Teaching vaginal examination

EDITOR,—Linda Cardozo and I agree that vaginal examination should not be distinguished from other examinations.^{1,2} Indeed, analysis of the law shows that it is not different.³ But the doctor-patient relationship is not the same as the student-patient relationship; there are different rules for students, and any examination can be taught under anaesthesia so long as the patient has consented. If the students Cardozo examined for the final MB did not know how to pass a speculum because outpatient clinics were too busy for teaching, that is a criticism of the medical school and the NHS, not consent procedures. And, as she herself points out, most women are happy to help with teaching when asked.

It is important that students learn about obstetrics and gynaecology in the same way as about other specialties. I do not agree with Anthony Papagiannis and James McGarry that vaginal examination should be omitted from the medical school curriculum; the argument that many doctors do not use the technique could equally well be applied to examination of the ear, knee, or mental state and is ultimately nihilistic.⁴ If vaginal examination is left out because students are embarrassed should breast, testicular, and rectal examinations be similarly ignored? The aim must be to train professionals to be able to perform a full physical examination without embarrassment to either patient or doctor.

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1 Cardozo L. Teaching vaginal examination. *BMJ* 1992;305:113. (11 July.)

2 Bewley S. The law, medical students, and assault. *BMJ* 1992;304:1551-3. (13 June.)

3 Papagiannis A. Teaching vaginal examination. *BMJ* 1992;305:113. (11 July.)

4 McGarry J. Teaching vaginal examination. *BMJ* 1992;305:113. (11 July.)

EDITOR,—As a registrar in obstetrics and gynaecology I assess women referred from various sources: general practitioners, consultants in obstetrics and gynaecology, and consultants and trainees in other specialties. It is always obvious when someone has not performed a vaginal examination before referring a patient—though this is generally hidden in the conversation, or the referral letter notes that examination has been “deferred.”

I contend that in so abrogating the responsibility for performing this essential examination the referring source has assessed the problem inadequately. It may well be embarrassing to some doctors to perform a vaginal examination,¹ but I suspect that Anthony Papagiannis would be incensed if a colleague referred a patient with a diagnosis of asthma without having auscultated the chest. I believe that a vaginal examination in obstetric or gynaecological matters is as fundamental as that.

James McGarry, an obstetrician, takes a similar line to Papagiannis, but nowhere does he justify his contention that teaching students vaginal examinations is “unjustified as well as educationally harmful to the students.”² In my experience medical students rapidly learn to examine women correctly and with respect; in this teaching hospital they have always gained consent.

Not teaching vaginal examination will lead to a generation of doctors who are ill informed about women in their practice and could lead to critical mistakes in diagnosis and referral.

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2 McGarry J. Teaching vaginal examination. *BMJ* 1992;305:113. (11 July.)

EDITOR,—We believe that Anthony Papagiannis and James McGarry, who think that vaginal examination should be taught to, and performed by, only general practitioners and gynaecologists, have forgotten the importance of vaginal examination in the assessment of patients presenting to accident and emergency departments.^{1,2} Doctors working in these departments must be competent in passing a speculum and performing a vaginal examination if they are to manage acute gynaecological emergencies safely. This is important in assessing spontaneous abortion, particularly if a policy of discharging patients with threatened abortions for later scanning and follow up is practised. In addition, products of conception at the cervical os can cause life threatening bradycardia and pain, which are treated only by passing a speculum and removing the products. Proper assessment of suspected pelvic inflammatory disease also requires passage of a speculum to obtain the appropriate cervical swabs.

Not all accident and emergency departments can obtain the immediate opinion of an experienced gynaecologist for patients presenting as an emergency, and thus training in vaginal examination is essential for these departments' medical staff.

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EDITOR,—The division of obstetrics and gynaecology in South Glamorgan Health Authority has introduced a separate consent form for vaginal examination by students as a routine for all gynaecological patients undergoing surgery. The consent form consists of an adhesive label, which can be stuck into the patient's notes. It reads: “I also consent to a gynaecological examination by a medical student as part of his/her training in gynaecology and obstetrics.”

Overall only 14 (12%) women have refused examination (table). The highest refusal rates tended to occur in younger women and the lowest in women undergoing total abdominal hysterectomy (who were all aged over 30).

Responses of 119 patients to request to allow medical student to perform vaginal examination under general anaesthesia, according to operative procedure and age

	Permission granted (n=105)	Permission refused (n=14)
<i>Operative procedure</i>		
Dilatation and curettage	18	1
Termination of pregnancy	20	4
Abdominal hysterectomy	22	
Colporrhaphy	7	3
Laparoscopy	30	4
Cone biopsy	4	2
Other	4	
<i>Age (years)</i>		
<20	5	2
20-29	28	7
30-39	37	2
40-49	19	1
50-59	6	1
≥60	10	1

There has been some anxiety that if patients were asked to give their permission for medical students to perform vaginal examination while they were anaesthetised they might refuse.¹ This has led to concern regarding training of medical students. Our study indicates that older patients are least likely to refuse permission, which is consistent with a previous report.² This may be due to older patients being less embarrassed by the

possibility of a vaginal examination; they may also be more aware of the need for medical students to practise clinical examination to become competent.

When signing a combined consent form a patient may not realise that she has also given permission for an examination by a medical student, and if she discovers this after the procedure it may lead to resentment. A separate consent form enables patients to distinguish clearly between permission for the procedure and permission for an examination. Our form has been endorsed by the Welsh executive committee of the Royal College of Obstetricians and Gynaecologists and is currently in use in all Welsh hospitals where medical students are trained in obstetrics and gynaecology.

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1 Bewley S. The law, medical students, and assault. *BMJ* 1992;304:1551-3. (13 June.)

2 Lawton FG, Redman WE, Luesley DM. Patient consent for gynaecological examination. *Br J Hosp Med* 1990;44:326-9.

EDITOR,—As a final year medical student I have just completed a 10 week attachment in obstetrics and gynaecology. I was astonished to read the opinions expressed by some correspondents concerning vaginal examination by medical students.

Most doctors and medical students appreciate that vaginal examination can be both uncomfortable and embarrassing for a patient, but it is an essential part of clinical assessment. The suggestion that a speculum should be passed and bimanual examination done only by those with experience is remarkable.¹ Should all women with a vaginal discharge or all those complaining of menstrual irregularity be referred to a gynaecologist? Furthermore, James McGarry's proposition that vaginal examination should first be taught to senior house officers embarking on a career in obstetrics and gynaecology is worrying.² It would mean a junior house officer being unable to deal with a common problem such as vaginal bleeding, having never previously performed the required examination. As with all aspects of clinical science, experience and appreciation of the variations of “normal” are obligatory if an abnormal condition is to be recognised.

For this reason clinical training in vaginal examination is, in my opinion, irreplaceable, and if medical students are taught well by their consultants there is little justification for the fumbling that Linda Cardozo has witnessed.³ The operating theatre is the ideal place to learn how to perform a vaginal examination, and if the patient's permission is requested in the routine preoperative consent form problems concerning the question of assault should not arise.⁴

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1 Papagiannis A. Teaching vaginal examination. *BMJ* 1992;305:113. (11 July.)

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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.