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- to review the draft guidance issued by the General Medical Council
- to prepare guidance in relation to practice in obstetrics and gynaecology
- to consider the implications of the guidance for future training and research in obstetrics and gynaecology
- to make recommendations to Council within six months.

The Working Party was reconvened in 2001 at the request of Council to review the report and key recommendations contained therein.

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As of July 2001:

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Summary

General considerations

- Vaginal speculum examination and bimanual palpation of the female internal genitalia are among the most intimate and potentially embarrassing examinations carried out in clinical medicine.
- Most women will accept vaginal examination if the necessity for the procedure is explained and the examination is performed by a healthcare professional who is skilled, sympathetic and gentle.
- Prior to performing pelvic examination, it is essential for the gynaecologist to consider what information will be gained by the examination, whether this is a screening or diagnostic procedure and whether it is necessary at this time.
- Verbal consent should be obtained prior to all pelvic examinations.
- A chaperone should be available to assist with gynaecological examinations, irrespective of the gender of the gynaecologist.
- Gloves should be worn on both hands during vaginal and speculum examinations.
- Patients should be provided with private, warm and comfortable changing facilities. After undressing there should be no undue delay prior to examination. Every effort must be made to ensure that such examinations take place in a closed room that cannot be entered while the examination is in progress and that the examination is not interrupted by phone calls, bleeps or messages about other patients.

Procedure

- Pelvic examination should not be considered an automatic and inevitable part of every gynaecological consultation. However, the management of many gynaecological problems is based on competent pelvic examination preceded by an explanation of its purpose and followed by effective communication about the findings. Pelvic examination should not be carried out for non-English-speaking patients without an interpreter/advocate except in an emergency.
- Assistance with undressing should be offered if absolutely necessary.
- Gloves should be worn on both hands during vaginal examinations.
- Remarks of a personal nature should be avoided during pelvic examination.
- Throughout the examination the clinician should remain alert to verbal and non-verbal indications of distress from the patient. Any request that the examination be discontinued should be respected.
- Easily understood literature and diagrams should be provided for women undergoing invasive procedures such as colposcopy and urodynamic investigations.
- There is no scientific evidence to support the use of rectal examination as means of assessing the cervix in pregnancy or labour and, as most women find it more distressing than vaginal examination, it cannot be recommended.
Special circumstances

- When examining a woman with particular cultural or religious expectations, clinicians should be aware of, and sensitive to, factors that may make the examination more difficult for the woman.
- Women who experience difficulty with vaginal examination should be given every opportunity to facilitate disclosure of any underlying sexual or marital difficulties or traumas. However, it must not be assumed that all women who experience difficulty with pelvic examination have a background history of sexual abuse, domestic violence or sexual difficulties.
- The basic principles of respect, privacy, explanation and consent that apply to the conduct of gynaecological examinations in general apply equally to the conduct of such examinations in women who have temporary or permanent learning disabilities or mental illness.
- When examining anaesthetised patients, all staff should treat the woman with the same degree of sensitivity and respect as if she were awake.
- Exceptional gentleness should be displayed in the examination of victims of alleged sexual assault. Equally important are measures aimed at restoring the woman’s violated sense of autonomy. The woman should be given a choice about the gender of the doctor and be allowed to control the pace of, and her position for, the examination.
- Fully informed written consent must be obtained for all still or video photography. The woman’s privacy and modesty must be protected and every effort must be made to ensure that the video and photographic images have no sexual connotations.

Training

- In order to ensure that women have access to the highest standard of care, undergraduate medical students and postgraduate trainees must be taught how to perform pelvic examination with appropriate expertise and sensitivity.
- Written consent should be obtained from women undergoing procedures under anaesthesia if a medical student is to perform a pelvic examination for purposes of education and training.
- Appropriate technique, behaviour and expertise in the performance of bimanual and speculum examination is an essential part of the training syllabus for both general practitioners and specialists. Postgraduate training should comprise genuine formative assessment of skills in these areas.
- Induction courses for new house staff should include a session on the appropriate conduct of gynaecological examinations.
- Trainees should be observed performing pelvic examination and should be prepared to accept constructive criticism of their technique and communication skills.
1. **Introduction**

All medical consultations, examinations and investigations are potentially distressing, but many patients find examinations and investigations involving the breasts, genitalia or rectum particularly intrusive.

Most women will accept vaginal examination if the necessity of the procedure is explained and the examination is performed by a doctor who is skilled, sympathetic and gentle. Many women with gynaecological complaints are reassured by such an examination and the management of many gynaecological complaints can be greatly enhanced by a competent pelvic examination, preceded by an explanation about its purpose and followed by effective communication about the findings.

Some patients may, however, experience considerable distress, anger and confusion following such an examination and, despite making no formal complaint, may experience long-lasting difficulties arising from an unpleasant or traumatic examination. In response to the concerns of the General Medical Council (GMC) Fitness to Practice Committee, the GMC’s Standards Committee has issued guidelines on standards for good practice for all doctors in the conduct of such examinations. These guidelines are reproduced in Appendix A of this report. The GMC Standards Committee recommended that the Royal Colleges should also draft detailed clinical guidelines to help establish recognisable standards of good practice with respect to intimate examinations. In view of the fact that the vast majority of patients in obstetrics and gynaecology will require at least one of these examinations or investigations, the Royal College of Obstetricians and Gynaecologists welcomed this invitation to review practice and set out guidelines for optimal practice and to consider the implications of these guidelines for future training and research.

The Working Party considered that all of the following examinations and investigations relate to the practice of obstetrics and gynaecology:

- digital vaginal examination in gynaecology
- speculum examination in gynaecology
- endovaginal ultrasound examination
- colposcopy
- hysteroscopy
- urodynamic investigations
- vaginal examination in pregnancy
- manual removal of the placenta or exploration of the uterus
- inspection of the external genitalia and vaginal examination of the child or adolescent
- rectal examination in gynaecology
- rectal examination in pregnancy
- anorectal manometry and ultrasound
- administration of medications by vaginal pessary or rectal suppository
- examination of the breasts in gynaecology
- examination of the breasts in pregnancy
- mammography.
Specific consideration was given to any of the above procedures in:

- the unconscious or anaesthetised patient
- adolescents
- mentally ill patients
- patients with learning disabilities
- women from ethnic minorities
- women who have previously had a traumatic intimate examination or who have been sexually assaulted in the past.

Obstetricians and gynaecologists may either be directly responsible for good practice in these areas because they or the trainees under their supervision perform these procedures or they may be vicariously responsible for the practice of midwives, nurses, radiographers, radiologists and anaesthetists who perform procedures instigated by them.

The working party also addressed the issue of training and supervision of undergraduate medical students and postgraduate trainees in obstetrics and gynaecology in the performance of intimate examinations.

2. Chaperones

The guidelines issued by the GMC’s Standards Committee suggest that, wherever possible, patients undergoing an intimate examination should be offered a chaperone or invited to bring a relative or friend to the consultation (Appendix A). These guidelines have been incorporated by the Royal College of Physicians in their guidelines for training for all specialties (1996).

In a study of male and female adults and teenagers in a general practice setting in the USA, Penn and Bourguet found that the majority of patients, of either sex and of all ages, did not express a strong opinion on the presence of a chaperone. However, substantial proportions of adult women (29%) and female teenagers (46%) preferred that a chaperone be present during a breast, pelvic or rectal examination by a male physician; 36% of adult women and 63% of female teenagers wanted a chaperone present during a first examination of these regions. Adults of both sexes thought that the nurse would be the best chaperone, whereas teenagers ranked a parent first and the nurse second. Patients indicated that they felt comfortable asking for a chaperone.

Phillips et al. assessed the attitudes of teenagers of both sexes to chaperones during intimate examinations. Young males and females strongly preferred to be accompanied, generally by a family member. With increasing age, males preferred to be alone with the physician whereas females preferred to be accompanied. Regardless of sex and age, virtually none chose the company of peers.

The US literature indicates that male paediatricians and specialists in adolescent health are more likely to use a chaperone during pelvic examination of adolescent females, but a surprisingly high proportion of male doctors from these specialities do not use chaperones. In a survey of general practitioners in the UK, Speelman et al. found that 75% of female and 21% of male general practitioners never use a chaperone when performing intimate
examinations on patients of the opposite sex. None of the female doctors and 16% of the males always offered a chaperone in these circumstances. Only 1% of respondents did not have a practice nurse.

The advantages of chaperones are self-evident. Chaperones are the ultimate safeguard for the patient against abuse during examination. Great emphasis is given to the role of the chaperone in protecting the patient against sexual abuse but this is probably very rare. A more important role for the chaperone may be the protection of the patient against other forms of real or perceived abuse. The presence of a chaperone acts as a safeguard against a doctor causing unnecessary discomfort, pain, humiliation or intimidation during examination. A chaperone may provide reassurance to an anxious patient. On occasions when the doctor’s attention is focused on performing procedures such as colposcopy or hysteroscopy, the nurse-chaperone may maintain communication and eye contact with the patient. A chaperone may assist an infirm or disabled patient with dressing and undressing. Obviously, the presence of a chaperone protects doctors against false allegations of sexual abuse. The medical indemnity organisations consider the presence of a chaperone helpful in the defence of a doctor against an allegation of sexual misconduct during an intimate examination. However, allegations of this kind are extremely rare and it is important that this aspect of using chaperones does not receive unnecessary emphasis. Such a public perception could reduce the chaperone’s ability to fulfil the roles described above.

There are theoretical disadvantages of a chaperone being present during a gynaecological examination. Gynaecological consultations occasionally provide an opportunity for women to confide deeply sensitive information about sexual abuse, previous termination of pregnancy or domestic violence. The presence of a chaperone may intrude in a confiding doctor–patient relationship and may lower a doctor’s acuity in detecting non-verbal signs of distress from the patient. This drawback is potentially offset by confining the presence of chaperones to the physical examination and allowing one-to-one communication for the consultation. Some patients’ levels of embarrassment may increase in proportion to the number of individuals present during an examination.

While some patients may welcome the presence of a family member acting as chaperone, there are potential disadvantages. The presence of a family member may reduce the likelihood of disclosure of sensitive information and delay the development of self-confidence in young women. The presence of a dominant male partner may inhibit communication about past gynaecological or obstetric history, marital or sexual problems or domestic violence. An accompanying female relative may bring to the consultation her own agenda of prejudices and fears about gynaecological examinations. It is the view of the Medical Protection Society that a family member would not fulfil their criteria for a chaperone, which they define as ‘someone with nothing to gain by misrepresenting the facts’.

After careful consideration, the Working Party recommends that a chaperone should be available to assist with gynaecological examinations irrespective of the gender of the gynaecologist. Ideally, this assistant should be a professional individual. However, the Working Party is aware that the costs of employing
a nurse or other suitable individual for this purpose may be a deterrent for small or charitably funded clinics and accepts that a secretary or receptionist, or otherwise a friend or family member, could act as a chaperone in these circumstances. For women who require an interpreter, a friend or volunteer may fulfil the role of both chaperone and interpreter.

3. Pelvic examination in the gynaecological patient

3.1 Guidelines

There is a need for guidelines relating to the performance of courteous, gentle and informative speculum and bimanual examinations, which it is hoped will be particularly helpful to relatively inexperienced practitioners and students.

In the course of a gynaecological consultation, it is usually best if the history is taken with only the patient present, as this will afford maximum confidentiality and enable the doctor to gain the patient’s confidence. Pelvic examinations, whether by male or female doctors, nurses or midwives, should, however, normally be performed in the presence of a female chaperone preferably unrelated to the patient. Women who require an interpreter or who communicate using sign language will obviously require an interpreter during both history taking and examination (see section 5).

Pelvic examination should not be considered an automatic and inevitable part of every gynaecological examination. Prior to performing pelvic examination, it is essential for the gynaecologist to consider what information will be gained by the examination and whether the same information is already available or is going to be obtained from another source such as ultrasound or examination under anaesthesia, regardless of the findings during clinical examination. It is useful to consider whether the planned examination is a ‘screening’ or a ‘diagnostic’ test. A skilled and gentle pelvic examination is a necessary and important part of the diagnosis of most gynaecological conditions. However, the predictive value of ‘routine’ bimanual pelvic examination as a screening test in asymptomatic women is very poor. The low productivity of pelvic examination in the asymptomatic young woman prior to commencing use of the oral contraceptive pill makes it difficult to justify such an examination, which may deter uptake of contraception in vulnerable young women. The British Society for Colposcopy and Cervical Pathology considers that bimanual examination of the pelvis should be performed in a woman attending for colposcopy only if indicated.

In symptomatic women, appropriate digital or speculum examination can be productive, for example, in assessing a patient with uterovaginal prolapse or in evaluating a patient with dyspareunia. Explanation about the contribution of the pelvic examination towards a diagnosis in the context of the presenting complaint is an essential part of the preamble to obtaining informed consent for examination. Verbal consent should be obtained prior to all pelvic examinations.

Patients should be provided with private, warm and comfortable changing facilities. Provision should be made for clothing to be laid aside appropriately and for the disposal of sanitary towels, tampons or incontinence pads.
undressing there should be no undue delay prior to examination. The practice in some outpatient clinics of interviewing one patient while another is waiting for examination may save a small amount of time but increases anxiety, conveys the impression of a conveyor belt and may lead to consultations being overheard. Gowns provided for outpatient gynaecology patients should be comfortable and compatible with modesty. Improvements in the design of gowns have been shown to reduce anxiety.10

Some patients will welcome a choice between donning a gown or continuing to wear some of their own clothes, e.g. a wide skirt with underwear removed. Alternatively, they may welcome the opportunity of bringing their own robe. Muslim women will wish to continue to wear their head attire.

The woman should be given every opportunity to undress herself with assistance from a nurse, chaperone or relative if this is necessary due to infirmity. No assistance should be given with removing underwear unless absolutely necessary.

Every effort must be made to ensure that gynaecological examinations take place in a closed room that cannot be entered while the examination is in progress and that the examination is not interrupted by phone calls, bleeps or messages about other patients. In addition to the explanation given prior to the examination, it may be helpful to give a running commentary on what is being done during the examination.

Terms of endearment such as ‘pet’, ‘love’ or ‘dear’ should be avoided during consultations, especially while performing pelvic examination. It is probably better to avoid the use of first names under these circumstances also. No remarks of a personal nature should be made during the examination, even if they may be clinically relevant. For example, advice about the risks of sunbathing prompted by the presence of a deep suntan should be given after the examination has concluded. Similarly, no comment or discussion about body weight should take place while the woman is undressed, despite its relevance to gynaecological problems.

Poor self-esteem and embarrassment may deter obese women from attending gynaecologists.11 In the assessment of a woman with dyspareunia, valuable information may be obtained by assessing the ability of digital examination to reproduce the discomfort. This is the only situation in gynaecological practice where sexual problems should be discussed during the examination as opposed to before and afterwards. It should be very clear to the patient that any questions asked during the examination are entirely technical, relating to the site and quality of the pain, and that the woman’s feelings and sexual response are not being discussed.

Throughout the examination, the doctor should remain alert to verbal and non-verbal indications of distress from the patient. Doctors who are trained to combine the physical examination with an awareness and acknowledgement of the patient’s feelings will learn more about the patient and give rise to fewer complaints.
The reasons for carrying out a speculum examination must be clearly explained to the patient and her verbal permission sought. As the object of speculum examination is inspection of the vulva, vagina and cervix, it may not necessarily be appropriate for such an examination to accompany bimanual palpation on every occasion. It may not, for example, be necessary for a patient being followed up subsequent to surgery for ovarian malignancy to have a speculum examination carried out, whereas it would be appropriate for such a patient to be examined bimanually.

Obviously, inspection of the clitoris is indicated in some cases of vulval cancer, female genital mutilation and congenital adrenal hyperplasia. In the course of routine pelvic examination, however, care should be taken to avoid digital contact with the clitoris.

3.2 Position for pelvic examination

The patient must be reassured and told what is about to happen at every stage of the examination. She will be asked to lie in an appropriate position for the examination. Usually the dorsal position is chosen for examination with a Cusco speculum. The Sims or left-lateral position is used for Sims speculum examination. The full lithotomy position is rarely used in the UK unless the examination is being performed as part of a colposcopic assessment of the lower genital tract. In a survey of practice in Great Britain, Amias noted that the choice of position for digital and speculum examination was determined more by habit and geography than by practical clinical considerations. Seymore et al. showed that pelvic examination in the semi-sitting position provoked less anxiety than examination in the supine position.

Whatever position is used, the patient must be made comfortable and provided with as much covering as feasible. It may be easier to preserve an appropriate degree of modesty with the patient lying on her side than on her back, but many women find an unseen approach from the rear most alarming and are less certain where the finger or speculum is going. It may be helpful in certain clinical scenarios to examine the patient in a standing position. Careful thought should be given to the necessity for this and to its appropriate conduct to minimise the additional embarrassment it is likely to induce.

3.3 Vaginal specula

Of the many forms available, the Cusco bivalve speculum and the Sims speculum are the most commonly used, the Cusco being particularly appropriate for cervical inspection and the Sims if a speculum examination is being performed as part of a full gynaecological examination in cases of suspected uterovaginal prolapse and urinary fistula. Specula should be warm but not excessively so. If they are of the metal variety and kept following sterilisation on a cloth over a radiator, held under a warm tap for a few moments or held in the doctor’s gloved hand prior to insertion, the degree of warming will usually be adequate. The temperature of the speculum should be checked after any procedures aimed at warming it to ensure it has not become excessively hot.

It is essential that an appropriate size of speculum be used and this may mean that a single-finger assessment of the introitus will need to be performed prior to selecting a speculum. This is particularly important in post-menopausal
women or post-operative patients in whom there may be some narrowing of the introitus. A small speculum may be required in the nulliparous or virginal woman, although such examination is rarely indicated in a virgin.

Specula appear to some patients to be large, cumbersome and potentially painful instruments – they must be used with gentleness and sensitivity. There is no excuse for fumbling with the instruments. If the examiner is relatively inexperienced in the use of specula, it is essential that he or she practises assembling the instruments prior to insertion rather than subsequently fumbling and causing distress. Some of the disposable plastic devices have a noisy ratchet device which some patients might find unnerving – the ratchet strip can be broken and the speculum used without it if need be. The use of a water-based, non-sticky lubricant such as one of the proprietary clear gels is advisable.

3.4 Performing a vaginal speculum examination

Gloves should be worn on both hands by the examining doctor for all vaginal and speculum examinations.

The patient must be told about each manoeuvre prior to it being undertaken. When she is in an appropriate position and is comfortable, she should be told that the examiner is going to examine the vulva, separate the labia and insert the speculum. It should be inserted to its full length and then gently opened, enabling inspection of the cervix. If the cervix is pointing anteriorly, such as would commonly be the case with a retroverted uterus, or deviated to one or other side, a certain amount of adjustment of the position of the blades may be necessary and this should be carried out with great gentleness. Sometimes it will be necessary to use a blunt instrument such as a sponge-holding forceps to gently move the cervix clear of the tips of the speculum blades if an adequate view is to be obtained. Sometimes the speculum is introduced too far and is in either the anterior or posterior fornix. In this case, the cervix will only appear if the speculum is gently opened and withdrawn.

The examination may now proceed, with the taking of swabs from the posterior vaginal fornix or the endocervical canal, if appropriate, and the taking of a cervical smear, should this be indicated. It may be necessary to mop secretions from the cervix in order to obtain a good view of its epithelium. It is important that the patient be told of all these manoeuvres before they are carried out in understandable and non-patronising language. When the operator is happy with the information obtained from speculum inspection of the cervix, the instrument will be slowly and gently withdrawn and the vaginal walls inspected during its withdrawal. There is a danger of trapping the cervix between the blades of the speculum if it is not held open a little as it is withdrawn.

Taking cervical smears is a separate subject and one of some complexity. Suffice it to say that appropriate sampling devices must be used and the whole range must be available, including spatulas with short and long tongues as well as endocervical brushes. The patient must be warned in advance if the operator is about to take a smear, as some discomfort can result, especially if an endocervical brush is used. She should also be told that there may be some bleeding following the taking of a smear and reassured that this is not usually of any clinical significance.
3.5 **Bimanual abdominal/vaginal examination**

This is considered by most women to be the most intimate of examinations and its use should be restricted to occasions when it is necessary that such an examination be performed. There are occasions when a speculum examination alone may be carried out but, in a woman with gynaecological symptoms, the two should usually be combined. In order to minimise the inevitable discomfort of bimanual examination and to obtain the most information from the procedure, it is important that the bladder is empty.

Gynaecologists should be trained to perform bimanual examination in both the left lateral and the dorsal position, in order to cater for the patient’s personal preference. The dorsal position is probably the most commonly used but some may feel that the left lateral or Sims position possibly allows the patient to preserve a greater degree of modesty. There may also be more abdominal-wall muscle relaxation in this position. Bearing in mind that it is the abdominal hand that does most of the palpating, it is obviously necessary for as much abdominal-wall relaxation to be obtained as is possible. Some patients find it extremely difficult to relax when being subjected to what for them is a most embarrassing procedure. Every effort should be directed to gain the patient’s confidence and reduce her anxiety.

It is important that abdominal palpation as part of the bimanual examination procedure commences with the ‘abdominal’ hand relatively high on the abdominal wall, as it would otherwise be possible to miss substantial masses arising from the pelvis. Feeling the outline of the uterus is best achieved by using the vaginal finger or fingers to elevate and bring forward the uterus by means of gently exerting pressure on or behind the cervix. It is not always mandatory to insert more than one finger, especially in very slim patients. Most students and junior doctors will require a considerable amount of practice before they can accurately and consistently delineate the uterine size, shape and contour, especially if the uterus is retroverted.

In addition to these features, it should be possible for the examiner to form an impression of the degree of mobility or fixity of the uterus. Following examination of the uterus, the adnexa are palpated bimanually. Normal-sized ovaries may not be palpable, especially in the overweight or postmenopausal patient. The right ovary is more readily palpable than the left, which may be difficult to feel if it is lying behind the bowel, particularly if the bowel is loaded. Clinical evidence of solid or cystic adnexal masses may also be detected, together with evidence of ‘cervical excitation pain’, produced by gently moving the cervix and putting the adnexal structures slightly on the stretch.

All these procedures must be carried out with extreme gentleness but even if this is achieved and even if a major degree of patient confidence is also obtained, there will inevitably be some discomfort associated with bimanual palpation. The examination may also be uninformative, particularly if the patient is obese or very tense and anxious.

At the conclusion of speculum or bimanual examination, the patient should be given some tissue with which to remove any remaining lubricating gel. Ideally, washing facilities and a mirror should be provided so that the patient can dress...
in comfort and privacy. Thereafter she should be told of the examiner’s findings, once she is seated back in the consulting room. Although the patient, particularly if elderly, may appreciate the presence or help of a nurse or chaperone while she is dressing, it is generally preferable if the consultation subsequent to examination is conducted with only the doctor and patient present, for reasons of confidentiality, unless of course the patient wishes otherwise or needs the services of an interpreter or sign language.

3.6 Rectal examination
Rectal examination may be indicated if there are symptoms such as change of bowel habit or rectal bleeding, which may suggest bowel disease. It is occasionally used as a means of assessing a pelvic mass in a virginal patient but many young women find this unacceptable. Rectal examination should be carried out with the patient in the left-lateral position. Proctoscopy, as well as digital examination, may be required if the symptoms are of rectal bleeding. Anorectal lesions such as anal fissures may be exquisitely tender and it is important that a thorough explanation be given to the patient with regard to the need for the examination. Extreme gentleness must be used during the examination and a full account of the clinical findings given to the patient. If there is any suggestion of significant bowel pathology, the opinion of a colorectal specialist should be sought.

4. Specific procedures and investigations in gynaecology

4.1 Colposcopy
Referral for colposcopy following abnormal cervical cytology is distressing and can lead to anxiety and psychosexual problems.14 The need for examination in the lithotomy position, the fear of malignant disease and an awareness of the association between cervical neoplasia and sexual transmission of disease combine to make this potentially one of the most traumatic investigations in gynaecology. The guidelines for good practice laid down by the National Health Service Cervical Screening Programmes in conjunction with the British Society for Colposcopy and Cervical Pathology9 are a model for the appropriate conduct of all intimate examinations and should be followed. Many of these guidelines are applicable to the conduct of analogous clinics, such as urogynaecology and outpatient hysteroscopy. They emphasise the need for an appropriate clinical environment with adequate privacy, changing facilities and a suitable couch. The Working Party endorses the recommendations for easily understood written and verbal information prior to and during attendance at a colposcopy clinic and the exclusion of any questions about the woman’s sexual history.

Informed consent for the colposcopic examination itself, and also for any destructive or ablative treatment at the same visit (the ‘see and treat’ approach), must be sought before the woman has undressed and sat on the colposcopy couch. It would be inappropriate to obtain consent for a procedure while the woman is already on the couch or in lithotomy position.

4.2 Hysteroscopy and outpatient endometrial biopsy
Outpatient hysteroscopy and endometrial biopsy are now a routine part of the investigation of menorrhagia, intermenstrual and postmenopausal bleeding in most units. Patients should be appropriately selected and well prepared for
this procedure. The provision of written material prior to clinic attendance and an adequate verbal explanation prior to starting the investigation is essential. Facilities and comfort should be of the same standard as for colposcopy. The presence of a fully trained nurse familiar with the procedure is essential, so that a chaperone will always be available.

### 4.3 Urodynamic investigations

These investigations are conducted by gynaecologists, urologists or nurse practitioners. The need for the modified lithotomy position, the insertion of rectal and urethral transducers and the requirement to micturate in public make this another embarrassing and undignified procedure. Once again, the provision of appropriate written information in advance and the presence of an encouraging nurse-chaperone may make the procedure less of an ordeal.

### 4.4 Endovaginal ultrasound examination

Transvaginal ultrasound has been found to carry many advantages over an abdominal approach. For example, the use of a vaginal probe overcomes the need for a full bladder and the poor resolution experienced with transabdominal ultrasound in obese patients. The deeper parts of the pelvis may be visualised accurately. It has become a standard preliminary investigation of many gynaecological problems, including menorrhagia, suspected pelvic masses and first-trimester bleeding.

While this technique is usually well accepted by patients, the fact that it is a much more invasive examination than transabdominal ultrasound must be borne in mind. Women who have never experienced ultrasound examination before or whose previous ultrasound experience consisted of transabdominal ultrasound may be taken aback by the appearance and use of the transvaginal probe and by the condom-like sheaths used to cover the probe. This examination is increasingly performed by a gynaecologist in an outpatient clinic but may be performed by a radiographer or radiologist. The gynaecologist initiating this investigation has a responsibility to explain to the patient what is entailed and to ensure that this investigation is not attempted in women for whom it is obviously inappropriate, such as women with an intact hymen, elderly women with a narrow atrophic vagina, women with radiation stenosis or vaginismus. If there is uncertainty as to the suitability of the woman for transvaginal ultrasound, preliminary digital vaginal examination by a gynaecologist is essential. The College of Radiographers has issued clear guidelines on the use of transvaginal ultrasound:

- Informed consent must be sought by the radiographer who is to perform the scan and the wishes of the woman must be respected. She must not feel unduly pressurised or coerced by the radiographer into having transvaginal ultrasound; rather, the radiographer must be positive and informative about the procedure.
- A written policy relating to the chaperoning of radiographers, regardless of their gender, should be agreed locally and women using the ultrasound service must be made aware of it.
- Wherever possible, transvaginal ultrasound should take place in a closed room where maximum privacy may be ensured.
The Working Party regards the presence of a chaperone as particularly important, as the radiographer or radiologist may be an unfamiliar person and the examination usually takes place in a dimly lit room. There was a unanimous view that the examination must take place in a ‘closed room’ on all occasions rather than ‘wherever possible’.

4.5 **Anorectal ultrasound and anorectal manometry**

These investigations now form part of the evaluation of anal incontinence in women. It is important that the referring gynaecologist explains the nature and purpose of these investigations to the woman. Again, informed consent should be sought by the individual performing the investigations, who should be accompanied by a chaperone.

5. **Intimate examinations in special circumstances**

5.1 **Ethnic, cultural and religious considerations**

The ethnic religious and cultural background of some women can make gynaecological examinations particularly difficult and some examples are given below.

Muslim and Hindu women have been brought up with a strong cultural taboo against being touched by any man other than their husbands and have a clear preference for women doctors when such examinations are necessary. In general practices or hospital clinics where this request is difficult to meet, it may be possible to staff a clinic with a female doctor on an occasional or sessional basis, e.g. one gynaecology clinic every two weeks. Community representatives with whom the Working Party consulted agreed that women from these cultural and religious backgrounds would accept the need to be examined by a male doctor in an emergency or as dictated by unavoidable clinical circumstances.

Evidence was given to the Working Party that cultural and religious factors make nudity particularly difficult and embarrassing for some women; for instance, inspection of the breasts requiring a woman to undress to the waist and sit upright with her arms behind her head. All sensible measures to reduce the extent and duration of nudity should be taken which do not jeopardise the thoroughness of the examination; for example, uncovering only one part of the body at a time.

As with all women, an adequate explanation of the nature and purpose of the examination given before the woman undresses will usually reduce anxiety. The presence of a female chaperone is regarded as essential. A nurse or healthcare assistant should be used in this role, as most women would find examination in the presence of a friend or family member embarrassing. A link worker or professional interpreter should be present when examining non-English-speaking patients, except in an emergency. Having a family member acting as interpreter is not ideal. The Asian Family Counselling Service is aware of rare cases where a family member has wittingly or unwittingly altered the sense of an interpreted conversation with a health professional.

Every effort should be made to provide translations of all written material on procedures, such as colposcopy, hysteroscopy and urodynamic studies, for women who are unable to read or understand English.
Many religions, including Islam, Hinduism and Orthodox Judaism, incorporate particular taboos about menstruation. For instance, Hindu women are barred from the kitchen at this time. For women from these cultural backgrounds, a pelvic examination during menstruation would be unacceptable, except in a medical emergency. As these taboos may extend to the presence of any bleeding from the vagina, women should be warned of the possibility of vaginal bleeding occurring after having a cervical smear performed.

Understanding of and sensitivity to such cultural considerations should be incorporated into the training of medical students and postgraduates.

5.2 The first vaginal examination

The conduct of the first vaginal examination may influence the young woman’s confidence in and uptake of gynaecological and family planning services for the rest of her life. As with all medical interventions, it is worthwhile taking a moment to consider the necessity for the examination, whether it is a screening or diagnostic procedure and its likely productivity. Digital or speculum examination is almost never indicated in a young woman who has not yet had sexual intercourse. The productivity of ‘routine’ examination prior to prescribing the oral contraceptive pill for the first time is extremely low. It is essential that teenagers are aware that prescription of the oral contraceptive pill is not conditional on undergoing a pelvic examination. There is no justification for taking cervical smears in teenagers. The British Society for Colposcopy and Cervical Pathology recommends that calls for routine cervical cytology should be initiated after a woman’s 20th birthday and before her 25th birthday.

Many young women approach the first vaginal examination with preconceptions that must be dispelled prior to proceeding with the examination. A study of a random sample of Danish teenagers found that, among those who had not had a pelvic examination, 48% thought the examination would be painful, 29% feared that the doctor would discover abnormal anatomy, 67% felt they would be embarrassed by exposing their genitals and 23% expected to be indisposed for the rest of the examination day. Against this background, it is obvious that the first vaginal examination must be used as an educational opportunity. Extra time must be devoted to an explanation of the purpose and nature of the pelvic examination. Such examinations are ideally carried out in a family planning clinic or adolescent gynaecology clinic by individuals with experience of taking adolescents through the first vaginal examination.

Following an explanation of the nature of vaginal examination, the first vaginal examination should begin with inspection of the external genitalia and reassurance about anatomical normality. The use of a mirror may be helpful. A gentle one-finger examination is necessary to establish whether the hymen is present or not. If speculum examination is being performed for the first time, it may be useful to demonstrate the speculum to the patient prior to the examination and to allow her to handle it. A small warmed, lubricated speculum is used. Some women are able to insert the speculum themselves and this technique has been found useful in forensic examination of women who have been raped or sexually abused.
In a particularly apprehensive woman, the process of the first pelvic examination may be spread out over a number of consultations, starting with information, working through inspection of external genitalia, handling of specula, to digital and speculum examination with the patient being given the option to halt, defer or proceed with each step. In a symptomatic young woman, especially presenting as an emergency, such an approach may not be practical.

5.3 Patients who experience difficulty with pelvic examination

A woman experiencing difficulty with vaginal examination may present in a number of ways. She may give a history suggestive of vaginismus or of rape, sexual abuse or domestic violence, or of a previously traumatic vaginal examination or psychologically or physically traumatic childbirth. Alternatively, there may be no evidence of a problem until vaginal examination is commenced. At examination she may exhibit great anxiety with hyperventilation, tearfulness or a ‘frozen’ or unusually detached attitude. Vaginal examination may be made difficult or impossible by inability to relax or abduct the thighs.

The best way to proceed in these cases will vary but it may be to abandon a ‘difficult’ examination and invite the patient to dress and then discuss the problem. A key factor is the nature of the presenting complaint. When the gynaecological presentation has been a request for screening or for management of a chronic problem such as infertility, investigation and management of the difficulty with vaginal examination can take priority. If, however, there is a significant or acute gynaecological complaint then its investigation and management must proceed, compensating for the information lacking because of failure to perform pelvic examination. The presence of a significant or acute gynaecological problem may mandate the use of pelvic (but not transvaginal) ultrasound or laparoscopy. A complaint of abnormal vaginal bleeding in a woman in whom speculum examination is impossible may require examination under anaesthesia. Following investigation and management of the acute problem, appropriate steps should be taken to address the underlying difficulty with vaginal examination.

Women who experience difficulty with vaginal examination should be given every opportunity to facilitate disclosure of any underlying sexual or marital difficulties or traumas. A calmly articulated statement such as ‘some women who find internal examinations difficult feel this was caused by something that happened to them in the past’ may open up a taboo subject for discussion. None of these discussions should take place until the woman is fully dressed and alone with the doctor. It must not be assumed that all women who experience difficulty with pelvic examination have a history of sexual abuse, domestic violence or sexual difficulties. It is important that they are not badgered into admitting to a problem when none exists.

A multidisciplinary approach may be necessary, with referral to the appropriate agencies for women traumatised by sexual abuse or domestic violence and for those requiring psychosexual counselling. Rehabilitation of a woman following a previously traumatic pelvic examination requires a detailed discussion of the circumstances in an attempt to identify which
elements of the examination caused distress. Many patients who are unable to have pelvic examination or who are unduly distressed by it can be helped to cope with the process. A modified behaviour therapy approach can be used to overcome anxiety. The woman may make one or more visits to the clinic when no examination takes place. Later she may be able to undress but not to proceed with examination. She should be given the opportunity to progress at her own pace through a hierarchy of increasingly more intrusive components of the pelvic examination. For instance, she may be encouraged to learn how to insert her own finger into the vagina prior to allowing the doctor to perform a digital examination. Handling the vaginal speculum and inserting it herself may help to reduce anxiety. These cases are rare, time-consuming and challenging for the professionals involved. Hospital-based gynaecology clinics may not be the ideal setting for this process and it may be handled more successfully in a general practice, family planning or community gynaecology clinic or by doctors trained in psychosexual medicine. Key factors for success in such cases are patience and continuity of care. The approach to the problem must be individualised and flexible, with constant emphasis on the woman's own autonomy and control over the process.

5.4 Pelvic examination of women with learning difficulties or mental illness

The basic principles of respect, privacy, explanation and consent that apply to the conduct of intimate examinations in general apply equally to the conduct of intimate examinations in women who have temporary or permanent learning disabilities or mental illness. A familiar individual such as a family member or carer may sometimes be the best chaperone in this situation. Many women in these groups are competent to consent to gynaecological examination, especially if a common vocabulary can be established between the doctor and patient. While these women may not be able to understand the concepts of cervical screening, a doctor may include these patients in the National Cervical Screening Programme if that is seen to be in the best interests of the patient and she is able to consent to and tolerate speculum examination. Where consent cannot be obtained due to severe disability or illness or unconsciousness, it is good practice to consult with those close to the patient, although legally nobody can give consent to treatment on behalf of another adult.18 In the absence of informed consent for any of the procedures listed as intimate examinations, the doctor must act in the patient’s best interests, giving careful consideration to whether the proposed examination is screening or diagnostic in intent. Resistance to pelvic examination should be interpreted as refusal. If the procedure has to be abandoned, alternative measures should be taken as necessary for the patient’s health.

5.5 Intimate examinations of the anaesthetised patient

Informed consent must be obtained for any intimate examinations that are undertaken under anaesthesia. It is good practice for all personnel in the operating theatre to treat the patient with the same gentleness and respect that they would apply were she awake, avoiding personal comments and protecting the patient’s modesty wherever possible. Women who are asked to walk to the operating theatre for surgery should be provided with dressing gowns. Women should be given the option of removing their own underwear prior to anaesthesia. If a woman chooses to wear disposable underwear to theatre, this should be removed by a female staff member.
5.6 Consent for the insertion of rectal suppositories under anaesthesia

Many medications, in particular analgesics, anti-emetics and anticonvulsants are administered by rectal suppository. Many patients in the UK are unfamiliar with this route of drug administration. A survey of 100 adult patients attending hospital for daycase surgery showed that over 50% of them did not wish to have medications administered rectally and almost all of them thought that the matter should be discussed with them beforehand. Some patients expressed very strong objections to rectal drug administration. In 1994, a consultant anaesthetist administered a diclofenac suppository for post-operative pain to a woman undergoing dental extraction under general anaesthesia. He did not seek the patient’s consent preoperatively but told her afterwards what had been done. Charged before the Professional Conduct Committee of the General Medical Council with failure to obtain consent and assault, the anaesthetist was found guilty of serious professional misconduct and admonished. Non-steroidal anti-inflammatory agents are commonly administered to women undergoing gynaecological procedures with or without general anaesthesia. Clearly, consent should be obtained from women beforehand by the doctor responsible. Some anaesthetists offer the woman the option of inserting the suppository herself shortly before the procedure. This practice may be more acceptable to many women.

5.7 Examination of an adult victim of an alleged sexual offence

The examination of a woman following an alleged sexual offence should usually be carried out by a doctor who has received specific training in the appropriate conduct of such an examination and in the collection of forensic evidence. However, circumstances may arise where a gynaecologist may be called upon to fulfil this duty, particularly when the victim is brought to a gynaecology department because of injury or where a request from the victim for examination by a female doctor cannot otherwise be honoured. A detailed account of the appropriate conduct of this examination is available elsewhere. Calls to such cases should be dealt with speedily, as undue delay may add to the distress of the victim and lead to a loss of potentially valuable forensic evidence. These patients should be handled sympathetically and should never be made to feel that their complaint has been doubted. A specially trained woman police officer will be made available to befriend and support the victim, chaperone and assist the examining doctor and ensure appropriate procedures are followed with respect to the preservation of the chain of evidence.

Consent for the examination and collection of forensic evidence must be obtained by the doctor and must never be assumed. The process of and reasons for the whole examination must be explained to the woman who should be informed that there is no obligation to consent. She must be made aware of the fact that the information from the examination will be passed on to the police, the courts and thereby, possibly, to the defendant. Written consent for examination is preferable under these circumstances.

Every effort should be made to establish a rapport with the woman before the examination commences and to make the examination the first step in a healing process rather than a continuation of the assault. Obviously, the examining doctor should display exceptional gentleness. Equally important
are measures aimed at restoring the woman’s violated sense of autonomy. The woman should be allowed to control the pace of the examination and given a choice about examination positions. Most gynaecologists would dispute the necessity for the examination in lithotomy position advised by Howitt and Rogers. The woman should be assured of her right to stop the examination at any time. Respect for her modesty is essential. At no time should she be subjected to total nudity.

Following the completion of the examination, arrangements are made for any medical treatment necessary. Postcoital contraception with verbal and written information is offered if indicated and screening for sexually transmitted disease organised. Referral to an appropriate agency for psychological counselling and support is arranged.

6. Examinations in pregnancy

6.1 Vaginal examination in pregnancy

There is no scientific evidence to support the use of ‘routine’ vaginal examination at the first antenatal visit. Clinical pelvimetry is not a valid means of predicting outcome of labour. Speculum examination may be necessary if cervical cytological screening or screening for bacterial vaginosis is indicated. ‘Routine’ vaginal examination later in pregnancy is practised widely in some European countries. There is no evidence that it reduces the risk of preterm labour or has any effect on pregnancy outcome. Three-quarters of the women interviewed as part of the randomised trial of routine vaginal examination in pregnancy rated the vaginal examinations as the most unpleasant aspect of their pregnancy care. Digital or speculum examination may be indicated in the evaluation of early pregnancy bleeding, the assessment of possible cervical incompetence, the assessment of the cervix prior to induction of labour or premature rupture of the membranes.

There is no scientific evidence to support the use of rectal examination as a means of assessing the cervix in pregnancy or labour and, as most women find it more distressing than vaginal examination, it cannot be recommended.

All the courtesies, explanations and need for privacy described for gynaecological examinations apply equally to the pregnant woman. As pregnancy advances, digital or speculum examination may become increasingly uncomfortable due to engagement of the head or the need to reach a posterior cervix.

A small proportion of women will find vaginal examination extremely difficult. This may be due to vaginismus relating to a previous traumatic vaginal examination, to previous sexual abuse or for reasons that are not known to either the woman or her doctor. In some cases, vaginal examination can be successfully accomplished following discussion and an agreement that it will be abandoned if it becomes intolerable. In cases where it remains impossible, alternative strategies need to be adopted. If the examination is required with a view to induction of labour the cogency of the indication for delivery should be reviewed. If there is an incontrovertible indication for
delivery, it may be necessary to proceed with epidural analgesia prior to performing vaginal examination, recognising that this may commit all involved to early delivery. Women who manifest a significant difficulty with vaginal examination during pregnancy should be invited to return after delivery for review by a gynaecologist, family planning specialist or general practitioner who has an interest in this problem.

6.2 **Vaginal examination in hospital**
A curtained-off bed in an antenatal ward or shared labour ward affords insufficient privacy for vaginal examination, especially if other patients or their partners are within earshot. A suitable examination room should be provided on all antenatal wards and labour wards and, with the exception of emergencies, women should be transferred to a private area for pelvic examination.

6.3 **Manual removal of a retained placenta**
Women who undergo manual removal of a retained placenta under epidural or spinal anaesthesia occasionally report a sense of personal violation because of the uniquely penetrative nature of the procedure. Adequate explanation, gentleness and support from attending midwives during the procedure will usually prevent this from being a traumatic procedure. However, fully informed consent may not be possible in the presence of postpartum haemorrhage. The obstetrician performing the procedure or a midwife familiar with the woman and her labour should visit the woman prior to discharge from hospital to ascertain that there is no residual confusion, anger or trauma.

6.4 **Abdominal examination in pregnancy**
Palpation of the pregnant abdomen and obstetric ultrasound examination require exposure of the abdomen from the costal margin to the pubic hairline. Patients should be invited to expose the abdomen without assistance from the obstetrician. She should be covered with a sheet or blanket, up to the level of the upper border of the pubic symphysis, to avoid unnecessary exposure.

As with the gynaecological examination, comments of a personal nature should be avoided while the patient is undressed. The Working Party does not consider it necessary for a chaperone to be present during abdominal palpation or ultrasound examination of the pregnant abdomen.

7. **Breast examination in obstetrics and gynaecology**

7.1 **Breast examination in gynaecology**
Breast examination may be performed in the gynaecology or family planning clinic, either as a screening procedure or as a diagnostic examination in a woman with relevant symptoms. The American College of Obstetricians and Gynecologists regards breast examination, inspection and palpation as an integral part of complete obstetric and gynaecological examinations. Among obstetricians and gynaecologists in the UK, practice varies. Many women expect breast examination to be included in a gynaecological examination. Obviously, breast examination is essential when the woman reports the presence of a relevant symptom. However, there is no evidence that mortality from breast cancer can be reduced by any screening procedure in women below 50 years of age.25 In women over 50 years, breast screening is effective but clinical...
examination has been evaluated only in conjunction with mammography and not alone. Clinical breast examination does not decrease breast cancer mortality beyond the reduction achieved by mammography alone.26

7.2 Breast examination in pregnancy
There is no evidence to support routine breast examination in the asymptomatic pregnant woman. Antenatal interventions for the management of inverted and non-protractile nipples are of no value.27 Indications for breast examination increase in the puerperium, where engorgement, mastitis and breast abscesses become more prevalent.

Verbal consent should be obtained prior to breast examination. As with vaginal examination, the purpose of the examination should be explained to the patient. All the courtesies already described for pelvic examination apply. A chaperone should be provided and personal comments should be avoided during the examination.

8. Training undergraduate and postgraduate students
8.1 Standards
In order to ensure that women presenting with gynaecological problems or requesting screening or contraception have access to the highest standard of care, undergraduate medical students and postgraduate trainees in general practice, family planning and obstetrics and gynaecology must be taught how to perform pelvic examination. This training includes all aspects of good practice already mentioned – explaining to the patient what is going to happen, obtaining consent, performing the examination in a skilled and gentle manner, detecting and interpreting abnormal findings and communicating these findings to the woman afterwards. The first step towards maintaining these standards is teaching by example. However, practical experience is also essential. Teaching pelvic examination is obviously difficult. Women are understandably reluctant to be examined by inexperienced individuals. The embarrassment and inexpertise of many students conveys itself to the patients. Any woman agreeing to be examined by a medical student has to have the examination repeated by the supervising gynaecologist. Women are particularly likely to refuse examination by male students.28

A survey of medical students in the UK and USA in 1984–85 revealed that 46% of medical students in the UK obtained their first experience of pelvic examination by examining an anaesthetised patient, while 70% of students in the USA performed their first pelvic examination on a volunteer.29 The use of non-patient volunteers, either paid or unpaid, is commonplace in the USA, Australia and the Netherlands. These women may be designated as gynaecological teaching assistants and often work in teams of two, with one woman instructing and the second woman undergoing the pelvic examination. They are not highly paid and appear to be motivated by altruistic feminism.

Examination under anaesthesia may have some value as a means of instructing medical students in the examination of the normal pelvis or as an opportunity to examine women with a specific finding such as a pelvic mass or utero-vaginal prolapse. It is, of course, of no value in teaching the combination of
communication and expert examination that characterise sensitive pelvic examination. Written consent should be obtained from patients for a single medical student to assist at the operation and perform an examination under anaesthesia.

The Working Party recommends the following approach to the teaching of pelvic examination to undergraduate medical students. The student is taught how to don gloves and handle a vaginal speculum in a classroom setting and practises this until fumbling has been eliminated. A certain amount of technical expertise can also be obtained by using a mannequin in a clinical skills laboratory. The student then observes the teaching gynaecologist performing a pelvic examination in an awake patient in an outpatient clinic. Permission for this should be sought by the consultant. Finally, the student performs pelvic and speculum examination in an awake patient under supervision.

8.2 Consent
It is properly accepted that explicit consent of patients is required for the presence of medical students:

- ‘sitting in’ during gynaecological and obstetric consultations
- in operating theatres as observers and assistants
- in performing clinical pelvic examinations of both conscious and anaesthetised patients.

Currently, practice varies between medical schools with respect to how consent is obtained and by whom. There may be some educational advantages to medical students seeking and obtaining consent personally. Such a practice may inculcate a lifelong respect for the autonomy of patients. However, an insistence that consent is obtained by a doctor indicates recognition of the importance of such consent and makes the doctor responsible for good practice. In cases where pelvic examination under anaesthesia is regarded as being of educational value, written consent must be obtained from the woman before she comes to the operating theatre.

8.3 Assessment of undergraduates
Traditionally, all medical undergraduates were called upon to perform a speculum examination as part of the final professional MB examination in obstetrics and gynaecology. Although a small number of academic departments adhere to this practice, it is rapidly disappearing, due partly to the practical difficulties of mounting this exercise but mainly to an acceptance that such assessments are better made during the course of clinical instruction. The ordeal of the exercise, perhaps mostly for the candidate, certainly for the patient and not least for the assessors could hardly be justified by the value of such assessments. The presence of at least five individuals, i.e. the patient, candidate, chaperone and at least two assessors, often seemed to turn such ‘intimate’ examinations into a public performance.

More telling, however, is the possibility that some candidates found such assessments the most daunting prospect of their entire training and would approach it with fear. Once over, there may have been a feeling of relief that they would never have to face such an ordeal again. The negative attitudes that
this might sometimes engender towards a crucially important clinical procedure were potentially counter-productive.

The need to produce doctors with a mature and confident attitude towards this most sensitive area of clinical practice has already been highlighted. If clinicians are embarrassed or lacking such confidence they may tend to shun procedures that are essential to the optimal care of their patients or add to their patients’ own anxiety. It is therefore a central objective of medical education to instil in trainees appropriate attitudes and confidence in their performance of these fundamental and crucial skills.

8.4 Postgraduate training and assessment
The ability to perform courteous and competent pelvic examinations is essential for all training in obstetrics and gynaecology. In the past, summative assessment of this skill has formed part of the Membership examination. It is essential that the performance of vaginal examination is properly taught and assessed during structured training and that appropriate technique, behaviour and expertise are not assumed. The induction programme for new house officers should include a session on appropriate conduct of gynaecological examinations. Trainees must be observed performing pelvic examination and should be prepared to accept constructive criticism of their technique and communication skills.

9. Still and video photography

9.1 Background
Still and video photography of operations, procedures, consultations and physical findings are sometimes required for educational purposes, to illustrate lectures and textbooks or to enable a patient to benefit from the opinion of another doctor who is not present. The General Medical Council has issued guidelines, which are reproduced in Appendix B.

The Working Party gave specific consideration to photography of the breasts and genitalia and filming of women undergoing pelvic examinations or giving birth. Good practice involves obtaining fully informed consent, protecting the woman’s privacy and modesty and ensuring that the video and photographic images have no sexual connotations. Lack of prior consent does not preclude the recording of some unexpected finding during surgery in an anaesthetised patient. In these cases, the situation should be explained to the patient afterwards and the film should be erased if she withholds consent.

9.2 Consent
Seeking consent for medical photography, which should be in writing, requires giving full and accurate information to the woman on the following points:

- the purpose of the photography
- where the images will be stored and for how long
- how these records will be protected
- how many copies will exist and where they will be stored
- who will see these photographs/video recordings
- whether her face will be shown in the photograph/video
- what steps have been taken to protect her anonymity.
The woman should be offered the opportunity to see the prints of any still photographs and the final edited version of any film or television programme complete with soundtrack before giving final consent to their use. She should be made aware of her right to withdraw consent at any stage.

10. Communication, consent and choice

10.1 Communication

The Working Party noted that communication, consent and choice emerged as recurrent themes in their discussions on good practice with respect to gynaecological examinations. Communication about the purpose of a proposed examination or investigation is essential to obtaining informed consent. Where the patient is about to undergo an unfamiliar procedure or investigation, verbal descriptions may need to be backed up by easily understood written or diagrammatic material. During such examinations and investigations, communication is a two-way process, with the examining doctor offering reassurance and courtesy while remaining alert to both verbal and non-verbal signs of distress from the patient. Following an examination or investigation, the findings must be communicated to the patient. In view of the reported incidence of young women who have anxieties or misunderstandings about the normality of their anatomy, the first vaginal examination should be used as an educational opportunity.

10.2 Consent

We have stressed the need for consent for all the procedures discussed. For pelvic or speculum examination, verbal consent is sufficient, as this is backed up by implied consent when the woman undresses to prepare for examination. In order to give informed consent for more complex procedures and investigations such as colposcopy, patients may require access to written, verbal and diagrammatic material. Consideration should be given to introducing written consent for some procedures, such as loop excision of the transformation zone, where current practice requires verbal consent only.

Many women whose IQ is in the mild to moderately handicapped range are competent to consent to gynaecological examination, especially if a common vocabulary can be established between the doctor and patient. Where consent cannot be obtained due to severe mental impairment or unconsciousness, it is good practice to consult with those close to the patient, although, legally, nobody can give consent to treatment on behalf of another adult. In the absence of informed consent, the doctor must act in the patient’s best interests. Resistance to pelvic examination should be interpreted as refusal.

Consent for examination and collection of forensic evidence from a woman who is the victim of an alleged sexual assault must never be assumed. Written consent for examination is preferable under these circumstances.

10.3 Choice

The Working Party identified a number of areas where it is possible to offer choice to patients undergoing gynaecological examinations or investigations. For many women, the availability of some choice about the conduct of the examination may reduce their sense of vulnerability and so it is particularly
important to offer choice to women who experience difficulty with vaginal examination and to those who have been assaulted. Women should be able to choose between left-lateral dorsal, recumbent and semi-recumbent positions for speculum and bimanual examination. Women who are finding examination distressing should feel free to discontinue it.

11. Implications for practice, training and research

11.1 Implications for practice

Most of the recommendations for good practice made by the Working Party describe what is already happening on a day-to-day basis in gynaecological and obstetric units. Some of the suggested modifications to practice will add a minute or two to a consultation or call for a gynaecologist to think a little harder before performing an examination. Improvements in privacy in clinics and on hospital wards may have some financial implications. The Working Party is concerned lest the requirement for chaperones should prevent any woman having a gynaecological examination where it is indicated. In hospitals, most male doctors are already provided with a chaperone. The recommendation that a chaperone should be available regardless of the doctor’s gender has some obvious implications with respect to staffing and costs. Family planning and community gynaecology clinics that are run on a low budget or charitable basis are often staffed by female doctors who work without chaperones. Unpaid chaperones such as friends or relatives may be asked to act as chaperones in these settings, although we have established that a professional chaperone is preferable.

11.2 Implications for training

There are inherent tensions between the need to train tomorrow’s doctors to be sensitive, skilled and competent at performing pelvic examination and the rights of women to refuse to be examined by medical students. Progress in this area is unlikely without a collaborative approach involving the Association of Professors of Obstetrics and Gynaecology, the Patients Association and the RCOG Consumers’ Forum.

11.3 Implications for research

The Working Party noted the poor sensitivity and specificity of bimanual pelvic examination. A randomised trial of conventional bimanual examination versus transvaginal ultrasound in combination with conventional bimanual examination would inform the future conduct of gynaecological outpatient clinics. The Working Party also identified the need for further research into consumer views of all aspects of intimate examinations.
References


APPENDIX A

Intimate examinations

The GMC receives complaints each year from patients who feel that doctors have behaved inappropriately during intimate examination. Intimate examination, that is examinations of the breasts, genitalia or rectum, can be stressful and embarrassing for patients. When conducting intimate examinations you should:

- Explain to the patient why an intimate examination is necessary and give the patient an opportunity to ask questions.

- Explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any potential pain or discomfort (paragraph 13 of our booklet Seeking Patients’ Consent gives further guidance on presenting information to patients).

- Obtain the patient’s permission before the examination and be prepared to discontinue the examination if the patient asks you to. You should record that permission has been obtained.

- Keep discussion relevant and avoid unnecessary personal comments.

- Offer a chaperone or invite the patient (in advance if possible) to have a relative or friend present. If the patient does not want a chaperone, you should record that the offer was made and declined. If a chaperone is present, you should record that fact and make a note of the chaperone's identity. If for justifiable practical reasons you cannot offer a chaperone, you should explain to the patient and, if possible, offer to delay the examination to a later date. You should record the discussion and its outcome.

- Give the patient privacy to undress and dress and use drapes to maintain the patient’s dignity. Do not assist the patient in removing clothing unless you have clarified with them that your assistance is required.

Anaesthetised patients

You must obtain consent prior to anaesthetisation, usually in writing, for the intimate examination of anaesthetised patients. If you are supervising students you should ensure that valid consent has been obtained before they carry out any intimate examination under anaesthesia.

General Medical Council Standards Committee
December 2001

[www.gmc-uk.org/standards/intimate.htm]
APPENDIX B

GENERAL MEDICAL COUNCIL

Making and using visual and audio recordings of patients

Scope of this guidance

This guidance covers all types of audio and visual recordings of patients, carried out for any purpose. ‘Recording’ in this guidance means originals or copies of video and audio recordings, photographs and other visual images of patients. A ‘recording’ does not include pathology slides containing human tissue (as opposed to an image of such a slide), or CCTV recordings of public areas in hospitals and surgeries, which are the subject of separate guidance from the Information Commissioner.1

The guidance sets out some basic principles in part 1 and then reviews the following topics:

- When permission is not required to make and use a recording (part 2).
- Obtaining permission to make and consent to use recordings as part of the assessment or treatment of patients (part 3A).
- Obtaining permission to make and consent to use recordings for use within a medical setting, for example for training or research, including the use of existing collections (part 3B).
- Specific issues about recordings made for public consumption, such as filming for television (part 3C).

Part 1: Basic principles

1. When making recordings you must take particular care to respect patients’ autonomy and privacy since individuals may be identifiable, to those who know them, from minor details that you may overlook. The following general principles apply to most recordings although there are some exceptions, which are explained later in this guidance.

- Seek permission to make the recording and get consent for any use or disclosure.
- Give patients adequate information about the purpose of the recording when seeking their permission.
- Ensure that patients are under no pressure to give their permission for the recording to be made.
- Stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.
- Do not participate in any recording made against a patient’s wishes.
- Ensure that the recording does not compromise patients’ privacy and dignity.

1 CCTV Code of Practice, available from the Office of the Information Commissioner, 01625 545 745, or online at: www.dataprotection.gov.uk
Do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.

Make appropriate secure arrangements for storage of recordings.

2. Where children who lack the understanding to give their permission are to be recorded, you must get to record from a parent or guardian. Children under 16 who have the capacity and understanding to give permission for a recording may do so. You should make a note of the factors taken into account in assessing the child’s capacity.

3. When a mental disability or mental or physical illness prevents patients giving their permission, you must get agreement to recording from a close relative or carer. In Scotland, you must seek agreement from any person, appointed under the Adults with Incapacity (Scotland) Act 2000, having an interest in the welfare of the patient.

4. People agreeing to recordings on behalf of others must be given the same rights and information as patients acting on their own behalf.

Part 2: Recordings for which permission is not required

5. You do not need to seek separate permission to make the recordings listed below. Nor do you need consent to use them for any purpose, provided that, before use, the recordings are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- images taken from pathology slides
- X-rays
- laparoscopic images
- images of internal organs
- ultrasound images.

6. Such recordings are unlikely to raise issues about autonomy and will not identify the patient. It may nonetheless be appropriate to explain to the patient, as part of the process of obtaining consent to the treatment or assessment procedure, that a recording will be made.

Part 3: Recordings for which permission is required

3A. Recordings made as part of the assessment or treatment of patients

7. You must seek permission to make any recording for the assessment or treatment of patients, other than those recordings listed in Part 2 above. You should explain that a recording will be made, and why. You need only give an oral explanation. You should record in the medical notes that the patient has given permission.

8. When conducting a hospital post-mortem examination, you must seek permission from a close relative or carer before making any recording from which the deceased may be identifiable. If the death is the subject of
a medico-legal investigation, the proposed recording should be discussed with the coroner or Procurator Fiscal (in Scotland) who has authorised the investigation.

9. Recordings made for clinical purposes form part of the medical record. As such, when considering disclosure of a recording, you should treat the recording in the same way as any other part of the medical record. In general, that means that you should seek consent for the disclosure. However, if you are sure that the patient will not be identifiable from the content of the recording, and the recording is effectively anonymised by the removal of identifying marks, you may use the recording for teaching purposes without consent.

10. When making a judgement about whether the patient may be identifiable, you should bear in mind that apparently insignificant features may still be capable of identifying the patient to others. Since it is difficult to be absolutely certain that a patient will not be identifiable from a recording, no recording other than those mentioned in paragraph 5 above should be published or used in any form to which the public may have access, without the consent of the patient. The GMC booklet *Confidentiality: Protecting and Providing Information* sets out detailed guidance on disclosure of personal information.

11. In exceptional circumstances, you may judge that it is in the patient’s best interests to make an identifiable recording of a patient without first seeking permission, and to disclose the recording to others without their knowledge. Before proceeding you should discuss the recording with an experienced colleague. You must be prepared to justify your decision to the patient and, if necessary, to others. If the recording will involve covert video surveillance of a patient, it is likely to be within the scope of the Regulation of Investigatory Powers Act 2000 and you should seek advice before proceeding. A decision to use covert video surveillance, for example in cases of suspected induced illness in children, will normally be based on discussions amongst all the agencies involved, and the surveillance itself should be undertaken by the police.

3B. Recordings made for the training or assessment of doctors, audit, research or medico-legal reasons

12. You must obtain permission to make and consent to use any recording made for reasons other than the patient’s treatment or assessment. The only exceptions to this are outlined Part 2.

13. Before the recording, you must ensure that patients:

a. Understand the purpose of the recording, who will be allowed to see it – including names if they are known – the circumstances in which it will be shown, whether copies will be made, the arrangements for storage and how long the recording will be kept.
b. Understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.

c. Are given time to read explanatory material and to consider the implications of giving their written permission. Forms and explanatory material should not imply that permission is expected. They should be written in language that is easily understood. If necessary, translations should be provided.

14. After the recording, you must ensure that:
   a. Patients are asked if they want to vary or withdraw their consent to the use of the recording.
   b. Recordings are used only for the purpose for which patients have given consent.
   c. Patients are given the chance, if they wish, to see the recording in the form in which it will be shown.
   d. Recordings are given the same level of protection as medical records against improper disclosure.
   e. If a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Existing collections used for teaching purposes

15. Some doctors may have existing collections of recordings which they use solely for teaching purposes within a medical setting. Both this guidance, and the previous edition published in 1997, require permission to be obtained to make any recording which is not part of the patient's assessment or treatment, regardless of whether the patient may be identifiable. However, recordings may have been made for teaching purposes prior to 1997 without it being recorded whether or not permission had been obtained. Such collections may have a significant value for teaching purposes.

16. You may continue to use recordings from which the patient is not identifiable, and which were made for teaching purposes prior to 1997. You should, however, seek to replace such recordings at the earliest opportunity with similar recordings for which permission can be shown to have been obtained. You may also continue to use effectively anonymised recordings that were originally made for treatment or assessment purposes, in line with paragraph 9 above. However, you should not use any recording, from which a patient may be identifiable, for teaching purposes if you cannot demonstrate that consent has been obtained for that use.

Recordings of emergency treatment and of unconscious patients

17. If recordings are to be used only for training or clinical audit, you may record patients who need emergency treatment but cannot give their permission for the recording to be made. You do not need a relative's
agreement before starting the recording but must stop it if a relative objects. Before these recordings are used, however, the patient’s consent must be obtained or, if the patient has died, a relative must agree to it.

18. When no recording has been planned, but a record of an unexpected development would make a valuable educational tool, you may record patients undergoing treatment. If you cannot get permission at the time because, for example, the patient is anaesthetised, you must ensure the patient is later told about the recording and gives consent to its use.

19. With recordings made in these circumstances, you must follow patients’ instructions about erasure or storage. The only exception is if you think you need to disclose the recording because of the advice in the GMC booklet Confidentiality: Protecting and Providing Information, for example to protect the patient or others from risk of death or serious harm.

20. Hospital policy on recording the treatment of unconscious patients should be adequately publicised, for example through notices in waiting areas.

**Telephone calls**

21. Recordings of telephone conversations fall into a category of their own. Anyone using a telephone is subject to licence conditions under the Telecommunications Act 1984. They require you to make every reasonable effort to inform callers that their call may be recorded, and maintain a record of the means by which callers have been informed.

22. Given the sensitive nature of calls to medical advice lines or similar services, you should pay particular attention to ensuring that callers are aware that their call may be recorded. You must not make intentionally secret recordings of calls from particular patients.

23. In general, the considerations set out in 3B above also apply to recordings for use in public media. There are, however, some issues that are specific to recordings to which the public will have access.

24. You must not make recordings for use in publicly accessible media without written permission, whether or not you consider the patient to be identifiable. ‘Publicly accessible media’ includes medical journals. The only exceptions to this are outlined in Part 2.

25. Before making any arrangements for external individuals or organisations to film patients in a health care setting, you must inform your employing or contracting body and the organisation in which the patients are being treated if this is different. You should obtain appropriate permission for the recording. Within the NHS, a contract with the filmmaker will normally be required.

26. If you are involved in any way with recording patients for television or other public media, you should satisfy yourself that patients’ permission
has been properly obtained, even if you are not responsible for obtaining that permission or do not have control of the recording process. Both the BBC and the Independent Television Commission issue guidance for television programme makers that requires permission to be obtained in a way that is consistent with this guidance.

27. In addition, you should make sure that patients understand that, once they have agreed to the recording, they may not be able to withhold their consent for its subsequent use. If patients wish to restrict the use of material, they should get agreement in writing from the owners of the recording, before recording begins.

28. You should be particularly vigilant in recordings of those who are unable to give permission themselves. You should consider whether patients’ interests and well-being, and in particular their privacy and dignity, are likely to be compromised by the recording, and whether sufficient account has been taken of these issues by the programme makers. If you believe that the recording is unduly intrusive or damaging to patients’ interests, you should raise the issue with the programme makers. If you remain concerned, you should do your best to stop the recording, for example by halting a consultation, and withdraw your co-operation.

Note

This revised Guidance was issued by the General Medical Council in May 2002. It is available electronically on the GMC’s website at www.gmc-uk.org/standards/AUD_VID.HTM.