

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'.

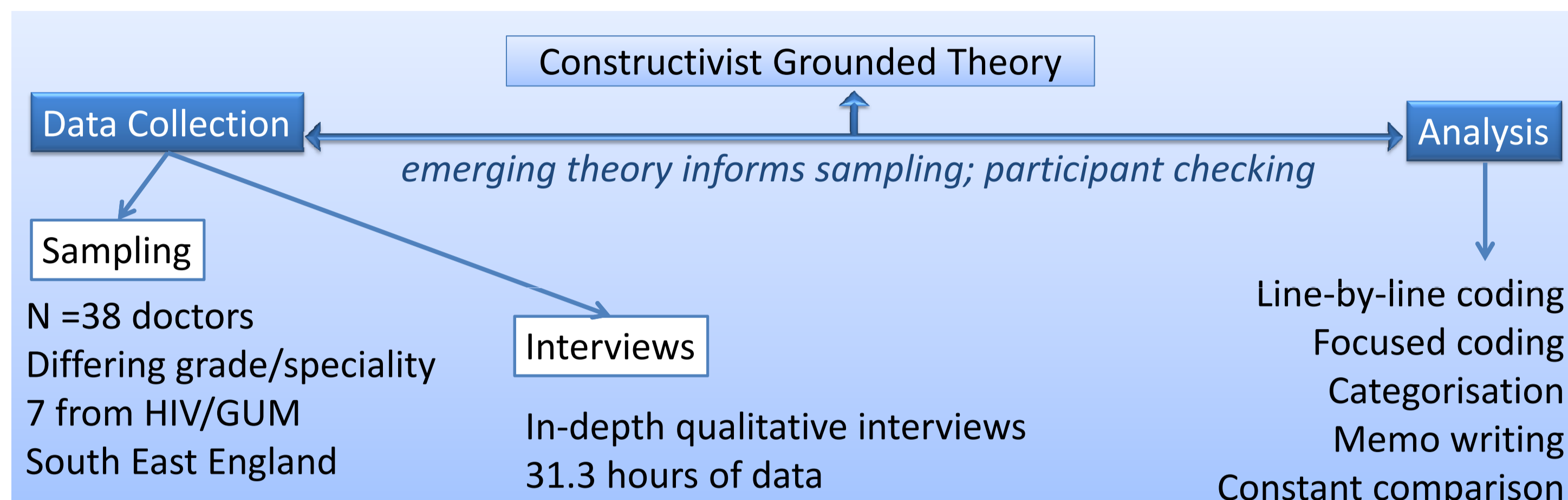
Why we started

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.

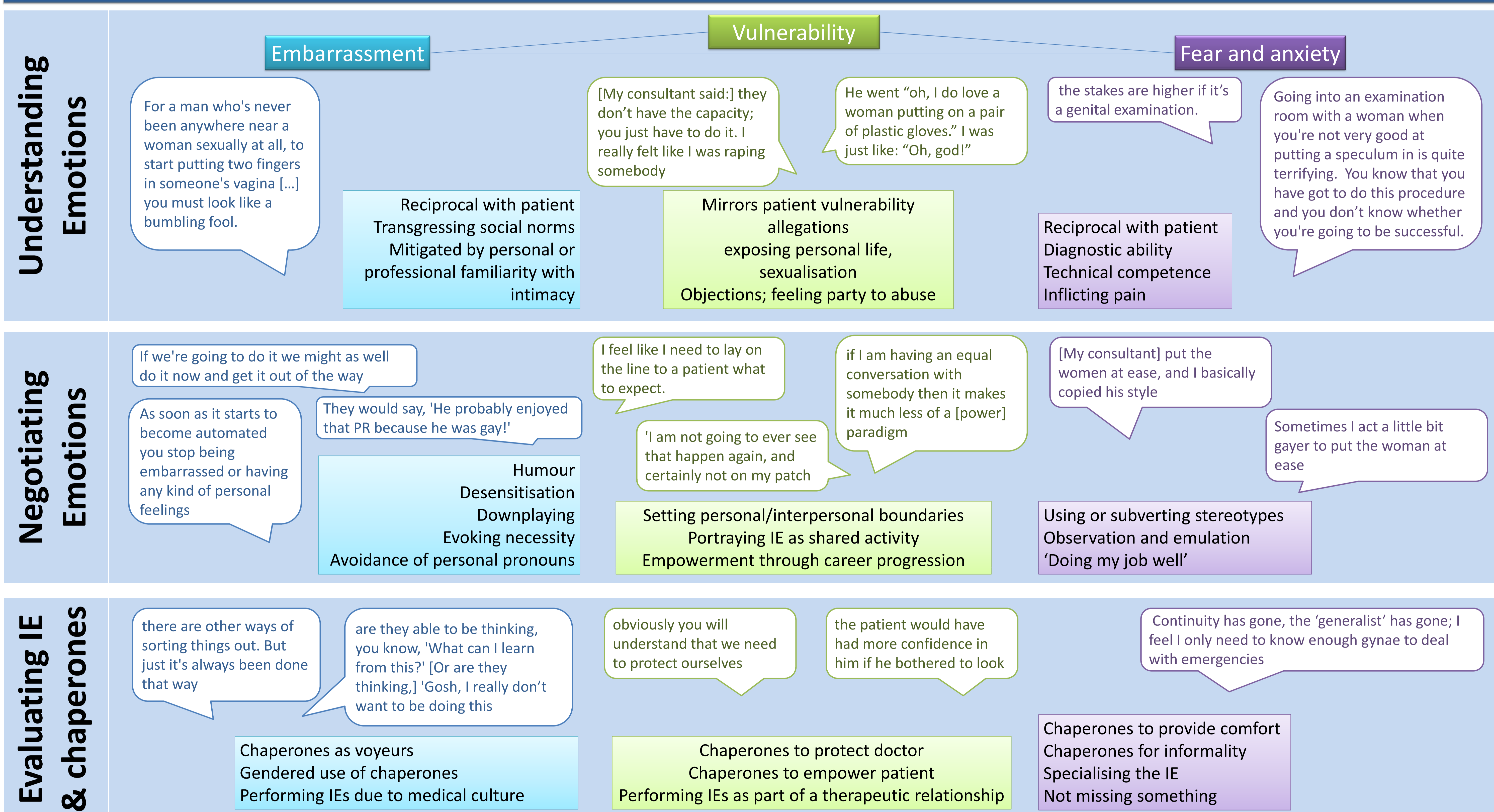
There is heterogeneity of practice around intimate examinations (IEs) and chaperones. Doctors frame clinical benefits of IEs on expert opinion, as objective evidence is lacking. Doctors hold widely differing beliefs about the clinical value of IEs. IEs may not take place with appropriate frequency, missing 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



WHAT WE FOUND



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.