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# Pelvic examination of asymptomatic women

## Attitudes and clinical practice

### Background

Many women see their general practitioner for 'well woman' checks, which often include Pap tests and a pelvic examination. A recent review of the evidence revealed pelvic examination in asymptomatic women is not a valid screening test, particularly with regard to ovarian cancer screening.

### Method

This project explored the attitudes of GPs regarding the performance of pelvic examinations in asymptomatic women. Twenty-seven GPs were interviewed about their current practice and opinions of the value, advantages and disadvantages of pelvic examinations in asymptomatic women. The interview data was analysed qualitatively.

### Discussion

The majority of the GPs interviewed perform pelvic examinations as part of a well woman check. Despite broad consensus by the GPs that the value of a pelvic examination as a screening test was questionable, they were performed for a range of reasons including patient reassurance, documenting the norm, 'because I was taught to', for legal reasons, and for completeness. The disadvantages of performing pelvic examinations in asymptomatic women noted by the GPs were time constraints, chaperone issues, intimacy concerns, and false reassurance and unnecessary anxiety caused by unexpected findings. However, neither these disadvantages nor the presentation of evidence based guidelines dissuaded the doctors from performing the examinations. This highlights the ongoing discrepancy between the theoretical development of such recommendations and their practical implementation.

■ **Well woman checks are commonplace in general practice and may include pelvic examination, usually in conjunction with a Pap test. These checks are performed with the assumption that they can detect pelvic pathology, including signs of ovarian cancer. An earlier review of the literature recommended against the use of pelvic examination as a screening test in asymptomatic women.<sup>1</sup> Of note, The Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) do not include pelvic examinations in their guidelines as a screening activity, either alone or in association with Pap tests.<sup>2,3</sup> However, personal experience suggests that the practice of these examinations is widespread. This project aimed to explore the attitudes of general practitioners to the use and value of pelvic examinations in asymptomatic women, and whether the evidence base for such examinations would change their practice.**

### Method

Eighty-seven GPs were invited to participate in the study (from a current list of practitioners provided by the local General Practice Network) and nonrespondents were not pursued. Twenty-seven GPs were interviewed using a semistructured format, piloted previously and revised. The questions were developed by the project investigators and research assistant after extensive literature review, and covered both breast and pelvic examination in asymptomatic women. Interviews were conducted face-to-face in local practices by the research assistant, audiotaped and transcribed with open coding. An inductive approach was used to analyse interview content, and themes developed using the Atlas Ti software program.

Ethics approval was granted by the James Cook University Ethical Committee (reference H2231). Funding for the project was through the RACGP Chris Silagy Research Scholarship.

## Results

The semistructured interviews were conducted with nine male and 18 female GPs, giving a response rate of 31%. The participating doctors had been working in general practice a minimum of 5 years and a maximum of 56 (average 19 years, median 17 years). Interview times ranged 11.45–36.55 minutes with an average time of 20.48 minutes. Themes arising from the data are listed in *Table 1*. Quotes are identified by the allocated interview transcript number (1–27).

### Well woman checks

In general, the GP respondents incorporated similar tests in well woman health checks. These included blood pressure measurement, breast examination, Pap test, pelvic examination and, time permitting, a skin check. General practitioners emphasised that their check was tailored to individual needs, age, family history and the interval since the check had been performed.

'Talk about their general health and issues of concern to them and it would include blood pressure, blood work, it would include a breast exam, doing Pap smear and at the same time an internal exam. Listening to the heart, checking their lungs and focusing on their areas of concern, age dependent'. (21)

Well woman health checks were viewed as a good opportunity to promote preventive activities such as mammography, cholesterol check, breast awareness, and to discuss lifestyle issues such as smoking and alcohol use.

'Patient awareness that cancer of the cervix isn't the only gynaecological problem there is, [is important]'. (27)

### Motivation for performing pelvic examinations

In general, patients rarely requested pelvic examinations, but after suggestion and/or explanation by the GP, were usually happy to proceed.

**Table 1. Themes arising from the interviews**

- Well woman checks
- Content and utility
- Motivation for performing pelvic examinations
  - to detect pathology
  - to assess pelvic floor
  - to reassure (patient and doctor)
  - to avoid litigation
  - as 'practice'
- Perceived value
  - variable
- Disadvantages
  - false reassurance
  - time
- Gender differences
- Implementation of guidelines

'I very rarely, if ever, have someone who says I don't want an internal. An internal is generally less uncomfortable than having a speculum passed. If a speculum has been uncomfortable or painful, I think it is essential to find out why. And, you can only find that out by doing an internal'. (3)

An opportunity to detect pathology was one of the most common reasons that GPs proposed as justification for doing pelvic examinations. Most doctors did report finding pathology due to a pelvic examination at some stage but only one doctor reported detecting a malignancy. Fibroids and ovarian cysts, as well as pelvic tenderness suggesting pelvic inflammatory disease, were the most often identified conditions.

'As far as the pelvic [exam] is concerned, the most common condition would be an enlargement of the uterus due to fibroids or enlarged ovaries. The other abnormality you could possibly find is that the patient is very tender and then you put the speculum in and then you ask them a question and you find they actually tell you that they do also have a lot of pain when they have intercourse. Often they haven't told you that before, until you actually find out they've got a very sore pelvic musculature. And, of course the other one is a prolapse or a cystocele or a rectocele'. (7)

Assessment of the pelvic floor was also reported as a reason to perform pelvic examination.

'You are also assessing pelvic floor tone at the same time so that is not pathology but it is part of the well woman check. So you are assessing pelvic floor tone. You are also checking for prolapses and you are looking for things that you can fix early'. (3)  
'I'd say the advantages are picking up pathology before it becomes symptomatic. I think it is a good little STD/STI screen, [check for] cervical excitation'. (6)

The potential legal implications of not performing a pelvic examination, and subsequently missing pathology, was given as further justification, despite a lack of supporting evidence or the GPs perception of the value of pelvic exams in such situations.

'There are times when the evidence will be there but when the individual case arises then, all the evidence is trashed away because the woman may say but I will swear that the doctor did a Pap smear and never really checked up in here. How could this be that a tumour has come up? How come he missed it? Why didn't he do an internal examination? With all this evidence you would be trashed in a common law. So sometimes it is a little bit dicey'. (2)

Alternatively, where pathology has not been present, GPs suggested that there was value in 'practising' the examination and gaining experience of examining 'normal anatomy'.

'One of the reasons you do any exam is to get a database in your head and your fingers and your arms and your brain about what is normal so you will recognise what's abnormal. Now I'll be honest, I do internals almost on autopilot. I'm quickly doing them, I chat to the patient and then there is the

wrong message coming back from my fingers – that is not what I normally feel. At that stage you say, hang on a second and you go back and you do it. Now that sounds awful but that is how most doctors work'. (3)

Another recurring theme was that a pelvic examination had value in providing reassurance for both the woman and the GP. The patient would feel better in the knowledge that the GP had found nothing abnormal and GPs could rest assured that they had fulfilled expectations and obligations.

'Also there is a reassurance thing. If she comes in and she has her blood pressure taken, her breasts, pelvic and Pap smear all done at once, it is like a tick in the box for a couple of years. So there is a reassurance there that they are okay and they get on with things'. (13)

'I have had a couple of occasions when patients have been quite surprised when they didn't have a pelvic examination as part of their Pap smear'. (20)

'The advantage is that I think feeling you are doing the right thing is very important for women'. (17)

Intimate examinations also involve a degree of rapport with the doctor that promotes the sharing of personal medical information, and due to this, details can be obtained from a patient during such examinations that would not otherwise be divulged.

'When I am doing an internal examination, quite often, or not infrequently people start talking about very personal things because you are doing a very personal examination. That gives you more insight into where the patient is coming from'. (23)

### Perceived value of pelvic examinations

Although the majority of doctors routinely performed pelvic examinations for the reasons discussed above, many were still sceptical as to their value. Many GPs performed pelvic examinations out of 'habit' or because this was what they were 'taught' to do. There were varying views about the evidence base.

'... but I do pelvic examination for completeness. But I am not sure it is such a reliable test'. (11)

'I now don't do a pelvic examination unless I have got an issue or something that I want to check. That is because it is my understanding that it is not a useful gynaecological assessment in asymptomatic women. There was a study that said even if women were anaesthetised and examined by gynaecologists just before surgery they had just as much chance as picking the pathology as missing the pathology'. (15)

'Usually say to them that the pelvic exam without any symptoms is not a very useful examination. I would tend to avoid doing it unless the woman specifically requests it. I would say to her about what it can and can't do'. (25)

'Research has shown that doctors can pick up tumours smaller than 2 cm'. (27)

### Attitudes to guidelines

The doctors were asked whether their clinical behaviour would change if they were presented with evidence regarding the poor performance of pelvic examinations as screening tools. Of the 22 respondents that routinely perform breast and pelvic examination on asymptomatic women, only three said they would change their practice if presented with contradictory evidence.

### Disadvantages of pelvic examinations

The GPs mentioned several disadvantages of performing pelvic examinations in asymptomatic women.

'The disadvantages are, that may you are giving false reassurance to people and also that it may not give you the information you need, it may not exclude what you are trying to exclude'. (18)

'If they ask me if it were worth doing a breast examination or pelvic examination, I would say that there is probably no evidence that either is really worth doing if you don't have any symptoms. Of course, if you do have symptoms, it's different. Certainly with women in their 20s, you are not likely to find anything... We are certainly more likely to find something benign which will end up causing you more worry than its worth'. (5)

'Performed based on the symptoms the woman presents with and ideally, least often as possible, because I think they are invasive and uncomfortable and it is hard to find a woman who relishes the prospect'. (25)

Time constraints were also a major limiting factor, particularly when a chaperone was needed.

'I had a conflict between trying to offer the best care that I can and the time that it takes. By the time I marshal my chaperone and get the woman up there and then talk a little bit, not a long talk but a little preparation before the exam, I can't get out of a Pap smear in less than 20 minutes. We have 15 minutely appointments so she had better not want to talk about a single other thing'. (4)

### Effect of GP gender

All interviewees, except for one male GP, performed well woman checks. Only male GPs offered a chaperone during the examination. There seemed to be a distinct gender trend as to whether pelvic examinations were performed. Only one-sixth of female GPs didn't routinely include pelvic examinations, while one-third of the men didn't.

'My suspicion is and I have no basis for this, is that men do checks far more regularly than women. I think that there are a lot of male GPs who do. Am I being sexist?' (25)

### Discussion

The interviews showed that, as suspected, the majority of GPs still perform pelvic examinations as part of a well woman check, sometimes at the patient's request, and usually with a Pap test. Although there was

a broad consensus that the value of a pelvic examination as a screening test was questionable, they were performed for a range of reasons including patient reassurance, documenting the norm, 'because I was taught to', for legal reasons, and for completeness.

Noted disadvantages of performing pelvic examinations in asymptomatic women were time constraints; gender and subsequently chaperone issues; intimacy concerns; and most importantly, false reassurance and unnecessary anxiety caused by unexpected findings. However, neither these disadvantages nor the evidence based dissuaded the doctors from performing the examinations.

The attitudes of the doctors toward implementing evidence based guidelines highlights the ongoing discrepancy between the theoretical development of such recommendations and their practical implementation. Our findings are similar to many over the years in other clinical areas such as hypertension<sup>4</sup> and depression.<sup>5</sup> While GPs value evidence based guidelines, their views of the impact of such guidelines in every day practice is low.<sup>6</sup> In particular, doctors' personal experience, training and ideas about clinical efficacy outweigh their views of the evidence base and these factors need to be taken into account when advocating change. But they also need to be considered when informing women about the purpose and efficacy of pelvic examination.

Further research is needed to explore the thoughts and expectations of patients in regard to these examinations, to see if they are justified to any extent by expectation and reassurance.

### Strengths and limitations of the study

The response rate of GPs was approximately 31%. This response rate may be considered as low, however, the investigators felt that data saturation had been achieved. It is highly likely that time commitments of GPs and general lack of research interest among GPs contribute to this low rate. It should also be noted that the study participants practise in a large urban centre and their perspective may not be representative of other GPs in Australia.

Conflict of interest: none.

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