Examining Ourselves: Exploring Assumptions about Teaching Pelvic Examinations in Midwifery Education

Amy Levi, CNM, PhD

A time-honored tradition in many midwifery programs is the "pelvic exam lab": an opportunity for students to learn how to do a thorough and competent pelvic exam by examining and being examined by each other. Proponents of this educational experience feel that being a patient is a valuable experience for beginning practitioners. They also believe that the opportunity to provide feedback to one's classmates during an exam provides a source of helpful information in the early stages of establishing one's comfort and skill while performing pelvic exams. Recently, students have questioned this practice, raising a variety of concerns. In addition to the invasion of privacy represented by the "intimate examination" of another person's reproductive organs, concerns about the potential for harassment and battery have been identified. In our increasingly liability-conscious environment, it is time to reflect on the usefulness of this practice in contemporary midwifery education.

The experience of genital self-examination was a hallmark of the feminist women's health movement of the 1970s. This experience became a symbol of self-discovery for the activist women of this generation. The opportunity to visualize one's vulva, vagina, and cervix represented the ultimate reclamation of self-knowledge and self-determination. As one feminist women's health advocate expressed, ". . . the fact that this particular area of the body that has been inaccessible to us is now visualized . . . It was so revolutionary! Just the simple act of putting a speculum in the vagina ourselves and bringing up that part of the body and being able to see it in the same commonsense way we look at our face every morning."[1]

In many ways, this act of self-discovery mirrored the way that second-wave feminist philosophy has as its basis women's personal experiences, which subsequently became the foundation of feminist political theory. Knowledge of one's own anatomy created the opportunity to control one's physical destiny in terms of reproductive health, including sexuality and the ability to choose pregnancy or not. The possibility of being able to have choices and some level of control about one's body and health care extended to childbirth ushered in an interest in unmedicated and family-centered birth options.[2]

The profession of nurse-midwifery benefited tremendously from this interest in women's desires to exert more autonomy in their birth experiences. Between 1963 and 1982, the number of practicing certified nurse-midwives in the United States increased from 275 to 2550.[3] The number of nurse-midwifery education programs also increased dramatically during this time, although teaching tools and opportunities for clinical education were limited. By having students learn and practice pelvic exams on one another, nurse-midwifery programs incorporated the promise of self-discovery proffered by the feminist health movement with the opportunity to increase the breadth of students' physical exam experience by being both the patient and provider. It was also congruent with the feminist belief systems of many midwifery faculty and students.[4]

Although nursing students often practiced procedures on one another, having nurse-midwifery students use their colleagues to practice pelvic examination represented a departure from the traditional model of medical education. Most medical schools incorporated the use of patients for teaching purposes, and examinations were often carried out when patients were under anesthesia, which required neither their consent nor knowledge that the exam was taking place. This practice has come under fire in the past decade, and is illegal in many jurisdictions.[5] In addition, the American College of Obstetricians and Gynecologists (ACOG) explicitly states that "[I]f any pelvic examination planned for an anesthetized woman undergoing surgery offers her no personal benefit and is performed solely for teaching purposes, it should be performed only with her specific consent when she has full decision-making capacity."[6]

Surprisingly, there is still some controversy about whether or not the performance of unauthorized exams under anesthesia is an acceptable practice. In 2003, the *British Medical Journal* published an exploratory survey of students in a medical school in Great Britain which reported that when medical students performed "intimate examinations" (i.e., pelvic and/or rectal exams) on anesthetized patients, only 24% were performed with written consent of the patient, and 24% were performed without

Address correspondence to Amy Levi, CNM, PhD, FACNM, 1001 Potrero, 6D-29, San Francisco, CA 94110. E-mail: levia@obgyn.ucsf.edu

1526-9523/08/$34.00 • doi:10.1016/j.jmwh.2008.05.011

either written or oral consent.[7] The researchers conducted the study in response to the concerns of students who questioned the ethics of their participation in exams performed without consent. The article concluded by emphasizing the importance of identifying that best practices are not always observed in medical education, and that there is a need to more vigorously address the issue of informed consent for intimate examination.

Within 8 weeks of publication, the online Rapid Response tool which records readers' reactions to articles from the *British Medical Journal* had logged 42 postings.[8] Many of these confirmed the inappropriateness of performing examinations without consent: "Informed consent has to be regarded as a 'sine qua non' condition in teaching our students."[9] Some respondents also noted that exams performed without consent were not only ethically problematic, but also sources of potential legal action. Conversely, a number of respondents questioned the purpose of a paper which ". . . seem[s] to make ethical mountains out of everyday molehills."[10] Those who wrote with negative responses to the article expressed uneasiness with compromising medical education by limiting students' exposure to clinical experience, and dismissed the possibility that "intimate examinations" required a different approach to medical student involvement: "For doctors, a vaginal examination should be no more of an ethical issue or an intimate moment than listening to a chest, or palpating an abdomen. [. . .] The idea that gynecological or rectal examinations are shocking is purely cultural. Breasts are not considered 'intimate' parts in many places in the world."[11]

Tecoult's[11] observations reflect an objectification of the human body which is necessary to the practice of allopathic medicine; distancing the person from the physical body makes it possible for us to perform the sometimes invasive and unpleasant procedures and manipulations that we believe restore health and support well-being. However, practitioners have a choice about whether or not to engage the person in the body being treated. When a patient is under anesthesia, we can ignore the person who has the diseased gallbladder or carcinomatous breast; but when she is before us in the office, we must look in her eyes and see her fear, her anxiety, and her sources of comfort. We can also choose to enlist her cooperation in the examination, assisting us in our visualization of her cervix and vagina with the speculum. It is equally important that we let her know that this most intimate of experiences is one that we share with respect. This kind of presence with patients requires specific interpersonal skills that students will be unable to practice with an unconscious woman.

The understanding of the importance of connecting to the woman on the exam table, coupled with the liberating effects of the feminist women's health movement, has encouraged the practice of midwifery students learning pelvic exams by examining one another. Educators see a tremendous benefit for students when they can share the experience of their peer's exams from the patient's perspective. It is also considered valuable to be able to provide colleagues with constructive feedback about sources of discomfort or poor technique. These benefits must be weighed against concerns for student safety, personal control, the maintenance of appropriate personal boundaries, and the potential for liability.

Midwifery educators are challenged with the responsibility of communicating to students the appropriate respect for patients while also ensuring that they develop appropriate clinical skills. This respect extends to the use of informed consent for the patient. Practitioners assume consent when a patient presents to a site for clinical care, and generally are able to conduct examinations with the patient's cooperation, which also implies consent.[5] When a student is involved with the care of a patient, it is expected that the student's role is made clear to the patient. This consent is congruent with the American College of Nurse-Midwives (ACNM) Standards for the Practice of Midwifery Care[12] and the ACNM Code of Ethics.[13]

The expectation that students learn and practice pelvic exams on one another may clash with what is practiced in the clinical setting. The possibility of informed consent is challenged or even removed when faculty unquestioningly expect that students will participate in student pelvic labs. Students may fear reprisal from their faculty if they refuse to participate, and consent cannot, therefore, be obtained without the potential for unspoken coercion. Even when students are given the opportunity to opt out of participation, they may feel that there is pressure to conform so as not to separate themselves from other students without explanation, or be labeled as "uncooperative." It is also difficult for students to identify themselves as not participating in an early education program activity, which is frequently when this clinical experience occurs.

Practicing pelvic exams on one another also raises a variety of other issues for students and faculty alike. To what extent is a student's privacy protected when a classmate identifies an abnormality, whether known or unknown to the student/patient? How is an equal learning experience offered to male students? How do students who would prefer not to participate because of a history of sexual abuse, transgender surgery, or other legitimate reasons for wanting privacy about their bodies register their concerns without drawing attention to a matter of personal privacy? There is potential liability for the

Amy Levi, CNM, PhD, FACNM, is the Co-Director of the Interdepartmental Nurse-Midwifery Education Program at the University of California-San Francisco, San Francisco, CA. Originally prepared as an Obstetric-Gynecologic Nurse Practitioner in 1981, she became a CNM in 1986, and has taught midwifery since 1991.

education program as the result of a missed diagnosis or unreasonable expectations of a student's participation.

There is also the potential for accusations of battery from students. Merriam-Webster's Dictionary of Law defines battery as ". . . the crime or tort of intentionally or recklessly causing offensive physical contact or bodily harm [. . .] that is not consented to by the victim."[14] Although an unskilled pelvic exam is engaged in intentionally, the possibility that it could be done recklessly and experienced as offensive represents the potential for legal action.

An alternative available to education programs is the use of trained gynecologic teaching associates (GTAs). The use of these surrogates, who are also referred to as standardized patients or pelvic exam models, has proliferated as an alternative to examination of anesthetized patients or peer examination.[15,16] GTAs are specially-trained women who guide students through the rudiments of pelvic examinations during the exam itself. Much like standardized patients, they engage in the patient–provider relationship to purposely assist students in their learning. Newer inanimate simulation models (e.g., Noelle; Gaumard, Inc., Miami, FL) may be an appropriate addition to the use of GTAs, allowing students to practice hand skills before practicing on an actual person. Although the use of paid patient models represents an added cost to education programs, their participation eliminates the potential for liability when students are examining one another. The cost of defending a battery complaint resulting from a student interaction during pelvic exam practice would be an unfortunate and painful expense.

The women's health movement introduced feminist philosophy into a re-examination of traditional allopathic approaches to women's medical care. The feminist credo "the personal is the political" extended to what women came to know about their bodies and how they interfaced with the system of care that provided their clinical care.[17] As we progress toward clearer definitions of what constitutes appropriate personal control and boundaries in the educational setting, the legal issues that must be considered, and the rights of students to expect a safe and respectful learning environment, it is time to reconsider this time-honored but unnecessary practice.

I would like to thank Julie Carlson, CNM, for her inspiration and assistance in preparing this commentary.

REFERENCES

1. Murphy M. Immodest witnessing: Vaginal self-examination and the evidence of experience in the U.S. feminist self help movement. Feminist Studies 2004;30:115–47.

2. Wertz RW, Wertz DC. Lying in: A history of childbirth in America. New Haven: Yale University Press; 1989.

3. American College of Nurse-Midwives. A brief history of nurse-midwifery in the U. S. Available from: *www.mymidwife.org/history.cfm* [Accessed February 19, 2008].

4. Cragin L. The integration of feminism and midwifery: Author's reply. J Midwifery Womens Health 2005;50:258.

5. Wilson RF. Unauthorized practice: Teaching pelvic examination on women under anesthesia. J Am Med Womens Assoc 2003;58:217–20.

6. American College of Obstetricians and Gynecologists Committee on Ethics. ACOG Committee Opinion No. 358: Professional responsibilities in obstetric-gynecologic education. Obstet Gynecol 2007;109:239–42.

7. Coldicott Y, Pope C, Roberts C, Nesheim B-I, MacDougall J. The ethics of intimate examinations—Teaching tomorrow's doctors. Br Med J 2003;326:97–101.

8. Rapid Responses to: Coldicott Y, Pope C, Roberts C, Nesheim B-I, MacDougall J. The ethics of intimate examinations—Teaching tomorrow's doctors. Br Med J 2003;326:97–101. Available from: *www.bmj.com/cgi/eletters/326/7380/97* [Accessed February 1, 2008].

9. Kersnick J. A prior notice to the patients entering the examination room helps in informed consent. Available from: *www.bmj.com/cgi/eletters/326/7380/97* [Accessed February 1, 2008].

10. Frayn EH. Mountains out of molehills. Available from: *www.bmj.com/cgi/eletters/326/7380/97* [Accessed February 1, 2008].

11. Teocult E. A Victorian era? Available from: *www.bmj.com/cgi/eletters/3267380/97* [Accessed February 1, 2008].

12. American College of Nurse-Midwives. Standards for the practice of midwifery 2003. Available from: *www.acnm.org/siteFiles/education/Standards_Practice_Midwifery_2003.pdf* [Accessed February 1, 2008].

13. American College of Nurse-Midwives. Code of ethics 2005. Available from: *www.acnm.org/siteFiles/education/Code_of_Ethics_June_2005.pdf* [Accessed February 1, 2008].

14. Merriam-Webster's Dictionary of Law. Available from: *http://dictionary.reference.com/browse/battery* [Accessed February 19, 2008].

15. Carr SE, Carmody D. Outcomes of teaching medical students core skills for women's health: The pelvic examination educational program. Am J Obstet Gynecol 2004;5:1382–7.

16. Theroux R, Pearce C. Graduate students' experiences with standardized patients as adjuncts for teaching pelvic examinations. J Am Acad Nurse Pract 2006;18:429–35.

17. Boston Women's Health Book Collective. Our bodies ourselves: Updated and expanded for the 90s. New York: Simon & Schuster; 2005.