Communication and Ethics in the Clinical Examination

Sharon Onguti, MD*, Sherine Mathew, MD, Christine Todd, MD

KEYWORDS

• Communication • Ethics • Physical examination • Clinical examination • Autonomy • Beneficence

KEY POINTS

- Effective patient-physician relationship is built on trust and sound communication skills.
- Observance and application of ethical principles is integral in this process.
- Recognizing barriers to effective communication and developing skills to address is essential in this process.

INTRODUCTION

At the heart of every effective patient-physician interaction is a relationship that is built on trust. Cultivating sound communication skills coupled with the awareness and application of ethical principles is integral to this process. One of the foremost challenges in competent practice is negotiating situations that arise at the bedside when such issues as patient autonomy, differing world views, honesty, and cost stewardship come into conflict. It is essential for health care providers to consider how to detect and prioritize these issues as they advocate for high-quality and patient-centered care.[1]

The following are different patient scenarios that simulate real-life cases we have encountered in our practice and the approach taken to help build an effective relationship in the setting of competing ethical priorities.[2,3]

CASE 1: THE RESISTANT PATIENT

You are on attending rounds and the team walks into Mary's room, a 32-year-old woman who was admitted for an emergent hematologic condition. She has been at the hospital for 3 weeks. She is finally improving and is tired of getting daily assessments. You are about to start examining her and she sternly says, "I was seen by

Disclosure Statement: No disclosures.
Department of Internal Medicine, SIU Medicine, Southern Illinois University, School of Medicine, 801 North Rutledge, PO Box 19628, Springfield, IL 62794-9628, USA
* Corresponding author.
E-mail address: sharon.onguti@gmail.com

Med Clin N Am 102 (2018) 485–493
https://doi.org/10.1016/j.mcna.2017.12.010
medical.theclinics.com

two other physicians earlier and I don't think you need to examine me." She is adamant about this and does not want to be touched.

Competing Priorities

1. Patient autonomy: We respect that this patient has the right to decide who to discuss her care with, and who can perform a physical examination on her. It is easy to empathize with her frustration over a long, complex, and tiring hospital stay.
2. Providing high-quality care: Although data gathered by other members of the health care team are helpful, physicians place the most value on observations made by themselves in person. Although we assume everyone is doing their best, the quality of data varies greatly with the experience and expertise of the examiner.
3. Impact on physician approach: The patient's response may evoke a sense of rejection in the physician, which can lead to a suboptimal physical assessment. This negatively impacts the quality of care provided.
4. Honesty: To be paid for their services to a patient, a practitioner must perform a portion of the history and physical in person.

Approach

It is difficult to ethically override a patient's authority unless they seem to be incapable of making decisions. In this case, the patient is simply frustrated with the routine of being a patient, and her refusal is understandable. A general appeal to be allowed to examine her would be asking her to submit to a hierarchy where her autonomy is less meaningful than the power that places the doctor "in charge" of what happens to her. This appeal could be successful in getting the patient to submit to an examination, but would be detrimental to the physician-patient relationship. Instead, a negotiation with the patient about the parts of the examination the doctor is particularly interested in verifying and why those would be important to her care could result in the patient rethinking their decision and allowing the examination to continue. In negotiating with the patient, it is important to acknowledge their frustration and provide reassurance of unwavering support. This requires a significant time investment; reorganizing the structure of rounds to accommodate this is essential.[4]

CASE 2: THE VERY INVOLVED FAMILY

Lillian is a 75-year-old woman admitted with pneumonia and acute hypoxic respiratory failure. She has two daughters and a son who are always present in her room. They are close to their mother and demand to be involved in every aspect of her care. Attempts at performing the physical examination are met with resistance and a need to justify its importance to her children. The patient is decisional, cooperative, and gives consent to be examined without restriction.

Competing Priorities

1. Appreciating a patient's support system: We want to respect the caring relationship of a patient's family in the same way we have respect for the patient themselves, particularly when their actions seem to be well-intentioned.
2. Patient autonomy: Although understanding that patients often act as part of a family unit, we want them to be enabled to make decisions independent of the unit when necessary, particularly in matters concerning their own well-being.
3. Beneficence: Although acknowledging the role the family plays, it is important to recognize when their involvement contributes to a harmful environment by obstructing the course of care.