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- 'docendo ac discendo' - 'by teaching and learning'

In this issue:

Executive Board

IJOCS
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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword

Surviving the Global Economic Crisis in the World of Clinical Skills

After a tremendously successful beginning, the International Journal of Clinical Skills (IJOCS) has had the pleasure of bringing together the international clinical skills community. Throughout 2008 the extremely positive response from both students and teachers has demonstrated the need for this quality peer reviewed Journal, whose remit is not only to publish research, but also to provide a centre point in the world of clinical skills.

The variety of papers published in IJOCS to date is in itself unique, many of which have been changing the way all healthcare professionals practice within the clinical arena. Only time will tell whether such change does ultimately lead to improved patient outcomes and quality healthcare; however, the remarkable feedback received from the many doctors, nurses and other professionals who read the IJOCS, encourages us to continue developing this exceptional resource.

As 2009 begins, countries all over the globe face what may be the worst economic outlook since the 1950's, hence it is prudent not only to be conscious of our spending habits, but also to consider how this may impact the teaching and learning of clinical skills – a vital part of healthcare. Many healthcare institutions have had to significantly reduce their educational budgets, which no doubt has a detrimental impact on the training of all professionals. Moreover, it is important not to lose sight of the fact that quality healthcare delivery is required to maintain healthy nations, which, in turn, can reduce financial burden.

Following the global financial crisis, the in-house publishing company for the IJOCS (SkillsClinic Ltd) has decided to launch the website www.clinitube.com in 2009. This will be a free website where professionals will not only be able to download clinical skills guidelines (the aim of the originally proposed Clinical Skills Lab – CSL), but also upload their own information and files onto clinitube.com so that other professionals can share these materials for free. At a time when resources are limited, clinitube.com will build an online community for the sharing of much needed resources.

In addition to our colleagues at clinitube.com, the IJOCS will continue to publish many articles which present novel research and offer readers comprehensive guidance on a variety of clinical skills subject areas, including effective teaching methodology. We hope our readers take advantage of this knowledge by disseminating the information, putting it into practice and benefiting from the numerous incentives.

We reflect with much enthusiasm, for what the IJOCS has achieved so far and look forward to what has begun.

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The clinical skills and biomedical ethics of vaginal examination

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Abstract

The sociology of vaginal examination is the subject of continuous discussions to consider the potential elements of professional co-operation and/or interpersonal conflicts. Socio-cultural changes influence, directly and indirectly, clinical skills and their interaction with biomedical ethics. Vaginal examination is a clinical skill that draws values from the reconsideration of biomedical ethics in today's society. The doctor-patient professional relationship, autonomy, privacy and the doctor's consciousness of beneficence and non-maleficence, respect of confidentiality and acting with fidelity and veracity, all should be proactively applied throughout every attempt of examination.

Introduction

The recent history of sociology of vaginal examination

The sociology of vaginal examination in clinical practice was an issue of discussions and consideration between clinicians, sociologists and psychologists. Over 20 years ago, sociologists addressed the subject, to analyse the different elements of human interactions that take place during what is a routine and common clinical procedure. Some view vaginal examination as an area of potential conflict (conflict theorists) and others view it as an area where cooperation is the essence of social life (cooperation theorists). We wish to examine the clinical skills and biomedical ethics involved in the process of vaginal examination, with reference to both areas of potential cooperation and conflict. We would also like to reflect on clinical experience and day-to-day observations of socio-cultural changes and sexual behaviour.

Cooperation theory sociologists identified the elements of vaginal examination, over 20 years ago, in the following five stages [1]:

1. **The personalised stage: the patient as a person;** the doctor greets the patient and enquires about the patient's own concerns, establishes the need for pelvic examination. The doctor allows the nurse and the patient to prepare for the pelvic examination in privacy.

2. **The de-personalisation stage: the transition from person to pelvic;** the nurse advises the patient on the need for pelvic examination (including undressing and getting prepared on the examination couch in the Lithotomy position and covers the patient).

3. **The de-personalised stage: the person as pelvic;** the attending doctor and nurse give the indication that their interaction will follow professional protocols. The nurse assists the doctor in preparing the gloved hand for the internal examination. The doctor performs the vaginal and speculum examination.

4. **The re-personalising stage: the transition from pelvic to person;** the doctor leaves the scene for the nurse to assist the patient (to come down from the Lithotomy position and prepare to redress).

5. **The re-personalised stage: the patient as a person once more;** the doctor discusses the clinical findings and suggests further medical care.

The *conflict theory sociologists* refer to areas of possible tension between the acting parties. The process of pelvic examination could be as intense to the attending doctor as it is to the attending patient. For example, examining a patient during an episode of pelvic inflammatory disease is fraught with expressions of distress, pain and tenderness. The internal examination is essential for establishing the diagnosis and severity of the condition. The examination could be unproductive, if the process is unsympathetic and leads to loss of patient cooperation.

Another extreme, but realistic scenario is the vaginal examination of a patient after a history of sexual assault. Most female patients exposed to this tragedy prefer to be assessed by a female doctor and their wishes must be anticipated and respected. Equally a patient who is not relaxed enough during the process can convey an atmosphere of tension and pressure on the attending professionals. Therefore, it is in the interest of all parties that full and real cooperation and understanding takes place.

Discussion

The biomedical ethics of vaginal examination in today's society

Our views on society have changed a great deal since the article, 'The Sociology of vaginal examination' was published in 1985. Some twenty years on, the socio-cultural parameters of western societies are changing. The public views on modesty are widening and their understandings of sexual norms vary. The culture in the eighties was that pelvic examination is of more significance if performed by a male doctor on a female patient. The different patterns of sexual behaviour and the presentation of gay medical problems in today's practice, suggest that the same process of *professionalism* should be applied, irrespective of the sex of the patient or that of the doctor (i.e. a chaperone is required even when a female doctor is undertaking genital/pelvic examination of a female patient).

The biomedical ethics [2] of pelvic examination are a reflection on every element of the assessment. Each step should be analysed by the attending doctor, for setting a framework for professional standards. Using the patient's surname (not the first name) assures a *professional relationship* rather than a personalised one. This is of more importance in the context of genital/pelvic examination rather than in a discipline like paediatrics, when dealing with the patients on a first name basis could be considered for a smooth interaction.

The doctor needs to establish at the start, the indication and necessity of the examination (whether it is deemed necessary or just part of a medical ritual). This ensures the concept of *beneficence*. A process of interaction between the attending doctor and the patient, best achieves the indication for examination. The process starts at the point of taking a history, to identify (with the patient) the need for such an examination.

Today's liberal cultures, TV soaps and sexualisation of articles in the media, magazines and newspapers can drive some patients into having no parameters or boundaries for sexual history. This risk needs to be understood by practitioners. The aspect of the sexual history that is of relevance to the clinical assessment, is the one that needs to be listened to and recorded. There are two extremes of patient situations. There are patients who are too shy to speak or respond to questions (and who need encouragement to relax and provide useful clinical history). The other extreme are those who would like to talk loosely and freely of sexual "adventures" and would drift away from the parameters of clinical necessity (and who need to be led back to the framework of clinical history).

"How can we help?" provides a good start for the interview. The question implies an offer from the clinician of the intention to provide this help. The answer to the question would imply a request, from the patient, for some kind of medical help. It sets the scene into an interaction and cooperation between the two parties; with the doctor taking the lead from the patient and the patient deciding on the aspects of assistance, as she considers necessary, in confirmation of her *autonomy*. It is necessary to make it clear to the patient that every aspect of the vaginal examination process is an offer that should be accepted and freely consented for by the patient.

Then there is the issue of explanation and informed consent; which should be provided by the attending doctor, as a *professional responsibility*. The scenario where a nurse explains a medical process is not one that will be accepted or viewed positively by the General Medical Council of the UK. Any procedure performed by an attending doctor, should be fully explained by the doctor with informed consent (and could be reiterated by a nurse). There have been occasions when patients attending a gynaecological practice refuted the concept of "implied consent" (i.e. attending a gynaecological clinic implies that the patient is prepared and has accepted the necessity and idea of "internal examination"). It is prudent for the doctor to provide a clear explanation (i.e. the reasons why it is required, how it is performed, what steps are used and the need for any procedures like inserting a speculum).

The issue of patient's *autonomy* needs to be well understood and respected by the attending doctor and nurse, who should take it into practical application throughout the process. This means that the patient has absolute control of the situation, with what should or should not be performed. It could be called for at instances when the examination could prove too much for the patient to proceed with. The doctor should be prepared to abort the examination, if the patient indicates so. An examination that provokes distress is unproductive. This fulfils the concept of *non-maleficence* [2].

There are also professional duties where the doctor needs to explain clearly (in language that the patient can understand), and good and clear communication, the findings and outcome of the examination. The concept of *veracity* [2] (the comprehensive, accurate and objective transmission of information) fosters good professional standing between the doctor and the patient. The patient trust in the doctor, that he/she will act in good faith and *fidelity* [2], ensures better co-operation and a positive outcome

of the consultation and pelvic examination (which both parties of patient and professionals are interested in and aiming for). A positive outcome will be achievable if all parties are comfortable, relaxed, understand their individual and collective role in the process, and engage in it with a conducive demeanour.

The role of the nurse in this process is to provide the professional role of a chaperone. Their presence adds to the scenario and atmosphere of professionalism. They lend assistance and emotional support to the patient. They prepare the examination room (couch, equipment, swabs) for the incumbent patient and rearrange it for the next one. They help the attending doctor, which is of importance when further tests/ swabs are necessary. They provide the patient with additional explanation (as some may view doctors in an academic status and view the nurses as mediators).

There have been medico-political targets in the UK, for patient's relatives to attend the process of clinical examination, with the aim of supporting the patient. This suggestion is not likely to be suitable for the *privacy* of pelvic examinations, where an additional third party (of non clinical background) can complicate the scenario. There is also the issue of *confidentiality,* where the patient may have not considered the clinical findings carefully, before the examination. In this context, the presence of a chaperone/nurse is a professional and practical necessity.

In our practice, we have a separate changing room, where the patient undresses in her own *privacy* (as some patients would find it uncomfortable to undress even in the presence of a female nurse). We use a long gown for cover so that the patient walks from the dressing room to the examination couch well gowned. The gown is loose so that it could be used as covering drape. This all takes place in a separate examining/dressing suite and the doctor is ushered in by the nurse once the patient is lying on the table well covered, except the area ready for examination. Patients would feel modesty if their knees are covered, and due care is exercised to keep the cover drawn to knee level.

It is not unusual to need more detailed aspects of history. Further clinical interactions may need to take place between the attending doctor and the patient, for more clarification on the clinical history. Therefore, the concept of "*depersonalisation*" that sociologists used twenty years ago is out of context. The patient continues to be a person throughout the process, with holistic need, part of it is pelvic examination, which is done, in a *professional* atmosphere.

It is prudent to continue to treat the patient as a person throughout the clinical assessment (history taking, examination and explanation). Most patients in today's culture would feel ignored if not spoken to. With training and practice, it is possible to keep a continuous management of the situation where the patient is treated with respect, dignity and consideration whilst communicating with her as a person, in a professional manner. A few words of explanation are necessary, to assure the patient, immediately, after the examination. A blank response could be very worrying. The few minutes, between the end of the clinical examination and the following interview, could prove a very long time for the patient. The immediate short explanation should be done whilst the patient is sitting and covered on the examination table. Most of today's couches allow this process. It is inappropriate to talk to a patient whilst she is lying down and half undressed.

Conclusion

Vaginal examination is the most private aspect of the doctor-patient relationships. It should be built on a professional relationship, with an appreciation of concepts of autonomy, beneficence and non-maleficence. It is part of a holistic assessment process, based on confidentiality, fidelity, veracity and privacy.

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The Clinical Skills Lab database will comprise information on over 200 clinical skills, broadly separated into:

- ➔ History taking skills
- ➔ Communication skills
- ➔ Clinical examination/interpretation skills
- ➔ Practical skills

Not only will this valuable resource provide material to students as a learning tool and revision aid, for example, OSCEs, it will also offer educational materials for teachers from all disciplines, allowing some standardisation of practice. The Clinical Skills community will also be encouraged to contribute, making this database interactive.

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