Teaching the Pelvic Exam: A Patient-Centered and Evidence-Based Approach to Training Medical Residents

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Beth Israel Deaconess Medical Center
Goals:

To discuss and explore ways to educate residents on a challenging component of the physical exam: the pelvic exam.
Objectives

- Discuss strategies to teach residents how to explain the pelvic exam to patients.
- Describe techniques to teach residents how to perform a comfortable and technically proficient pelvic exam/Pap smear.
- Describe how to provide constructive feedback to residents both during and after performing a pelvic exam.
- Explore a toolbox of resources to consider for use in developing individual pelvic exam teaching program. Attendees will begin to develop a plan to implement improvements in their specific setting.
Workshop schedule

- Welcome and introduction – a review of what residents need learn including indications and limitations of the exam
- Discussion of pelvic exam teaching techniques and evaluation methods
- Round table discussion (20 min at each table)
  - Group 1: Teaching residents a patient-centered approach for the pelvic exam including pre- and post-exam counseling
  - Group 2: Teaching tips regarding the challenging pelvic exam
  - Group 3: Providing feedback: Role play and use of standardized checklists
- Summary and questions
Introduction

- Internal medicine residents must perform pap smear and endocervical culture safely and competently.
- ABIM requirements include this as 1 of 5 procedural skills required for Internal Medicine Certification.
ABIM Requirements regarding procedures recommended:

Candidates must be:

- knowledgeable in indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results;
- able to recognize complications and;
- able to explain to a patient all facets of the procedure necessary to obtain informed consent.
Indications for pelvic exam include:

- Vulvar or vaginal complaints
- Abdominal pain in a woman
- Exposure to sexually transmitted infection
- Pregnancy (known or proven)
- Health maintenance (to perform pap smear)
Components of the pelvic exam

- Gynecologic history
- Counseling and expectations
- External exam
- Speculum exam
- Specimen collection
- Bimanual exam/recto-vaginal exam
- Microscopy
Counseling and expectations

- Explain to the patient the different components of the exam and what to expect
- Purpose of the exam
- Appropriate followup of results
Preparation

- Exam best performed when patient has empty bladder
- Make sure the resident has all of the necessary materials for the exam:
  - Gloves
  - Speculum (appropriate size plastic or metal)
  - Lamp
  - GYN cotton-tipped “Qtips”
  - Lubricant
  - Pap material (brush/spatula/broom)
  - Slide and fixative or liquid media
  - Ph paper, culture material, slides, KOH/saline
During the exam:

- Coach the resident on positioning the patient and on appropriate terms to use during the exam:
  - “Move to the bottom of the exam table until the edge”
  - “Relax your legs”
  - “You may feel some pressure now”
  - “Appears normal”

- Instead of:
  - “Looks good”
  - “Spread your legs”
  - “I’m going to scrape your cervix now”
External exam

- Inspect: hair, labia majora and minora, clitoris, urethral meatus, perineal body, prepuce, hymen, and anus
- Palpate: Bartholin’s glands
Speculum exam

- Insert speculum at an oblique angle
- Insert speculum with downward pressure and open
- Inspect the vaginal mucosa, cervix and external os
- Adjust speculum to visualize the cervix by closing the speculum and repositioning
- Remove the speculum and palpate the cervix if necessary
Screening intervals

Populations that need annual screening:
- DES exposure in utero
- Immunocompromise (HIV+)
- History of CIN II/III or cervical cancer
Cervical cancer screening guidelines

“When To Start”

- Assess gynecologic history and sexual history at first visit and every preventive health visit
- Screen 3 years after onset of sexual activity but no later than age 21
<table>
<thead>
<tr>
<th></th>
<th>Pap Interval (yrs)</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Cancer Society (ACS)</td>
<td>1</td>
<td>Conventional smear (before age 30)</td>
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<tr>
<td></td>
<td>2</td>
<td>Liquid based cytology (before age 30)</td>
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<td></td>
<td>2-3</td>
<td>30 yrs or older with at least 3 consecutive normal results</td>
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<tr>
<td>American College of Obstetrics</td>
<td>1</td>
<td>Younger than 30 (conventional or liquid)</td>
</tr>
<tr>
<td>and Gynecology (ACOG)</td>
<td>2-3</td>
<td>30 yrs or older with 3 normal smears</td>
</tr>
<tr>
<td></td>
<td>3 plus HPV (-)</td>
<td>30 yrs or older; if (-) for both tests, screen every 3 yrs</td>
</tr>
<tr>
<td>United States Preventive</td>
<td>3</td>
<td>Any age in women with at least 2 normal smears</td>
</tr>
<tr>
<td>Services Task Force (USPSTF)</td>
<td></td>
<td>* Has not endorsed liquid cytology or HPV test</td>
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## When To Discontinue Screening

<table>
<thead>
<tr>
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<th>Age (yrs)</th>
<th>Considerations</th>
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<tbody>
<tr>
<td>ACS</td>
<td>70</td>
<td>3 consecutive normal results; no abn in last 10 years</td>
</tr>
<tr>
<td>ACOG</td>
<td>N/A</td>
<td>Screen based on annual pelvic exam</td>
</tr>
<tr>
<td>USPSTF</td>
<td>65</td>
<td>Recent normal smears, not at high risk for cervical cancer</td>
</tr>
<tr>
<td>American Geriatrics Society</td>
<td>70</td>
<td>Regular screening</td>
</tr>
</tbody>
</table>
Specimen collection: Conventional Cytology

- Extended tip spatula + endocervical brush samples ectocervix, transformation zone, and endocervix
- Rotate brush in one direction after insertion into cervical os
- Rotation of 180 degrees is adequate
- Rotation greater than 180 degrees may cause bleeding, does not improve adequacy
Cervical brooms are designed to sample all three components (ectocervix, transformation zone, endocervix) with one instrument.

Broom may be used for conventional cytology as well as liquid based cytology. Rotate in one direction for 5 rotations (do not reverse directions).

Specimen collection: Liquid based Cytology
Specimen collection: Liquid based Cytology

- 2000 study over 1 year
- 10,241 Paps using ThinPrep liquid cytology
- Results showed:
  - Using spatula + cytobrush and broom + cytobrush showed statistical significance over broom alone in Pap adequacy (endocervical component)

Specimen collection: HPV typing

- Use liquid cytology media (HPV typing can be added on up to 3 weeks after collection date)
- Collect sample as if collecting for Pap smear
- Current FDA indications for High Risk HPV typing:
  - 1. **Triage ASCUS**
    - If HR HPV NEG, may repeat Pap in 6 months.
    - If HR HPV POS, proceed to colposcopy
  - 2. **For cervical cancer screening in women over 30 in conjunction with Pap smears (ACOG, ASCCP)**
    - If Pap NEG and HR HPV NEG, may repeat Pap in 3 years
    - If Pap abnormal and HR HPV NEG, triage according to Pap result
    - If Pap normal and HR HPV POS, repeat both tests in 1 year. If HR HPV POS 1 year later, proceed to colposcopy*

2007 American Society for Colposcopy and Cervical Pathology
Specimen collection

- Chlamydia and Gonorrhea PCR: Swabs placed in cervical os for 5-10 seconds prior to placing in M4 media
Bimanual exam

- Using water-based lubricant, insert index and middle finger into the vagina with dominant hand to elevate vagina.
- With other hand, apply pressure to abdomen and simultaneously assess size, shape, symmetry, mobility and presence of masses in the uterus, cervix, and adnexa.
- Normal ovary size is 2-3 cm in diameter.
Bimanual exam

- Limitations of the bimanual exam:
  - Ovaries can be difficult to palpate
  - Ovaries detected in bimanual exam performed by Ob/Gyn under anesthesia:
    - 30% in women > 55 years old
    - 51% in women < 55 years old
    - 9% in women > 200 lbs

Ueland FR; et al. The accuracy of examination under anesthesia and transvaginal sonography in evaluating ovarian size. Gynecol Oncol. 2005 Nov;99(2):400-3.
Bimanual exam

- Poor evidence for distinguishing benign from malignant adnexal masses:
  - Pooled sensitivity 45%
  - Pooled specificity 90%

Rectovaginal exam

- Performed by inserting index finger of dominant hand in vagina and middle finger in rectum
- Possible indications include palpation of a retroverted uterus, adnexa, cul-de-sac, and uretersacral ligaments
- Other indications include detecting rectal tumors, hemorrhoids, and occult blood
How Should We Teach?
How Should We Assess?

A Brief Survey of Methods

Jennifer Potter
Learning Objectives

- List barriers to teaching the pelvic exam
- Describe pros and cons of available teaching techniques
- Discuss the merits and limitations of learner assessment strategies
We’ve Come a Long Way...
...But Not Far Enough

- Cervical cancer remains a major cause of premature morbidity and mortality
- Disparities in screening are particularly high in certain populations
- Insufficient training of health care providers is an important barrier
Our Experience

- N = 20: 10 male, 10 female graduates
- Mean # paps: 27 (women); 1 (men)
- Endocervical zone absent: 14% overall
- Men need more opportunity
- Both men and women need more training
- Objective assessment is critical
What Should Training Consist Of?

- ABIM recommendations:
  - Begin procedural training with simulations
  - Each resident should “have an opportunity to perform each procedure at least 5 times, under supervision, as an active participant.”

- What is the evidence?
Confidence Rises with # of Paps

- 2006 survey of 142 IM residents in a university training program.

- Residents who did > 10 Pap smears were significantly more likely to feel confident (95% CI 2.15-36.26) and less likely to want more training (CI 0.06-0.93) than those who did ≤ 5.

- 42% in this sample performed < 5 Paps.

Experience ≠ Competence

- 2003 study of pelvic exam skills:
  - 10 Ob Gyn vs. 9 IM interns
  - 26-item OSCE checklist completed by GTA

- Actual performance did not correlate w/:
  - Amount of previous experience
  - Perceived competence

Optimal Training Must...

- Address gender bias:
  - Men need more opportunity
- Identify effective teaching techniques:
  - Both men *and women* need better training
- Include constructive educational feedback
- Include a rigorous evaluation component
- Be easy and practical (time, cost)
Gender Bias: Data

- Female providers...
  - Know more about cervical cancer risk
  - Are more likely to discuss sexual risks
  - Are more likely to perform Paps themselves

- Women with female providers...
  - Are more likely to be UTD w/ screening

Franks & Clancy. Medical Care 1993;31:213.
Gender Bias (cont.)

- 1997 survey of patients at family planning clinic
  - N = 1,437; 75% participation

- More likely to permit exam if provider female (any):
  - More comfortable w/ a woman
  - Don’t want men examining female body parts
  - Women explain things better/are more compassionate
  - Less difficult to talk about sexual matters

- More likely to permit a male resident to:
  - Do the exam if training level explained to them
  - Watch an exam if the attending was a woman

Gender Bias: Suggestions

- Acknowledge that some women are reluctant to be examined by a male doctor
- Explain training and qualifications to perform the exam
- Explain that the exam will be conducted with a female assistant or attending physician in the room
- Reassure the patient that her questions will be addressed
Optimal Teaching Strategies: What Has Been Tried?

- Passive:
  - Lecture
  - Observation
  - Video tutorials

- Active:
  - Pelvic simulators
  - Standardized patients
  - Actual patients
    - Anesthetized
    - Awake
Video Tutorials
http://services.aamc.org/jsp/mededportal/basicSearch2.do
No data on educational effectiveness
Pelvic Simulators

A reasonable way to review basic techniques
Digital Feedback

Gimmicks aside, suboptimal quality limits educational value
Standardized Patients

- Used frequently for teaching & evaluation of clinical skills in medical school
- Used less often in residency programs
- Few data re: benefit of such methods in postgraduate medical education
- Feasibility (cost)
# Female Genital (Pelvic) and Rectal Exam

Anne-Marie Amies-Oelschlager, MD  
Assistant Professor, Obstetrics and Gynecology

**Friday, September 23, 3:30 - 5:20**

**Description:**
In the lecture portion of this session, we will present general principles of the female genital and rectal exam. You will see a videotape of the exam, and review the specific parts of the advanced exam. We will review the logistics of the pelvic exam tutorials where you will learn and practice the exam on synthetic models and then on paid "patient-instructors".

**Goals:**
- learn to perform a competent genital and rectal exam on a female patient  
- learn to write up the female genital and rectal exam  
- learn to be sensitive to patient comfort during the exam, and to communicate with the patient throughout the exam

**Logistics:**
- sign up for two hour tutorial outside ICM office (J-5588). The ICM office is located on the 5th floor of the T-wing around the corner from the student lockers, across from the windows facing Pacific St.  
- sessions are at 8:00 a.m. or 10:00 a.m., nine students per session

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[http://courses.washington.edu/medicm/icm2/0506/A05lecturepelvic.shtml](http://courses.washington.edu/medicm/icm2/0506/A05lecturepelvic.shtml)
Actual Patients

- Study of 37 interns
- 4 wkly sessions, 2-3 pts / session
- Direct supervision by preceptor
- Real-time feedback, skills checklist
- Self-assessment questionnaire pre- and 3 months post- intervention
- Significant improvement in ability to locate the cervix and obtain an adequate specimen
- Trend toward increased “likelihood to perform routine pelvic exams”

Evaluation

- Form
  - Verbal feedback
  - Written checklist
  - Videotaped encounter?

- Evaluator
  - Standardized patient
  - Preceptor
  - Actual patient?
# Pelvic Exam Check Sheet for Observed Exam

<table>
<thead>
<tr>
<th>Expectations – ensuring comfort</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>Explains examination procedure</td>
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<tr>
<td>Positions patient correctly</td>
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<tr>
<td>Drapes correctly</td>
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<tr>
<td>Patient centered approach</td>
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<tr>
<td>Warns patient prior to exam maneuvers</td>
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<table>
<thead>
<tr>
<th>External exam</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
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</thead>
<tbody>
<tr>
<td>Recognizes normal and abnormal findings</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Speculum exam</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>Understands speculum choices and selects to maximize comfort</td>
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<tr>
<td>Lubricates speculum</td>
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<tr>
<td>Wears gloves and avoids contact with light source and other surfaces during exam</td>
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<tr>
<td>Inserts and withdraws speculum carefully</td>
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<tr>
<td>Locates cervix with minimal discomfort</td>
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<tr>
<td>Recognizes normal and abnormal findings</td>
<td></td>
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<thead>
<tr>
<th>Specimen collection (when indicated)</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses correct sample collection technique with spatula or broom + cytobrush</td>
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<td></td>
<td></td>
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<tr>
<td>Uses correct sample preparation technique for liquid-based cytology or slide</td>
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<tr>
<td>Prepares wet prep/KOH slides correctly</td>
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<tr>
<td>Uses correct technique in obtaining Chlamydia/GC PCR (5-10 secs in os)</td>
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<thead>
<tr>
<th>Bimanual (when indicated)</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>Lubricates gloved fingers</td>
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<tr>
<td>Assesses cervical motion tenderness</td>
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<tr>
<td>Uses correct technique to size uterus</td>
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<tr>
<td>Effectively examines adnexa</td>
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<tr>
<td>Identifies abnormal findings</td>
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<tr>
<td>Recto-vaginal (if indicated)</td>
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<tr>
<th>Microscopy (when indicated)</th>
<th>N/A</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>Correctly identifies cellular elements</td>
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<tr>
<td>Correctly identifies fungal elements</td>
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Ideally, Clinical Outcomes

- Subjective criteria:
  - Patient satisfaction
    - Likelihood that would participate again
  - Learner self-assessment
    - Likelihood that training will Δ practice

- Objective criteria:
  - Increased number of Paps done
  - Cytological adequacy
Impact of Education/Feedback on Pap Smear Adequacy Rates

- 23 residents in intervention group/30 controls
- 3-part intervention:
  - 20 min PPT/video demo
  - 30 min skills training (manikin)
  - Peer comparison of Pap smear quality
- # Paps / cytological adequacy 6 months pre- and 10 months post- intervention
- Residents who received the intervention were twice as likely to obtain an adequate Pap (OR 2.13; 95% CI 1.15-3.96)

Workshop Station #1
Counseling

Jill Catalanotti
Amy Weinstein
Counseling

Objectives:
By the end of the session the preceptor will be able to:
- Teach residents how to counsel patients presenting for a Pap and pelvic exam
- Perform real-time teaching at the bedside and be able to correct errors if necessary
Case:

1. A 24-year-old woman presents to clinic for a routine physical exam with your new intern in July. She has no past medical history and has never had a pelvic exam. She is sexually active with her husband, who she notes is her only lifetime partner and has never been pregnant. They use condoms all of the time for contraception.

The intern mentions to you that he/she has not done many Paps and the last one was during his/her third year OB/GYN rotation in med school. He/she appears nervous. How do you proceed?
Counseling (3)

2. You and the intern enter the room. The patient is on the examining table and ready for the exam. The intern explains the pelvic exam to the patient. The intern inserts the speculum, and despite readjusting a few times, has not yet located the cervix. How would you handle this scenario?

What other challenging scenarios have you experienced and how have you handled them?
Workshop Station #2
Challenging Pelvic Exam

Carol Bates, MD
Jennifer Potter, MD
Learning Objectives

- Identify common reasons for pelvic exam avoidance (patients and trainees)
- Describe techniques to facilitate successful pelvic exam in women:
  - who are very anxious (first exam, trauma history)
  - who have disabilities (vision, hearing, mobility, or cognitive impairment)
  - who experience pain on speculum insertion (vulvodynia, vaginismus, atrophy, post-XRT)
  - whose cervix is not readily apparent
Whose Challenge?
Pelvic Exam Avoidance

Patient:
- Cost
- Accessibility
- Skepticism @ screening
- Fear of pain
- Fear of cancer
- Prior sexual trauma
- Prior negative experience

Provider:
- Time
- Inexperience
- Embarrassment
Finesse Especially Needed

- Adolescent (first) exam
- Trauma survivor
- Vaginismus & vulvodynia
- Postmenopausal atrophy
- Post-radiation stricture
- Women with disabilities
- Redundant vaginal walls
- Morbid obesity
- Female circumcision
Things to Think About

- Psychological
  - Education
  - Consent
  - Support
    - Chaperone
  - Empowerment
    - Relaxation techniques
    - Self-insertion
    - “Stop”

- Technical
  - Exam table
  - Positioning
  - Speculum choice
  - Lubrication
  - Topical anesthetic
  - Tips for finding the os
Education

- Information
- Co-expert model of care
Brochures

Table Manners

www.cril-online.org/.../bhawd.gif
Pelvic Models
Chaperone

Benefits:
- Patient comfort
- Technical assistance
- Legal protection

No universal guidelines:
- Survey published in 1997
  - 47% state boards have information
  - 6.5% published policies
  - 18% published positions
  - 14% informal or unpublished policies

### Chaperone – Patient Preference

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<thead>
<tr>
<th></th>
<th>Female examiner</th>
<th>Male examiner</th>
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<tbody>
<tr>
<td>Prefer chaperone</td>
<td>11%</td>
<td>62%</td>
</tr>
<tr>
<td>Object to chaperone</td>
<td>34%</td>
<td>9%</td>
</tr>
<tr>
<td>No preference</td>
<td>55%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Study of 1000 women in Scottish family planning clinic

Women <25 and/or nulligravid more likely to dislike exam, but didn’t change preferences on chaperones

Fiddles P. Contraception 2003;67:313-317
Chaperone - Provider Utilization

- 2003 AAFP survey, n = 5,000, 71% response
- 75% use routinely
- Male (84%) > female (31%) providers
- More frequent use among providers who:
  - Are younger, do fewer Paps, practice in South
- Impact on visit volume unclear

Chaperone - Recommendations

- Inform patients of availability
- Male providers—recommended
- Female providers—ascertain preference
- Preferable to have staff member, rather than family member/friend
Etiquette

- Discuss first with patient clothed
- Always obtain consent (verbal or written)
- Be cognizant of and respond to the needs of special populations
Blind or Visually Impaired
Deaf or Hearing Impaired
Obese Patients
Bariatric-Friendly Facility
Mobility Impaired
Accessible Exam Table
Mobility Impaired (cont.)
Removable Hydraulic Fins
Trauma Survivor
Empowerment Paramount

- Always obtain consent
- Negotiate timing and specifics:
  - Long visit
  - May take months-years
  - Support person of pt’s choice
  - Alternate speculum insertion
    - By self or partner
- “Stop” means STOP
Positioning

- Patients report less discomfort and feelings of vulnerability if:
  - Semi-reclining vs. supine
  - No stirrup method used

- Routine in UK, Australia, N. Zealand

- ? Impact on cervical specimen adequacy

Pelvic Exam Positions (1)
Pelvic Exam Positions (2)
(None of These Requires Stirrups)
Appropriate Speculum Choice

Grave’s speculum
Width 20-38 mm
Length 75-115 mm

Pederson speculum
Width 13-25 mm
Length 75-120 mm
Lubrication

- Enhances patient comfort & ease of exam

- RCT (n = 2,900) comparing water-soluble gel to water alone found no difference in rate of unsatisfactory cytology

Topical Anesthetic

- At the introitus
- On the speculum
Pre-Exam Vaginal Estrogen

- A option in women w/ postmenopausal atrophy who have no contraindications
- How much?
  - ½ applicator per vagina QHS x 2 weeks
- Also reduces reactive cellular changes

2006 ASCCP guidelines, available at:
http://www.asccp.org/edu/faqs/bcc.shtml
Anti-anxiety Measures

- Relaxation exercises:
  - Breathing techniques

- Pre-medication (short-acting benzo):
  - Signed consent
  - Require chaperone
  - Document their presence
Finding the Os

- Digital (internal) exam first
- Careful re-direction (know your speculum)
- Condom on speculum (redundant walls)
Condom on Speculum

http://www.freepatentsonline.com/7063664.html
If Unsuccessful...

- Stop
- Try again another day
- Ask a colleague to help
- Consider referral to an expert
- Consider examination under anesthesia
Anatomical Reasons to Refer

Patent hymen

Female circumcision
Workshop Station #3
Role Play: Preceptor and Medical Resident

Kim Ariyabuddhiphong
Diane Brockmeyer
Preceptor:

You are precepting a junior resident who has not performed a pelvic exam since medical school. In the room, (s)he appears nervous and quiet, speaking little to the patient during the pelvic exam. The speculum insertion was slightly abrupt and appeared to make the patient uncomfortable. After some maneuvering, the resident was able to find the cervix and obtain a pap smear.

Your role is to discuss with the resident and give feedback on how things went.
**Junior Resident:**

You have not done a pelvic exam at all since medical school, and then only on the model patient. You felt very awkward about the whole exam, and feel like you didn’t do a very good job. You don’t really know how to ask for help, since you feel like you should know by now how to do a pelvic exam.
Giving Feedback on Pelvic Exam: Tips and Tricks

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PRELUDE to giving feedback:

- Giving good (accurate, critical, helpful) feedback can be hard, but it is also probably one of the most USEFUL things we can do for our residents.
- It is helpful to have a sense of what the “ideal” pelvic exam should look like. Obviously, we aren’t expecting all residents to be perfect from the beginning. But, it’s useful to have a clear (and clearly communicated) set of expectations.
- Consider use of standardized form as prompt to help structure observation and feedback
PRELUDE to giving feedback:

- In order to give feedback, first step is to EVALUATE the resident – where are they? How does their performance compare to goal/ideal/model performance?

- Observe the learner carefully. Take notes if that helps you.

- Consider thinking about the “Travel Agent Model” of Evaluation and Feedback:
  - Where are we starting from?
  - Where are we going?
  - How are we going to get there?
The Feedback Session:

- **Effective feedback:**
  - Is timely
  - Is specific
  - Can include positive and negative feedback
  - Contains *examples* of resident behavior or resident performance:
    - “I noticed that you didn’t use lubrication.”
  - Offers explanation for *why* performance was correct or incorrect:
    - “Your positioning of the light gave you a good, clear view.”
  - Is done for the sake of the resident and patient
  - Is not punitive
  - Can be interactive to trouble-shoot the situation – Develop an action plan
  - Can be given in a critical/constructive way even to those who are doing very, very well
The Feedback Session:

- **Tougher cases:**

- **Self Assessment can be a useful step:**

- Use “Double-you” phrases:

  - “How do you think you did?” “Where do you think you had a hard time?”

- **Possible phrases to use:**

  - “One of the most important goals in doing a Pap smear is to make the experience comfortable enough for the patient to be able to come back next year. How do you think that went from the patient’s perspective?”
The Feedback Session:

- General tips to set the climate:
  - Be supportive
  - Listen
  - Be open to the learner’s point of view
  - Remember and be aware of the power difference between teacher and learner
References