A postscript to 'Professional probity post-Fernando: A terrible beauty is born' (NZFP 2007; 34(4): 282–284)

Thank you Ian, for an excellent and thought-provoking response to recent events in New Plymouth. Your messages about the importance of appropriate propriety between male doctors and female patients were clear and unequivocal; the obvious examples of unacceptably poor behaviour you give are depressing reading in 2007.

But it would be equally wrong for practitioners (and I do, in the main, mean general practitioners) to take your remarks as an excuse or reason to avoid undertaking intimate examinations when there is a clinical indication for doing so. Nowhere in your article do you suggest this, but unfortunately I have heard more than one GP recently refer to your comments as a warning to avoid clinical examination. Notwithstanding the examples you gave of unnecessary examinations where management is unchanged, there are always going to be situations where an appropriately conducted physical examination will add a great deal of immediate information, and sometimes immediate reassurance, to an acute and/or worrying clinical problem.

I have been saddened to hear younger practitioners than I am, both male and female, talking recently of the ever-increasing need to send women for imaging procedures simply because they are unwilling to undertake an appropriate physical examination.

Part of this unwillingness stems directly from a fear of being accused of inappropriate behaviour when none was genuinely intended, but more comes from finding a convenient excuse to not spend the time to undertake the examination with appropriate decorum and/or finding a suitable chaperone. In busy general practices, practice nurse time is often at a premium, and it is all too easy to spend one minute filling in the online radiology request form rather than spending five or 10 minutes locating and waiting for a nurse to finish her own consultation. Well organised practices will have systems in place to manage such waiting times, but such organisation is by no means universal.

To me, this avoidance of simple clinical responsibility and the resultant cost shifting is highly questionable, especially when it is nearly always the patient who pays for the unnecessary mammogram or the transvaginal ultrasound, both of which can easily be far more uncomfortable and more invasive than a well-explained and well-performed examination by a clinician sensitive to the patient's comfort.[1]

But an even more important issue that I also hear about from younger colleagues is their resultant lack of confidence and competence in undertaking a clinically useful breast or vaginal examination. It takes practice to become competent and confident in both breast and vaginal examinations, or for that matter, the examination of male genitalia. To understand what is normal, so that the undiagnosed ectopic pregnancy, the normal but tense premenstrual breast, or the genital warts under the foreskin can be accurately assessed, requires us all to gain, and then maintain, competence in these intimate examination skills.

I graduated in 1978, very nearly 30 years ago. But because I was perhaps a rather slow learner of these skills, I still remember that moment when I 'understood with confidence' what a normal non-pregnant uterus felt like, as opposed to one that was eight weeks gravid. (It's not for nothing that the Latin root of the word 'gravid' means heavy). And it was on about vaginal examination number 20. By the time I'd done 50 I had become slowly but surely, confident and competent. To get that practice, I followed the advice of one of New Zealand's most outstanding clinical teachers. I did do bimanual examinations along with cervical smears, or when women came for pregnancy tests. I examined testes when men came for VD checks and vasectomy pre-checks.

In this respect I owe a very great debt to Dr Margaret Sparrow, who was without doubt the best clinical teacher I have ever had. Long before the term 'patient-centred care' came into common parlance, she taught me to treat every patient, no matter what their outward appearance, with deference and respect, while at the same time being acutely aware of their individual clinical need. She also took me step-by-step through a safe, sensitive and anatomically informed approach to intimate examinations; directly observing me in these skills until she was satisfied that I could not only conduct the examination with care and sensitivity but also understand and correctly interpret the anatomical findings.

To my mind, there are three issues that need attention. Firstly, there is the need for better training and

better supervision of clinical skills learning. Clinical skills training for intimate examinations needs to include much more specific attention to appropriate language, appropriate conduct, and maintenance of comfort throughout, as well as to the technical aspects of the procedure. I am all too well aware, for example, of the difficulties that some (often male, but sometimes female) medical students currently face in gaining this crucial early supervision for vaginal examinations, but it can and must be done. Innovative and acceptable ways of organising this type of training can be achieved with adequate resources and support. Some resources, such as clinical skills facilities,[2] informed consent training,[3] and GTAs (gynaecology teaching associates; women who volunteer to be available for examination and train to give constructive feedback) have already been in use for some time,[4] but more is needed.

But second is the need to consider other valid and important reasons for undertaking examinations. While we have insufficient evidence to justify the use of routine vaginal, breast, or testicular examinations as screening tests, they still have an important place in the context of diagnosis, or understanding of anatomy.

For example, when the cervix is a little difficult to locate for a smear or an STI check, when the LMP and the onset of other symptoms of pregnancy don't match, when a patient is particularly anxious about a first speculum examination, a sensitively conducted vaginal examination with concurrent explanation of the anatomy, will nearly always help. Not as a meaningless ritual, but as an adjunct to an associated clinical procedure or problem. Empowering patients with accurate and factual knowledge about their own anatomy and physiology, about what is normal, and what can be expected in individual situations is one of the underlying tenets for effective practice in sexual and reproductive health. For both men and women, such knowledge can be a powerful protection against all types of sexual exploitation.

And thirdly, situations such as these also provide an opportunity for regular clinical skills practice. In the right clinical context, and in full discussion with the patient, this is also an important and valid reason for undertaking physical examinations. It is far better that we gain and maintain our skills in clinically appropriate consultations, than be faced with the unenviable task of being unable to undertake an examination when the immediate clinical situation urgently demands it.

Rural practitioners are obviously faced with such situations where no ultrasound is immediately to hand; but so are all GPs. Is it good clinical practice in downtown Wellington to send an anxious but fiscally poor young man (convinced he has a lump that spells cancer) for an expensive ultrasound without examining him, only to have the report come back identifying the 'lump' as a normal epidydimis? If your answer is 'yes', then a terrible beauty is indeed born; a world where the art of general practice (imperfect though it is) is not augmented but replaced by diagnostic machinery is truly full of dangers with unknown consequences.

Sue Pullon

References

1. Broadmore J, Carr-Gregg M, JD H. Vaginal examinations: women's experiences and preferences. New Zealand Medical Journal 1986; 99(794):8-10.
2. Gynaecological examination, Clinical Skills Unit. 2007. (Accessed 12.10.07, at http://www.chmeds.ac.nz/skillsunit/skills.htm.)
3. Code of practice for obtaining informed consent when an internal examination is carried out. Wellington School of Medicine and Health Sciences, 2005. (Accessed 12.10.07, at http://www.otago.ac.nz/wsmhs/academic/OandG/undergraduate/5thyearhandbook.html.)
4. Teaching medical students to perform pelvic exams. 1992. (Accessed 12.10.07, at http://www.womens-health.org.nz/patientsrights/rights.htm.)

In reply

Dr Pullon characterises her letter as a postscript to my paper. She writes that nowhere in my article do I suggest that the recent events in New Plymouth are an excuse or reason to avoid undertaking intimate examinations when there is a clinical indication for doing so, and she is right: nowhere did I suggest that.

There is much to agree with in her letter, which discursively covers other issues around the intimate examination somewhat tangential to my point – and that is simply that *man doctors have to desexualise the intimate examination of woman patients if they are to avoid the risk of misunderstanding.*

There are a couple of points on which I do wish to comment.

Dr Pullon writes, '*...we have insufficient evidence to justify the use of routine vaginal, breast, or testicular examinations as screening tests.*' In my view we do have sufficient evidence, and it suggests we abandon the use of routine vaginal, breast, or testicular examinations as screening tests.

She also writes, '*...situations such as these also provide an opportunity for regular clinical skills practice. In the right clinical context, and in full discussion with the patient, this is also an important and valid reason for undertaking physical examinations.*' As a feminist I have some difficulty with that proposal.

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