Doctors' Attitudes to Intimate Examinations

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WHAT WE LEARNT

Doctors negotiate emotions around intimate examinations (IEs) in many different ways, some of which may be detrimental to patient care.

Emotional constructions cause doctors to attribute values to IEs and chaperones that extend beyond 'responding to indications' or 'following guidelines'.

Why we started

People with HIV should have access to investigation and diagnosis of STIs. They have increased risk of malignancy, including anal and cervical neoplasia, which could be detected on examination.

There is heterogeneity of practice around intimate examinations (IEs) and chaperones. Doctors frame clinical benefits of IEs on expert opinion, as objective evidence is lacking. Doctors hold widely differing beliefs about the clinical value of IEs. IEs may not take place with appropriate frequency, missing opportunities to detect disease. Conversely, inappropriate decisions around IEs may have adverse medicolegal implications.

This study sought to address a paucity of inductive enquiry in this area, by asking how doctors make decisions to perform IEs and negotiate emotional aspects of IEs.

What we did

Constructivist Grounded Theory

Data Collection ⟷ Analysis

emerging theory informs sampling; participant checking

Sampling

N =38 doctors
Differing grade/speciality
7 from HIV/GUM
South East England

Interviews

In-depth qualitative interviews
31.3 hours of data

Analysis

Line-by-line coding
Focused coding
Categorisation
Memo writing
Constant comparison

WHAT WE FOUND

Understanding Emotions

Vulnerability

Embarrassment

For a man who's never been anywhere near a woman sexually at all, to start putting two fingers in someone's vagina […] you must look like a bumbling fool.

Reciprocal with patient
Transgressing social norms
Mitigated by personal or professional familiarity with intimacy

[My consultant said:] they don't have the capacity; you just have to do it. I really felt like I was raping somebody

He went "oh, I do love a woman putting on a pair of plastic gloves." I was just like: "Oh, god!"

Mirrors patient vulnerability allegations
exposing personal life, sexualisation
Objections; feeling party to abuse

Fear and anxiety

the stakes are higher if it's a genital examination.

Going into an examination room with a woman when you're not very good at putting a speculum in is quite terrifying. You know that you have got to do this procedure and you don't know whether you're going to be successful.

Reciprocal with patient
Diagnostic ability
Technical competence
Inflicting pain

Negotiating Emotions

If we're going to do it we might as well do it now and get it out of the way

As soon as it starts to become automated you stop being embarrassed or having any kind of personal feelings

They would say, 'He probably enjoyed that PR because he was gay!'

Humour
Desensitisation
Downplaying
Evoking necessity
Avoidance of personal pronouns

I feel like I need to lay on the line to a patient what to expect.

'I am not going to ever see that happen again, and certainly not on my patch

if I am having an equal conversation with somebody then it makes it much less of a [power] paradigm

Setting personal/interpersonal boundaries
Portraying IE as shared activity
Empowerment through career progression

[My consultant] put the women at ease, and I basically copied his style

Sometimes I act a little bit gayer to put the woman at ease

Using or subverting stereotypes
Observation and emulation
'Doing my job well'

Evaluating IE & chaperones

there are other ways of sorting things out. But just it's always been done that way

are they able to be thinking, you know, 'What can I learn from this?' [Or are they thinking,] 'Gosh, I really don't want to be doing this

Chaperones as voyeurs
Gendered use of chaperones
Performing IEs due to medical culture

obviously you will understand that we need to protect ourselves

the patient would have had more confidence in him if he bothered to look

Chaperones to protect doctor
Chaperones to empower patient
Performing IEs as part of a therapeutic relationship

Continuity has gone, the 'generalist' has gone; I feel I only need to know enough gynae to deal with emergencies

Chaperones to provide comfort
Chaperones for informality
Specialising the IE
Not missing something

Explanation / Theory

- Doctors' emotional constructions of IEs coalesce around embarrassment, fear and anxiety, and vulnerability.
- Participants' understandings of gender, sex, and power influence emotional constructions.
- Doctors utilise varying methods to negotiate emotions, some of which may be detrimental to patient care.
- The emotional constructions identified lead doctors to attribute values to IEs and to chaperones that extend beyond responding to indications or following guidelines.
- Doctors who resolve their own feelings of embarrassment, anxiety, and vulnerability may be more likely to perform IEs when indicated, to use chaperones appropriately, and to offer the best standard of patient care.

Implications

- Encouraging doctors to reflect on and resolve emotions around IEs may encourage them to practice IEs more consistently in situations where they are clinically valuable.
- Trainers should seek to provide trainees opportunities to navigate the 'hurdle' of the socially transgressive nature of IEs without relying on repeated patient exposure.
- Training should recognise doctors' own vulnerabilities without overstating these, to avoid fostering a culture where doctors are reluctant to perform IEs when appropriate.
- Training around IEs should empower doctors to challenge other professionals when they feel they may be abusing patient vulnerability.
- National Organisations should seek to provide guidance on when particular IEs are appropriate, and the evidence-based reasoning behind this.

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