination is sought by staff who will be neither assessors nor tutors of these students, non-consenting students are immediately apparent to their colleagues, creating peer pressure to participate. The emotionally vulnerable are the most likely to accede to this and the most likely to be distressed.

It is unsafe to rely on all staff seeking consent and behaving appropriately at all times. In one Australian medical school, students were told that they all had to “bring their swimmers” to wear so that they could be examined by other students. The statement that peer physical examination “has high acceptability”¹ is not supported by the cited literature, and it is not clear to whom it is highly acceptable.

There are good arguments for learning physical examination skills on the healthy. If young bodies are needed for this, universities are full of students from other faculties, and medical schools are not so poor they cannot pay the small amounts of money valued by these students for their participation.

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¹ Outram S, Nair BR. Peer physical examination: time to revisit? *Med J Aust* 2008; 189: 274-276. □

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IN REPLY: Marley states that consent for peer physical examination “always contains elements of coercion”. It could be argued that this applies equally to medical practice and research, as one can never be 100% sure that participants have not felt some coercion. The ethical imperative is to balance the issues, to gain the best outcome.

The article by Nair and myself reviewed the literature, reported additional research in the main area where difficulties had been noted (culturally and linguistically diverse students) and, on the basis of that evidence, suggested best practice.¹ Contrary to Marley’s assertion, the articles we reviewed do support high levels of acceptability: 98%,² 97%,³ and 94%,⁴ respectively. Marley’s statement that emotionally vulnerable students are most likely to accede to peer physical examination and then be distressed may sound correct, but there is no evidence for this. In our experience, medical students are assertive, including those from the minority groups surveyed.

Although the cost of direct payment to non-medical university students acting as “models” may be relatively small, the process of recruitment, training and processing by overstretched academic staff has significant opportunity costs. Additionally, medical students acting as models have the opportunity to experience the patient’s perspective.

We acknowledge some criticisms of the practice of peer physical examination. However, it is currently widely used and will continue to be. The intent of our article was to draw attention to unforeseen difficulties and to improve practice.

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1 Outram S, Nair BR. Peer physical examination: time to revisit? *Med J Aust* 2008; 189: 274-276.

2 Chang EH, Power DV. Are medical students comfortable with practicing physical examinations on each other? *Acad Med* 2000; 75: 384-389.

3 Rees CE, Bradley P, McLachlan JC. Exploring medical students’ attitudes towards peer physical examination. *Med Teach* 2004; 26: 86-88.

4 O’Neill PA, Larcombe C, Duffy K, Dorman TL. Medical students’ willingness and reactions to learning basic skills through examining fellow students. *Med Teach* 1998; 20: 433-437. □