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Women's attitudes and expectations regarding gynaecological examination

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Introduction

The gynaecological examination is an essential part of gynaecological care and is the most commonly performed procedure in gynaecological practice. A large number of women in the world will have a gynaecological examination at some time in their lives, and some may undergo several examinations during their lifetime. Gynaecological examination is performed for several reasons, including pregnancy diagnosis, gynaecological screening and as a measure in differential diagnosis (Nylenna, 1985; Wijma et al., 1998; Fiddes et al., 2003; Hilden et al., 2003).

The examination should be performed in a way that makes it a positive experience for women. Since the 1970s, research has investigated the experience of gynaecological examination from women's perspectives. During the examination, women are in an extremely vulnerable situation (Olsson and Gullberg, 1991; Wendt et al., 2004). Pelvic examination can provoke many negative feelings such as fear of illness, pain, embarrassment and awkwardness (Wendt et al., 2004). Many women have negative experiences of gynaecological examination. Women receive insufficient information about how the examination is performed (Jeppesen, 1995; Larsen and Kragstrup, 1995; Larsen et al., 1997; Wijma et al., 1998), and about the anatomy and physiology of their genitalia (Jeppesen, 1995; Larsen and Kragstrup, 1995). The procedure may be experienced as very unpleasant and humiliating (Wijma et al., 1998). Apart from the physical discomfort, the psychological factors are important, as gynaecological examination involves exposure of intimate parts of the body in a vulnerable situation with loss of control. Women experience many feelings such as embarrassment about undressing, worries about cleanliness, qualms about vaginal odour, concern that the gynaecologist might discover something about sexual practices, fear of discovery of a pathological condition, and fear of pain (Millstein et al., 1984; Seymore et al., 1986; Hilden et al., 2003). Cold instruments, lack of information about the procedure and lack of gentleness from the examiner are also perceived as important factors. Most of the abovementioned aspects may be even more conflicting when the gynaecologist is male (Hilden et al., 2003).

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Women's reluctance to undergo gynaecological examination, due to the nature of the examination, fear or concerns about the gynaecologist's attitude, may result in delay or avoidance of examination with potentially harmful health effects (Hilden et al., 2003).

From women's perspectives, these intimate physical examinations have the potential for embarrassment, anxiety and discomfort. Doctors also have anxieties with regard to pelvic examinations, including a lack of confidence in their clinical findings, the fear of allegations of misconduct and, ultimately, the potential for litigation or prosecution. Not infrequently, doctors use the view that 'women don't like pelvic examinations' as a justification for not doing them. Over recent years, medico-legal concerns have become more prominent and the issue of chaperones has become the focus for much of the debate surrounding intimate examinations (Bignell, 1999; Torrance et al., 1999).

According to some research, women want information about the procedure, they prefer a warmed speculum, and they want the doctor to consider their feelings (Broadmore et al., 1986). A Danish project on women's attitudes towards pelvic examination is one of the few based on women's own experiences (Jeppesen, 1995). Twelve women aged between 27 and 76 years were interviewed 1 week before hospitalisation for a planned gynaecological operation with the aim of illustrating their experience of pelvic examination. The study demonstrated that women's experiences of pelvic examination were negative when communication between the women and the doctors was poor. The examination could be a positive experience if the doctor gave information about the procedure and about the findings. Information about the anatomy of the genitalia could also diminish the discomfort of the situation.

There is a general belief, supported in part by the literature, that many women dread pelvic examinations and many prefer to see a female doctor for gynaecological problems (Cooke and Ronalds, 1985; Heaton and Marquez, 1990; Lang, 1990; Levy et al., 1992; Philliber and Jones, 1992). A number of studies in the literature suggest that both male and female patients prefer to see physicians of the same gender, particularly for evaluations that involve examination of the genitalia (Heaton and Marquez, 1990; Lang, 1990; Levy et al., 1992). Communication relating to the outcome of an examination remains an issue. Evidence from one study relating to doctor-patient communication suggests that although the doctor may think that dialogue with a patient was satisfactory, the patient's experiences of the examination may differ (Lunde, 1993).

The aims of this study were: (1) to describe women's expectations of nurses and doctors during gynaecological examination; (2) to identify if women have a preference for the doctor's gender; (3) to investigate women's feelings during gynaecological examination; and (4) to determine why women consult the gynaecological outpatient clinic.

Methods

Sample and the period of study

This was a descriptive, cross-sectional survey. Women were recruited to the study from those making an appointment for gynaecological examination at the gynaecological outpatient clinic, Manisa Maternity and Child Hospital between September 2004 and February 2005. Women making an appointment were asked the reason for their appointment, and if it was for a gynaecological matter, they were informed about the study and invited to participate. Women considered to be in an adverse situation (e.g. consulting for an abortion), those who had serious pelvic disease or acute pelvic pain, and women who were staff at the hospital were excluded from the study. In total, 465 women who were considered eligible for inclusion were invited to take parting the study. Of these, 32 refused to take part and the remaining 433 women gave their informed consent to participate in the study.

The questionnaire

A questionnaire, developed by the researchers and consisting of two parts, was used to collect data. The first part included questions about the woman's sociodemographic and reproductive characteristics, including education level, employment status, income, number of pregnancies, parity, and if she had had any previous miscarriages or abortions. The second part of the questionnaire included questions about her feelings with regard to undergoing pelvic examination, her expectations of the nurse and doctor during the examination, questions relating to preferences about the gender of the doctor, and questions about the reasons for needing an examination. When designing the questionnaire, 10 women were consulted in depth for ideas about appropriate terminology. The comprehensibility and applicability of the questionnaire were checked in a pilot study in which 25 women were asked to complete the questionnaire, following which modifications were made.

Data collection and ethics

Manisa National Health Directorate approved this study. Written informed consent was obtained from all participants. The interview was conducted after obtaining a final formal verbal informed consent. Women were informed about the aim of the study, and were under no pressure to complete the questionnaire. There was no disclosure to any other person that the questionnaire was offered or completed, and all data were confidential. The interview took place in a room separate from the gynaecological outpatient clinic, but in the same building. The questionnaire was administered by means of face-to-face interview before the consultation in the outpatient clinic and took approximately 10 mins to complete.

Statistical analysis

Statistical analyses were undertaken using Statistical Package for the Social Sciences for Windows Version 10.0. Frequency and summary statistics were calculated for all variables. Pearson's Chi-squared test was used to determine the significance of associations between variables. A p -value <0.05 was considered to be significant.

Results

Characteristics of the study population

The demographic and reproductive characteristics of the study population are presented in Table 1. The 433 women ranged in age from 18 to 76 years [mean 30.5 years, standard deviation (SD) 9.5]; 37.4% were aged ≤ 25 years and 62.6% of women were aged >25 years. In total, 60.5% of women were educated to elementary level or less, 39.5% had completed more than elementary level, and 96.1% of women were married. Overall, 21.5% of women were working full- or part-time, and 66.7% reported that their income was equal to their outgoings. Overall, 79% of women had previously been pregnant.

Reasons for and frequency of consultations at the gynaecological outpatient clinic

Most women attended the clinic for routine assessment of a previously diagnosed pelvic problem, such as vaginitis, uterine bleeding, pregnancy or pain (36.7%), and 19.9% of women attended because of pregnancy problems. Gynaecological reasons for outpatient consultation also included chronic pelvic pain (27.3%), abnormal uterine bleeding (15.5%), infertility (3.5%), vaginitis (17.6%) and itching (9.9%). Reasons for consultation are shown in Table 2.

Overall, 19.4% of women had not undergone pelvic examination previously. Approximately one in 10 women said that they required pelvic examination regularly (9.5%). Most women (68.6%) attended the gynaecological outpatient clinic if they had a specific problem. The frequency with which women attended for pelvic examination is shown in Table 3.

Women's feelings during pelvic examination

This study found that 54.8% of women felt anxious or worried about their health situation during pelvic examination, and 41.8% of women were embarrassed about having to undress. Overall, 38.3% of respondents stated that fear of discovery of a pathological condition or fear of severe illness were their main concerns. One out of four women expressed worries about cleanliness or fear that the equipment used during the examination was unsterile. In total, 18% of women feared that they would experience pain during the examination. Table 4 shows women's feelings during pelvic examination.

Women's preferences for doctor's gender

When asked about their preferences with regard to the gender of the examining doctor, 45.5% of women reported that they would prefer a female doctor, 4.2% of women would prefer a male doctor, and the remaining women (49.9%) expressed no preference (Table 5).

Women who expressed a preference for a female doctor were asked why this was so. Almost all of them stated that they felt more comfortable with a female doctor. Reasons given by women who wished to consult a female doctor also included religious beliefs, reluctance to discuss sensitive and confidential issues with a male doctor, and cultural objections. Reasons given by women who expressed a preference for a male doctor included that they felt they had a greater opportunity to gain more information about management, or that they could communicate more freely about reproductive problems (data not shown in the table).

When responder characteristics were examined, women aged ≤ 25 years, with elementary school education or less, who were unemployed, had a lower income, or were more likely to report that they felt ashamed during the examination were more likely to prefer a female doctor; this difference was statistically significant ($p < 0.05$). Overall, 56.0% of nulliparous women expressed a preference for a female doctor compared with 42.7% of multiparous women, although this difference was not statistically significant. Women who attended for regular pelvic examinations were less likely to prefer to have a female doctor, but this difference was not statistically significant. Associations between some selected characteristics and women's preferences for the gender of the doctor are shown in Table 6.

When asked about their preference for another clinician to be present during their pelvic examination, 24.7% of respondents stated that they preferred to have a single doctor present during this examination. Approximately half of the women preferred to have a doctor and nurse present, but only 4.0% of women said that they would prefer to have a doctor, nurse and medical student. Almost one in five women expressed a wish for their partner to be present during this examination. Women's preferences for another person to be present during pelvic examination are presented in Table 7.

Women's expectations of nurses and doctors during gynaecological examination

Women were asked about their expectations of what the doctor should tell them about their pelvic examination. Most women (62.1%) expected the doctor to explain their health situation after the examination, and several women (22.4%) thought that the doctor should talk to them before the examination. Almost half of the women said that the doctor should have an understanding, gentle manner. Overall, 30.0% of women stated that the doctor should listen to them, and 38.6% of women expected the examination to be comprehensive and thorough.

Women were also asked about their expectations of the nurse during pelvic examination. In total, 71.8% of women said that the nurse should have an understanding, gentle manner, and 28.2% of women stated that the nurse should offer information about the examination. Overall, 20.8% of women said that the nurse should prepare the woman for the examination (how to

get into the chair and how to put her feet into the lithotomy position), and 20.8% of women expected the nurse to help to relax the woman (Table 8).

Discussion

This study surveyed women attending an outpatient clinic about their attitudes towards pelvic examination and their expectations of the practitioners. The study also aimed to get feedback from women. This was necessary to determine and improve the quality of the health service. The study sample comprised 433 (93.1% response rate) of the 465 eligible women. According to the women's feedback, most were pleased with being asked for their opinion on this issue, and offered positive feedback on the study. In addition, the study results were fed back to hospital management and nurses/doctors, as outcomes will inform planning strategies for reproductive health care in Manisa Maternity Child Hospital.

Bimanual pelvic examination and speculum examination form an essential part of the work of practitioners involved in the provision of reproductive health services. Most women have to undergo this procedure several times in their lives. Pelvic examination is essential for the early detection of genital cancer, infection or other abnormalities. Outcomes for genital cancer will be enhanced if the cancer is found early, and early detection and treatment of other problems can often prevent problems from becoming more serious. A study of pelvic examination in 2623 healthy volunteers taking part in an ovarian-cancer-screening programme concluded that pelvic examination is of questionable value as a screening tool (Grover and Quinn, 1995). In the present study, only one out of 10 women said that they attended the gynaecological clinic regularly. Women should be informed of the benefits of intimate examination and be offered an explanation of the procedure involved, possibly including information about the limitations of pelvic examination and engendering realistic beliefs in the patient.

In this study, almost half of the respondents said that they had no preference regarding the doctor's gender. Only 4.2% of women had a definite preference for a male doctor, and almost half of the women in this study expressed a clear preference for a female doctor. This finding is similar to that of Webb and Opdahl in 1996. They found that 43% of female patients preferred to have a female doctor (Webb and Opdahl, 1996). However, Fiddes et al. (2003) and Rizk et al. (2005) reported that 76% and 86.4% of women preferred to be treated by female physicians, respectively. Similar to the present survey, the patient's educational level (Elstad, 1994; van Elderen et al., 1998; Rizk et al., 2005), socio-economic status (Schmittziel et al., 1999; Franks and Bertakis, 2003; Rizk et al., 2005) and parity (Rizk et al., 2005) have been reported to affect their preference for the gender of their obstetrician and gynaecologist providers. According to the present study findings, women aged ≤ 25 years preferred to have a female doctor for gynaecological examination. A preference for a female provider has also been found in women < 30 years of age in some studies (ACOG News Release <http://www.acog.org>).

It is noteworthy that the experience of discomfort during gynaecological examination was independent of the gender of the gynaecologist. There is some evidence that women prefer a female gynaecologist when asked prior to an examination; nevertheless, when asked after an examination, undertaken by a doctor of either gender, the preference is not as strong (Seymore et al., 1986). Hilden et al. (2003) evaluated women's experiences of gynaecological examination and assessed possible factors such as discomfort. This study of consecutive patients visiting the Department of Obstetrics and Gynaecology at Glostrup County Hospital, Denmark used a postal questionnaire that included questions about the index visit, obstetric and gynaecological history, and history of sexual abuse. The degree of discomfort during gynaecological examination was indicated on a scale from 0 to 10. Experiencing discomfort was defined as a score of 6 or more, based on the 75th percentile. Discomfort during gynaecological examination was strongly associated with a negative emotional contact with

the examiner and young age. Additionally, dissatisfaction with present sexual life, a history of sexual abuse and mental health problems such as depression, anxiety and insomnia were significantly associated with discomfort. They stated that gynaecologists need to focus on emotional contact and re-evaluate issues for communication before the examination (Hilden et al., 2003).

According to the present study, there was a significant association between experiencing shame and age ≤ 25 years compared with age > 25 years. A tendency towards decreased shame with increasing age was found. This supports earlier findings (Millstein et al., 1984; Brixen and Kragstrup, 1995; Wijma et al., 1998; Hilden et al., 2003) that young women and women having their first examination experience discomfort or anxiety to a greater extent than women who have undergone repeated examinations.

In the present study, one out of four women did not want another person present during pelvic examination. Women may feel shame and embarrassment when other people are looking. However, this finding has an adverse effect on the involvement of medical students and clinical tutors in outpatient obstetric and gynaecologic care, and consequently in teaching and acquisition of clinical skills. A report from New Zealand (Broadmore et al., 1986) concluded that female patients prefer a chaperone during pelvic examination. The study by Larsen et al. (1997), a qualitative study in 13 women, found that none of the women expressed any wish for a chaperone, because a chaperone may even increase the feelings of embarrassment. If the doctor's need for security over-rides the wishes of women, the presence of a chaperone must be clearly explained, and not introduced on behalf of women (Larsen et al., 1997).

In the present study, a significant proportion (41.8%) of women said that pelvic examination leads to feelings of lost dignity and shyness. Most women mentioned different aspects of being undressed in front of the doctor. This finding indicates that sexuality is a common connotation of pelvic examination. Nearly half of the women in this study said that they were nervous about the consultation. These results are similar to those from other studies in Turkey (Mete, 1998; Şirin and Nar, 1999; Akarer, 2003). According to Mete (1998), women experience a high level of anxiety during gynaecological examinations. The most important reasons for anxiety among women undergoing gynaecological examinations are: fear of learning that they have cancer; fear of pain; being examined by a male doctor; the tool used for examination; and the examination position (Mete, 1998). One qualitative study reported women's experiences of pelvic examinations and found that nearly all women were nervous before the consultation. Some women were affected by the gender of the doctor (Larsen et al., 1997). In a study on behavioural indicators of anxiety during gynaecological examination, it was found that the gender of the examiner and his/her professional training had no bearing on anxiety levels (Reddy and Wasserman, 1997).

The present study found that one out of five women stated that they would feel pain because of speculum examination. Larsen and Kragstrup (1995) found that among teenagers who had not previously undergone pelvic examination, almost half thought that the examination would be painful. It is concluded that a considerable proportion of teenagers have negative expectations of pelvic examination, and increased effort to improve teenagers' expectations and knowledge about pelvic examination may be recommended (Larsen and Kragstrup, 1995). Reddy and Wasserman identified easily recognisable behaviours reflecting high anxiety in gynaecology patients. Upon recognising these behaviours, clinicians can take the necessary measures to reduce patient anxiety and prevent delays in and avoidance of gynaecological examinations (Reddy and Wasserman, 1997).

Gynaecological examination requires a physician–patient or nurse–patient interaction that involves a high degree of personal intimacy, and it requires the patient to disrobe and to expose

intimate parts of their body. These individuals often prefer to be seen by female physicians in the belief that female physicians are more empathetic and thus would provide better and more thorough care (Kreuter and Strecher, 1995). The findings of the present study emphasise the importance of good emotional contact between patients and nurses/doctors. Good emotional contact is established by showing empathy and having time to listen to the patients' needs, expectations and worries, as well as giving them information on procedures. Most women expected doctors to provide an explanation about their health situation and to communicate with them. As in earlier studies, this study showed that information is an important part of the examination situation. Women want their doctor to talk about what happened during the examination; when doctors listened to women and understood them, the situation became more positive (ACOG News Release <http://www.acog.org>; Larsen et al., 1997; Mete, 1998; Wijma et al., 1998; Şirin and Nar, 1999; Wendt et al., 2004). When information is insufficient, women may be worried. This may contribute to women revisiting the clinic unnecessarily, or possibly not returning at all (Wendt et al., 2004).

Psychosomatic and communication skills of doctors and nurses may help to decrease the frequency of negative experiences during the first gynaecological examination. Pelvic examination could be a positive experience; doctors and nurses should provide information about the examination, listen to women and show that they have time for them. Health-care providers should notice women's problems and use terminology that lay people understand (Wendt et al., 2004).

Previous research has shown that pain, anxiety or both are frequently reported following a woman's first pelvic examination (Larsen and Kragstrup, 1995; Reddy and Wasserman, 1997; Wijma et al., 1998). As the experience of the first pelvic examination is such a key experience for future pelvic examinations, it is a great challenge for the obstetric/gynaecological profession to try to change the experience of the first pelvic examination into a positive experience.

The provision of information and a respectful and engaged behaviour during gynaecological examinations was of great importance for women. This study could help to improve health programmes to improve the experience of gynaecological examination for women.

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Table 1

Characteristics of study population.

Characteristics	n	%
Age (years)		
≤25	162	37.4
>25	271	62.6
Mean age of women (years) 30.5±9.5(12–76)		
Level of education		
Elementary or less	262	60.5
More than elementary	171	39.5
Marital status		
Married	416	96.1
Unmarried	6	1.4
Divorced	11	2.5
Occupation		
Employed	93	21.5
Unemployed	340	78.5
Income status		
Income is higher than outgoings	92	21.2
Income is equal to outgoings	289	66.7
Income is lower than outgoings	52	12.0
Previous pregnancy		
No	91	21.0
Yes	342	79.0
Total	433	100.0

Table 2

Reasons for attending gynaecological outpatient clinic.

Reasons	n	%
Routine check (routine disease-related examination)	159	36.7
Chronic pelvic pain	118	27.3
Pregnancy problems	86	19.9
Vaginitis	76	17.6
Abnormal uterine bleeding	67	15.5
Itching	43	9.9
Menopause	30	6.9
Infertility	15	3.5

* Total n may exceed 433 as participants may have reported more than one reason.

Table 3

Frequency of women's attendance for pelvic examination.

Frequency	n	%
First visit	84	19.4
Prenatal examination previously	58	13.4
For delivery previously	31	7.2
For postpartum examination previously	22	5.1
Attended for a specific problem	297	68.6
Attended for regular pelvic examinations	41	9.5

Table 4

Women's feelings during pelvic examination.

Feelings	n	%
Anxious about health	237	54.8
Embarrassment about undressing and feelings of shame	181	41.8
Fear of discovery of a pathological condition (fear that severe illness might be diagnosed)	166	38.3
Worries about cleanliness, fear about equipment being unsterile	113	26.1
Feel excited	106	24.5
Fear of pain during speculum examination	78	18.0
Anxiety about examination not being performed correctly	56	12.9
Did not feel anything	47	10.9
Fear about curettage	17	3.9

* Total n may exceed 433 as participants may have reported more than one feeling.

Table 5

Women's preferred gender of the doctor performing pelvic examination.

Preference	n	%
Female doctor	197	45.5
Male doctor	20	4.6
No preference	216	49.9
Total	433	100.0

Table 6

Association between some selected characteristics and women's preference for the gender of the doctor performing pelvic examination.

Characteristics	Women's preferred gender of the doctor				Test
	Female doctor	Male doctor	No preference	Total	
Age of women (years)					
≤25	87 (53.7)	6 (3.7)	69 (42.6)	162 (100.0)	$X^2=21.827$ df=2 $p=0.000$
>25	110 (40.6)	14 (5.2)	147 (4.2)	271 (100.0)	
Education of women					
Elementary or less	140 (53.4)	15 (5.7)	107 (40.8)	262 (100.0)	$X^2=21.827$ df=2 $p=0.000$
More than elementary	57 (33.3)	5 (2.9)	109 (63.7)	171 (100.0)	
Occupation					
Employed	30 (32.3)	3 (3.2)	60 (64.5)	93 (100.0)	$X^2=10.143$ df=2 $p=0.006$
Unemployed	167 (49.1)	17 (5.0)	156 (45.9)	340 (100.0)	
Income status					
Income is higher than outgoings	31 (33.7)	4 (4.3)	57 (62.0)	92 (100.0)	$X^2=9.967$ df=4 $p=0.041$
Income is equal to outgoings	135 (46.7)	14 (4.8)	140 (48.4)	289 (100.0)	
Income is lower than outgoings	31 (59.6)	2 (3.8)	19 (36.5)	52 (100.0)	
Parity					
Nulliparous	51 (56.0)	3 (3.3)	37 (40.7)	91 (100.0)	$X^2=5.219$ df=2 $p=0.074$
Parous	146 (42.7)	17 (5.0)	179 (52.3)	342 (100.0)	
Had regular pelvic examination					
Yes	13 (31.7)	5 (12.2)	23 (56.1)	41 (100.0)	$X^2=7.871$ df=2 $p=0.020$
No	187 (46.9)	15 (2.8)	193 (49.9)	392 (100.0)	

Characteristics	Women's preferred gender of the doctor				Test
	Female doctor	Male doctor	No preference	Total	
Feeling ashamed					
Yes	106 (58.6)	9 (5.0)	66 (36.5)	181 (100.0)	$X^2=22.985$
No	91 (36.1)	11 (4.4)	150 (59.5)	252 (100.0)	df=2
					p=0.000

df, degrees of freedom.

Table 7

Women's preference for another person being present during pelvic examination.

Preference	n	%
Doctor alone	107	24.7
Doctor and nurse	208	48.0
Doctor, nurse and medical student	19	4.0
My mother	13	3.0
My partner	96	22.2
My friend	9	2.1
My relatives	25	5.8

* Total n may exceed 100 as participants may have reported more than one preference.

Table 8

Women's expectations of doctors and nurses during pelvic examination.

Expectations of doctor	n	%
No expectations	23	5.3
Doctor should provide explanation after examination	269	62.1
Doctor should have understanding, gentle behaviour	239	55.2
Examination should be thorough	167	38.6
Doctor should listen to woman	130	30.0
Doctor should provide explanation before examination	97	22.4
Expectations of nurse		
No expectations	29	6.7
Nurse should have understanding, gentle manner	311	71.8
Nurse should provide explanation about examination	122	28.2
Nurse should prepare woman for examination	90	20.8
Nurse should relax the woman	90	20.8
Nurse should assist during the examination	53	12.2
Nurse should show woman to the examination room	39	9.0

* Total n may exceed 433 as participants may have reported more than one expectation.