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Perspective

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Naked

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There is an exquisite and fascinating scene in *Kandahar*, a movie set in Afghanistan under the Taliban regime, in which a male physician is asked to examine a female patient. They are separated by

an opaque screen. Behind it, the woman is covered from head to toe by her burka. The two do not talk directly to each other. The patient's young son serves as the go-between. She has a stomachache, he says.

"Does she throw up her food?" the doctor asks.

"Do you throw up your food?" the boy asks.

"No," the woman says, perfectly audibly, but the doctor waits as if he has not heard.

"No," the boy tells him.

For the exam, the doctor has cut a two-inch circle in the screen. "Tell her to come closer," he says. The boy does. She brings her mouth to the opening, and through it he looks inside. "Have

her bring her eye to the hole," he says. And so the exam goes. Such, apparently, can be the demands of decency.

When I started my surgical practice two years ago, I was not at all clear about what my own etiquette of examination should be. Expectations are murky; we have no clear standards in the United States; and the topic can be fraught with hazards. Physical examination is deeply intimate, and the way a doctor deals with the naked body — particularly when the doctor is male and the patient female — inevitably raises questions of propriety and trust.

No one anywhere seems to have discovered the ideal ap-

proach. A surgical colleague who practices in Iraq told me about the customs of physical examination there. He said he feels no hesitation about examining female patients completely when necessary, but because a doctor and a patient of opposite sex cannot be alone together without eyebrows being raised, a family member will always accompany them for the exam. Women do not remove their clothes or change into a gown for the exam, and only a small portion of the body is uncovered at any one time. A nurse, he said, is rarely asked to chaperone: if the doctor is female, it is not necessary, and if male, the family is there to ensure that nothing unseemly occurs.

In Caracas, according to a Venezuelan doctor I met, female patients virtually always have a chaperone for a breast or pelvic exam, whether the physician is male or female. "That way there

are no mixed messages,” the doctor said. The chaperone, however, must be a medical professional. So the family is sent out of the examination room, and a nurse brought in. If a chaperone is unavailable or has refused to participate, the exam is not done.

A Ukrainian internist told me that she has not heard of doctors in Kiev using a chaperone. If a family member is present, he or she will be asked to leave. Both patient and doctor wear their uniforms — the patient a white examining gown, the doctor a white coat. Last names are always used. There is no effort at informality to muddy the occasion. This practice, she believes, is enough to solidify trust and preclude misinterpretation of the conduct of care.

A doctor, it appears, has a range of options.

In 2003, I set up my clinic hours, and soon people arrived to see me. I was, I realized, for the first time genuinely alone with patients. No attending physician in the room or getting ready to come in; no bustle of emergency room personnel on the other side of a curtain. Just a patient and me. We’d sit down. We’d talk. I’d ask about whatever had occasioned the visit, about past medical problems, medications, the family and social history. Then the time would come to have a look.

There were, I will admit, some awkward moments. I had an instinctive aversion to examination gowns. At our clinic they are made of either thin, ill-fitting cloth or thin, ill-fitting paper. They seem designed to leave patients exposed and cold. I decided to examine my patients while they were in their street clothes. If a patient with gallstones wore

a shirt she could untuck for the abdominal exam, this worked fine. But then I’d encounter a patient in stockings and a dress, and the next thing I knew, I had her dress bunched up around her head, her tights around her knees,



and both of us wondering what the hell was going on. An exam for a breast lump one could manage, in theory: the woman could unhook her brassiere and lift or unbutton her shirt. But in practice, it just seemed weird. Even checking pulses could be a problem. Pant legs could not be pushed up high enough. Try pulling them down over shoes, however, and . . . forget it. I finally began to have patients change into the damn gowns. (I haven’t, however, asked men to do so nearly as often as women.)

As for having a chaperone present with female patients, I hadn’t settled on a firm policy. I found that I always asked a medical assistant to come in for pelvic exams and generally didn’t for breast exams. I was completely inconsistent about rectal exams.

I surveyed my colleagues about what they do and received a variety of answers. Many said they bring in a chaperone for all pel-

vic and rectal exams — “anything below the waist” — but only rarely for breast exams. Others have a chaperone for breast and pelvic exams but not for rectal exams. Some did not have a chaperone at all. Indeed, an obstetrician–gynecologist estimated that about half the male physicians in his department do not routinely use a chaperone. He himself detests the word “chaperone” because it implies that mistrust is warranted, but he offers to bring in an “assistant” for pelvic and breast exams. Few of his patients, however, find the presence of the assistant necessary after the first exam, he said. If the patient prefers to have her sister, boyfriend, or mother stay for the exam, he does not object — but he is under no illusion that a family chaperone offers protection against an accusation of misconduct. Instead, he relies on his reading of a patient to determine whether bringing in a nurse–witness would be wise.

One of our residents, who was trained partly in London, said he found the selectivity here strange. “In Britain, I would never examine a woman’s abdomen without a nurse present. But in the emergency room here, when I asked to have a nurse come in when I needed to do a rectal exam or check groin nodes on a woman, they thought I was crazy. ‘Just go in there and do it!’ they said.” In England, he said, “if you need to do a breast or rectal exam or even check femoral pulses, especially on a young woman, you would be either foolish or stupid to do it without a chaperone. It doesn’t take much — just one patient complaining, ‘I came in with a foot pain and the doctor started diving around my groin,’ and you could be suspend-

ed for a sexual-harassment investigation.”

Britain’s standards are stringent: the General Medical Council, the Royal College of Physicians, and the Royal College of Obstetricians and Gynaecologists specify that a chaperone must be offered to all patients who undergo an “intimate exam” (i.e., involving the breasts, genitalia, or rectum), irrespective of the sex of the patient or of the doctor.^{1,2} A chaperone must be present when a male physician performs an intimate exam of a female patient. The chaperone should be a female member of the medical team, and her name should be recorded in the notes. If the patient refuses a chaperone and the examination is not urgent, it should be deferred until it can be performed by a female physician.

In the United States, we have no such guidelines. As a result, our patients have little idea of what to expect from us. To be sure, some minimal standards have been established. The Federation of State Medical Boards has spelled out that touching a patient’s breasts or genitals for a purpose other than medical care is a disciplinable offense. So are oral contact with a patient, encouraging a patient to masturbate in one’s presence, and providing services in exchange for sexual favors. Sexual impropriety — which involves no touching but is no less proscribed — includes asking a patient for a date, criticizing a patient’s sexual orientation, making sexual comments about the patient’s body or clothing, and initiating discussion of one’s own sexual experiences or fantasies.³ I can’t say anyone taught me these boundaries in medical school, but I would like to think that no one needed to.

The difficulty for those of us who do not behave badly is that medical exams remain inherently ambiguous. Any patient can be led to wonder: Did the doctor really need to touch me there? Even when doctors simply inquire about patients’ sexual history, can anyone be certain of the intent? The fact that all medical professionals have blushed or found their thoughts straying during a patient visit reveals the potential for impropriety in any encounter.

The tone of an office visit can turn on a single word, a joke, a comment about a tattoo in an unexpected place. One surgeon told me of a young patient who expressed concern about a lump in her “boob.” But when he used the same word in response, she became extremely uncomfortable and later made a complaint. Another woman I know left her gynecologist after he made an offhand, probably inadvertent, but admiring comment about her tan lines during a pelvic exam.

The examination itself — the how and where of the touching — is, of course, the most potentially dicey territory. If a patient even begins to doubt the propriety of what a doctor is doing, something is not right. So what then should our customs be?

There are many reasons to consider setting tighter, more uniform professional standards. One is to protect patients from harm. About 4 percent of the disciplinary orders that state medical boards issue against physicians are for sex-related offenses. One of every 200 physicians is disciplined for sexual misconduct with patients sometime during his or her career.⁴ Some of these cases involve such outrageous acts as having inter-

course with patients during pelvic exams. The vast majority of cases involved male physicians and female patients, and virtually all occurred without a chaperone present.⁵ About one third of cases studied in one state involved actual sexual intercourse with patients; two thirds involved sexual impropriety or inappropriate touching short of sexual contact. Another goal might be to reduce false accusations arising from misinterpretation.

Nonetheless, eliminating misconduct and accusations would be the wrong aim to guide medical care. The trouble is not that such acts are rare (though the statistics suggest they are), nor that total prevention — zero tolerance — is impossible. It is that, at some point, the measures required to achieve total prevention will approach the Talibanesque and harm care of patients.

Embracing more explicit standards for medical encounters, however, might actually improve relationships with patients — and that does stand as a worthy goal. The new informality of medicine — with white coats disappearing, and patient and doctor sometimes on a first-name basis — has blurred boundaries that once guided us. If physicians are unsure about what is appropriate behavior for themselves, is it any surprise that patients are, too? Or that misinterpretation can occur? We have jettisoned our old customs but have not bothered to replace them.

My father, a urologist, has thought carefully about how to avert such uncertainties. From the start, he felt the fragility of his standing as an outsider, an Indian immigrant practicing in a rural Ohio town. In the absence of guidelines to reassure patients

that what he does as a urologist is routine, he has made painstaking efforts to avoid question.

The process begins before the exam. He always arrives in a tie and white coat. He is courtly. Although he often knows patients socially and doesn't hesitate to speak with them about personal matters (the subjects can range from impotence to sexual affairs), he keeps his language strictly medical. If a female patient must put on a gown, he steps out while she undresses. He makes a point of explaining what he is going to do during the examination and why. If the patient lies down and needs further unzipping or unbuttoning, he is careful not to help. He wears gloves even for abdominal examinations. If the patient is female or under 18 years of age, then he brings in a nurse as a chaperone, whether the exam is "intimate" or not.

His approach has succeeded. I grew up knowing many of his

patients, and they trust him completely. I find, however, that some of his practices do not seem quite right for me. My patients are as likely to have problems above the waist as below, and having a chaperone present for a routine abdominal exam or a check of groin pulses feels to me absurd. I don't don gloves for nongenital exams. Nonetheless, I have tried to emulate the spirit of my father's visits — the decorum in language and attire, the respect for modesty, the precision of examination. As I think further about his example, it has also led me to make some changes: I now uniformly use an assistant not just for pelvic exams but also for rectal exams of female patients and as patients desire, for breast exams as well. For the comfort and reassurance of patients, these seem to be reasonable customs, even expectations, for more of us to accept.

A professor once told my medical school class that patients can

tell when you've seen a thousand naked patients and when you haven't. I now know that's true. But I have also come to recognize that no patient has seen a thousand doctors. They therefore have little idea, coming to a doctor's office, of what is "normal" and what is not. This we can change.

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4. Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA* 1998; 279:1883-8.
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Medical Marijuana and the Supreme Court

Susan Okie, M.D.

Angel McClary Raich, a California woman at the center of the recent Supreme Court case on medical marijuana, hasn't changed her treatment regimen since the Court ruled in June that patients who take the drug in states where its medicinal use is legal are not shielded from federal prosecution. A thin woman with long, dark hair and an intense gaze, Raich takes marijuana, or cannabis as she prefers to call it, about every two waking hours — by smoking it, by inhaling it as a vapor, by eating it in foods, or by applying it topically as a balm. She says that

it relieves her chronic pain and boosts her appetite, preventing her from becoming emaciated because of a mysterious wasting syndrome. Raich and her doctor maintain that without access to the eight or nine pounds of privately grown cannabis that she consumes each year, she would die.

Although Raich has embraced a public role advocating the medicinal use of marijuana, she says that her health suffered during the hectic days following the announcement of the Court's decision, when a whirlwind schedule of press conferences and congress-

sional meetings in Washington prevented her from medicating herself with cannabis as regularly as she needed to. "My body was shutting down on me," she said in an interview from her Oakland home last month. "I'm scared of my health failing. I'm scared of the federal government coming in and doing more harm. [Recently,] the city of Oakland warned there were going to be some raids" on marijuana dispensaries. "We're all just waiting. Sitting on the frontline is extremely stressful."

In the Supreme Court case