How can we improve competence in conducting pelvic exams?

Provider discomfort with sensitive examinations of people assigned female at birth persists in our health care system and has implications on patient care. Change is needed to optimize medical student education and begin to alter the culture of reluctance around gynecological evaluations.

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A young female-identifying patient presented to an emergency department in British Columbia with several years of debilitating abdominal pain. She described severe, cramping pain in her lower abdomen that increased with menstruation. She had previously seen several physicians in the United States, including two hospital admissions, during which extensive investigations were completed. No source of her symptoms had been identified and she was relying on opioid medications to control her pain. On further history, it became apparent she had never previously been offered a pelvic examination. As a medical student with a passion for patient advocacy, hearing this story from a fellow physician shocked me. I found it difficult to conceive that despite all her assessments, admissions, and expensive tests, a simple pelvic examination had never been offered. This patient proceeded to have a complete assessment in the BC emergency department, including her first-ever pelvic examination, which led to a gynecological consultation and a diagnosis of stage 4 endometriosis.

Throughout the early stages of my medical training, I have too often encountered similar, though less egregious, situations, where the care of people assigned female at birth is compromised. Experiences like this have prompted me to consider the degree of provider discomfort with sensitive examinations that persists in our health care system and the implications it has on patient care. A search of the literature reflected this discomfort, with a median patient pickup time of 12 minutes for the chief complaint of vaginal bleeding, compared with a median of 6 minutes for all other complaints in United States emergency departments.[1] Additionally, retrospective chart reviews demonstrate that 33% to 74% of patients fail to receive a pelvic exam when one is clinically indicated.[2,3] Clearly, female patients presenting with abdominal and pelvic complaints are not receiving pelvic examinations as frequently as they should be. This raises the question: what holds physicians back from performing this vital examination?

A critical factor in determining whether a patient is offered a pelvic examination is the practising physician's ability to recognize when the exam is indicated and accurately and comfortably conduct a gynecological evaluation. To better understand the competence and perceptions toward pelvic exams that physicians hold, it is essential to explore the way in which the skill is taught and how our perceptions develop initially as medical students.

Students experience several concerns prior to performing their first pelvic examination. Sources of student anxiety include patient discomfort and fear of hurting the patient.[4] However, students who completed training with a gynecological teaching associate (GTA) experienced reduced anxiety and greater confidence while performing their first pelvic examination.[5,6] I personally found this teaching method to be very helpful, as GTAs are trained to provide real-time feedback during the examination. Learning with a GTA allowed me to gain confidence in my technique and eliminated the tendency to rush through the exam due to fear of patient discomfort.

For students to consolidate their skills, it is important for us to conduct multiple pelvic examinations in the clinical setting.[7,8] There is a strong correlation between the number of exams completed and the competence of the student.[9] However, students are allowed to participate in only approximately 60% of encounters requiring a gynecological examination during our clinical clerkship.[10] Medical students perceive several barriers

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to our involvement, including provider discomfort with the pelvic exam, residents' lack of interest in teaching, resident and staff time constraints, and patient reluctance to have a student involved.[8] Patient factors that frequently inhibit student involvement are a desire for privacy, history of sexual assault, fear of pain, and cultural beliefs.[10]

A common, modifiable concern for medical students is the way in which supervising physicians perceive and introduce us.[10] Supervisory staff expect a higher degree of patient reluctance than students do, and they frequently perceive students as less competent than we perceive ourselves.[8] Medical students have suggested that being introduced by our supervising physician as future colleagues or members of the health care team increases patient confidence and comfort in having students involved in their care.[7,8] A Canadian study also suggested the benefit of educating nurses involved in obstetric and gynecology rotations about medical student objectives to increase overall participation and skill enhancement.[8]

An additional well-known barrier to medical students performing pelvic exams is male gender. Compared with students identifying as female, students identifying as male experience a significantly higher incidence of being denied involvement in a gynecological consultation, perform fewer pelvic examinations, and report a higher incidence of discrimination by their supervising physician based on their gender.[7-9,11] The gender bias exhibited by some supervising physicians can have a significant impact on the opportunity for male students to develop their skills and build confidence in conducting pelvic examinations.

Numerous times, when a gynecological evaluation was required during my clinical clerkship, I was asked, "Will you be 100% confident in your findings, or will I have to repeat the exam?" For other examinations, I was not routinely asked this question. As I tried to advocate for opportunities to practise my skills, my supervising staff would often decline my request to perform the pelvic examination because of my lack of experience. It was a recurring and frustrating paradox that my lack of experience was a barrier to me gaining experience and confidence in conducting this crucial exam. In these circumstances, I thought there was an unsuitable balance between patient privacy and advocacy for student learning, contributing to an overall sense of discomfort and reluctance surrounding sensitive exams. Conversely, when preceptors decisively offered indicated pelvic exams and encouraged student involvement, it served to reinforce the importance of completing sensitive examinations without hesitation.

To uphold the quality of women's medical care, it is imperative that graduating medical students are comfortable performing pelvic examinations. GTA-led teaching is an impactful educational tool; however, there is clearly room for improvement in the culture surrounding gynecological evaluations in clinical practice. It is of utmost importance for physicians to clearly understand the indications for a pelvic examination and possess the ability to conduct the exam accurately and confidently, without hesitation. By intentionally exhibiting this competence and involving learners wherever possible, we can optimize medical student education and begin to change the culture of reluctance around gynecological evaluations. ■

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