

**‘Poorly relaxed women:’ A situational analysis of pelvic exam learning materials for medical students**

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## **Abstract**

This thesis analyzes how patients are represented in pelvic exam learning materials used by Canadian medical students. Adopting a postmodern form of qualitative analysis and drawing on conceptual frameworks of discourse theories, the social construction of the biomedical body, and relational autonomy, I demonstrate that these documents present a narrow depiction of bodies, identities, experiences, and patient choice related to the procedure. Through these limited depictions, the documents uphold normative ideologies of the body and position providers as authorities over patients on when and how the procedure will occur.

The pelvic exam has historically been a loaded procedure, one that continues to pose challenges in the realms of patient care and medical training. Textbook and training manuals present just one aspect of how medical students learn to perform the exam; however, the representations in these documents matter. I suggest that the depictions contained in these materials are harmful to medical students – and ultimately patients – by not adequately preparing future clinicians to provide empowering, trauma-informed, and culturally sensitive care that meets the needs of people who receive pelvic exams. I conclude by suggesting detailed improvements to the learning materials and medical curricula more generally that work towards an ethic of inclusion in medical education.

## **Résumé**

Dans cette thèse, j'analyse comment les patients sont représentés dans le matériel d'apprentissage au sujet des examens pelviens qui sont utilisés par les étudiants médicaux canadiens. En utilisant une forme d'analyse qualitative et postmoderne et en appliquant les cadres conceptuels des théories du discours, de la construction sociale du corps biomédical et des théories d'autonomie relationnelle, je démontre que ces documents présentent une représentation restrictive des différents physiques, des identités, des expériences et des choix du patient associé à l'intervention. Avec ces représentations limitées, les documents soutiennent des idéologies normatives du corps et positionnent des médecins comme autorités sur les patients, particulièrement au sujet de quand et comment l'intervention va arriver.

Historiquement, l'examen pelvien a été une intervention chargée et va continuer à poser des défis dans le domaine des soins aux patients et de la formation médicale. Les livres et les manuels de formation représentent seulement un des aspects de l'apprentissage de l'intervention.

Cependant, les représentations dans ces documents sont importantes. Je suggère que les représentations dans ces documents sont malfaisantes pour les étudiants médicaux – et en fin de compte pour les patients – parce qu'elles ne préparent pas adéquatement les futurs médecins à fournir des soins qui sont responsabilisant et tenant compte des traumatismes et qui répond aux besoins des patients. Je conclus ma thèse en suggérant des améliorations détaillées pour les matériels d'apprentissages et les programmes médicaux en général qui poursuivent une éthique d'inclusion dans l'éducation médicale.

## Acknowledgements

*Nowhere is there a more intense silence about the reality of class difference than in educational settings – bell hooks*

*Now that I'd seen the other students – watched them march into the classroom in neat rows, claim their seats and calmly fill in their answers, as if they were performing a practiced routine – it seemed absurd that I had thought I could score in the top fifteen percent. That was their world. I stepped into my overalls and returned to mine. – Tara Westover, Educated.*

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## **Contribution of Authors**

I, Sarah Towle, the student, was the sole writer and contributor to each chapter. Jennifer Fishman and Phoebe Friesen provided feedback.



## CHAPTER 1: INTRODUCTION

*Representation is a crucial location of struggle for any exploited and oppressed people asserting subjectivity and decolonization of the mind.*  
– bell hooks

*The female reproductive system occupies a special place in our curriculum for two reasons: (i) the vagina is a 'private part' and (ii) the female reproductive organs are internal. These two conditions contribute to what I refer to as 'the quandary of the sacred vagina.'*  
– Glenn Posner

Few medical procedures receive the level of attention that is awarded to the pelvic exam. A crucial component of care used to detect gynaecological diseases in those assigned female at birth, this sensitive procedure has long documented iatrogenic effects for patients. As well, major health disparities persist as a result of heightened negative experiences with the exam in vulnerable and marginalized populations. Despite these known challenges, medical practices surrounding the pelvic exam have continued to raise ethical concerns. In the realm of medical education, harmful teaching practices that prioritize the learning of the exam over the autonomy of patients have led to public backlash. In clinical practice, doctors continue to use the pelvic exam as a method of gatekeeping access to contraception, in addition to unnecessarily performing the procedure in adolescents and young adults. Though great strides have been made over the years in how the pelvic exam is both taught and administered, the persistence of these issues related to patient care suggests there is room for further improvement. Medical education represents an opportunity to transform how the pelvic exam is performed at a foundational level.

One of the first exposures medical students have to the pelvic exam is in classrooms via medical textbooks and other training documents. To my knowledge, no one has examined how patients are depicted during the procedure in these materials. Overall, patient representation in medical curricula has been found to be deficient; medical textbooks depict normative notions of the body, lack diversity, and use framing that perpetuates both bodily objectification and misogynistic stereotypes (Elder et al., 1988; Moore and Clarke, 1995; Parker et al., 2017; Scully and Bart, 1973). As well, a lack of instruction on trauma-informed care practices has been identified in Canadian medical curricula, specifically in the field of gynaecology (Ali, 2017). Pedagogical theory suggests that textbooks are students' first encounter with the culture of medicine and that the messages contained therein may influence attitudes, behaviours, and

beliefs going forward (Burke et al., 2015; Parker et al, 2017; Risberg et al, 2003). As such, greater understanding is required of how medical students are initially exposed to the pelvic exam and what messages they may be absorbing and carrying to future practice.

The overall purposes of my study were as follows: 1) to examine how patients are represented in learning materials on the pelvic exam used by medical students and 2) to explore what improvements could be made, given the documented importance of considering patient experience, identity, and autonomy when administering the procedure. By examining 10 required learning materials at various Canadian medical schools and applying a discursive form of critical analysis, I demonstrate that patient representation is lacking in depictions of the pelvic exam. Normative notions of the ‘ideal’ patient (one that is white, cis-gendered, able-bodied, and without a history of trauma) emerged from the data, and discourses failed to centre alternative choices, up-to-date guidelines, and most importantly, patients’ authority to make their own decisions regarding the procedure. This suggests clear improvements that could be made to the curricula, ones that could provide solutions to long-standing issues with the pelvic exam in both medical education and in clinical practice.

In this thesis, I begin with a comprehensive review of the literature related to the pelvic exam, presenting both its problematic history in biomedicine and contemporary challenges that continue to pervade the procedure related to patient care and medical training. Following this review, chapter 3 explores the conceptual frameworks that guided my study; these include post-structuralist approaches to discourse theory – drawing on the works of Foucault and Derrida – as well as notions of bodily representation generally and in biomedicine. I also discuss feminist approaches to autonomy, given the weight this ethical principle carries in the clinical encounter and patient experience of the procedure. Chapter 4 discusses my methodological approach to data collection and analysis. This rests on qualitative methods including purposive sampling and situational analysis (Clarke, 2005).

In chapter 5, I present the findings of my data analysis using a cartographic tool of my methodology: positional maps. Several positions that emerged in the data are charted on two maps, with each position discussed individually. Prominent themes from my analysis included certain normative notions about patients’ bodies and a centering of providers as what I call ‘ultimate decision makers’ on determining whether the pelvic exam is to be performed. Discourses and images in the documents constructed notions of an ‘ideal’ patient, suggested that

bodily variation posed a ‘challenge’ that providers must overcome, and objectified patients during the actual procedure. As well, overall discourses failed to provide information both on alternatives to the pelvic exam – such as self-sampling strategies – and on up-to-date guidelines that limit patient exposure to the procedure. But most importantly, notions of patient autonomy and consent were overall underrepresented; clinicians were framed as the authority on whether the procedure was to occur. This depiction persists despite the noted importance of patient autonomy and consent that permeates the pelvic exam.

I conclude my study with a discussion (chapter 6) and conclusion (chapter 7) in which I situate these findings in relevant literature and theory and suggest improvements to the documents and medical curricula more generally. This includes improved representation of patient experience and identity, as well as clarity on pelvic exam clinical guidelines and alternative practices for patients. I argue that these improvements are necessary if medical practices aim to address known health disparities linked to the exam and to provide more culturally sensitive and empowering care to patients.

## **Definitions**

### *PE versus cervical cancer screening*

Before continuing, it is important to clarify language surrounding the pelvic exam (henceforth referred to as the PE). Clinical, public, and even academic discourses often conflate the PE with other gynaecological procedures. Complicating matters is the fact that cervical cancer screenings – such as the Papanicolaou (Pap) and/or the Human papillomavirus (HPV) tests – involve components of the PE. As such, there can be confusion between the two.

A PE is a physical examination performed by a clinician (doctor, nurse, or midwife). The procedure consists of an inspection of the external genitalia, a speculum examination of the vagina and cervix, a bimanual (two-handed) examination of the adnexa, uterus, ovaries, and bladder, and sometimes a rectal or rectovaginal examination. Cervical cancer screenings consist of a Pap- and/or HPV-test. These tests involve a clinician swabbing a patient’s cervix for cells and as such require the use of a speculum (Qaasem et al., 2014).

Both the PE and cervical cancer screenings can be and traditionally were performed as one procedure. Previously, both were recommended yearly for asymptomatic patients, with a PE (with or without cervical cancer screening) also being administered prior to prescription of

hormonal contraception (Morrison, 1994). Now, most North American guidelines state that PEs are indicated *only* when a patient presents with gynaecological symptoms such as vulvar complaints, pelvic pain, abnormal vaginal bleeding or discharge, infertility, urinary incontinence, or pelvic organ prolapse (Evans et al.; 2019 Qaseem et al., 2014; Tonelli et al., 2016). Cervical cancer screenings, however, are still recommended routinely, and this frequency varies based on a patient's age and history (though is typically every three years from age 21 or 25) (Government of Canada, 2017; Centre for Disease Control, 2019).

What this means is cervical cancer screenings in asymptomatic patients should take place without any other components of the PE; for instance, a clinician can perform a Pap-test without inspecting the external genitalia or performing the bimanual or rectal/rectovaginal exam. However, research findings demonstrate that, despite updated recommendations, PEs and cervical cancer screenings are still linked in healthcare practice, routine PEs are still being performed in asymptomatic patients, and both are being over-performed in certain populations (Qin et al., 2020). And as will be expanded upon in the literature review, certain regulatory bodies – while noting that routine PEs are unnecessary – still leave the decision of whether to perform one in tandem with a cervical cancer screening up to the discretion of individual providers (Evans et al., 2019, p. 1222; Committee on Gynecologic Practice, 2018).

Recognizing the difficulty that clinical practice, guidelines, research, and – as will be discussed in my findings – even my data set have in isolating these two procedures, my study will include discussions of both. For clarity's sake, when using the term 'pelvic exam' in this thesis, I am referring to a PE without a cervical cancer screening, and vice versa. Certain studies included in the literature review refer to both PEs and cervical cancer screenings as one procedure; in such cases, this distinction will be noted. While my research question focuses strictly on the PE, some overlap naturally occurs in the data and in my analysis between both the PE and cervical cancer screenings.

### *Women versus those assigned female at birth*

I have chosen to adopt a gender-inclusive use of language. This respects that those who identify as women are not the only people to receive PEs. For instance, a person who was assigned female at birth but now identifies otherwise (gender non-binary, gender fluid, or trans, to name a few) may still receive PEs if they have not had their female reproductive organs

removed and/or genitals altered. As such, I will be referring to people who receive PEs predominantly as 'people' or 'patients' and occasionally as those assigned female at birth, when syntax requires. In the literature review, various studies reference 'women' as those who receive PEs. When necessary, I have reflected this gender-binary language in my literature review, as it is unclear what the researchers meant when they used the word (though one can assume, perhaps, cis-gendered women). In the conceptual framework chapter, I do use the term 'women' when referring to feminist theories on the body, as this again reflects the language of this field.

## CHAPTER TWO: LITERATURE REVIEW

### Introduction

The purpose of this study is to explore how patients are represented in PE learning materials at Canadian medical schools. This chapter presents relevant literature divided into historical and contemporary sections. The contemporary review includes both patient and medical student perspectives on the procedure to provide context for the challenges the PE presents. I focus on medical students over licensed clinicians due to the scope of my research. I also present an overview of issues related to patient representation in medical-school curricula and culture. I then provide a summary of North American screening guidelines for the PE and cervical cancer and discuss findings related to the clinical uptake of these recommendations. Patient suggestions for how to improve the PE will also be reviewed.

But first, I begin with a historical overview of the PE, from its roots in medical bondage to the feminist reclamation of the procedure. This background provides necessary contextualization of present-day practices.

### I. Historical Review

#### a. The invention of the speculum: Lucy, Anarcha, and Betsey

The story of the speculum and the PE begins in the 1840s with seven enslaved black women in Alabama and the violent use of their bodies for experimentation. The names of only three of the seven survived documentation: Lucy, Anarcha, and Betsey (Owens, 2017).

Brought to so-called ‘plantation’ doctor James Marion Sims by their owners, the women were all suffering from vesico-vaginal fistulas – vaginal-wall tears from traumatic births that can cause incontinence (Ojanuga, 1993). Previously, the repair had been impossible as it was inaccessible to surgeons; however, Sims began experimenting with silverware to hold open the vagina and stitch the tear. This was the basis for the Sims speculum, still in use to this day (Kapsalis, 1997). The women were operated on in a tent in his backyard, one more than 30 times. Part of what motivated these experiments was Sims’ underlying and racist assumption that black bodies could sustain more pain than those of their white counterparts (Owens, 2017). These women were “totally without any claims to decision-making about their bodies or any other

aspect of their lives” (Ojanuga, 1993, p. 29). Afterwards, no other patients – with the ability to dissent – could sustain the pain tolerance required of the surgery Sims created (Ojanuga, 1993).

Sims’ grossly unethical performance of vaginal surgeries continued throughout his career. At a women’s hospital in New York, he practiced more experimental surgeries, this time on working-class Irish immigrants. His ‘treatments’ included cervical amputations, the splitting open of the cervix for infertility, and hymenectomy (Kapsalis, 1997). These techniques were often open for other physicians to observe and participate in, a practice that feminist scholars have since linked to the use of anesthetized patients for teaching medical students how to perform PEs (Kapsalis, 1997).

Sims gained both honours and notoriety for his techniques in America and Europe. Until recently, he was praised in introductions to gynaecology texts and medical history books without references to his horrific practices, and a monument dedicated to him stood in New York’s Central Park until 2018 (Choo, 2018). Modern theorists place a critical lens on this history; much has been discussed about how to reconcile the medical advances that stemmed from abuse, how female bodies must still interact with procedures developed from such wrongdoings, and how racial disparities persist to this day in gynaecology and obstetrics (Choo, 2018; Owens, 2017; Kapsalis, 1997). Though Sims’ clinical practice reached far beyond the PE, its contribution to the exam’s overall development cannot be overlooked.

### **b. Sex workers, ‘models,’ and marginalized groups**

With the discovery of the Pap-test and its uptake for cervical cancer screening in the 1940s, PEs became a routine part of care for those assigned female at birth (Carter et al., 2013). As such, the exam also became a standard part of medical education (2013). But issues arose on how exactly to train medical students in such a sensitive procedure. Beyond the use of mannequins and cadavers, live bodies were needed, and this burden fell on vulnerable populations, including sex workers and lower income and racialized groups (Kapsalis, 1997).

It is uncertain when and how extensively medical schools began hiring sex workers for PE practice; however, reports in American medical journals and from doctors in Canada have suggested this approach occurred in the early 1970s and as recently as 1985 (Hall, 2012; Godkins, 1974; Kapsalis, 1997; Kearney et al., 2018). Narratives from these women are difficult to uncover, but a report from an Iowa institution suggested their feedback – that the exams were

too rough and speculums too cold – was negative (Kapsalis, 1997). Sex workers were eventually deemed inappropriate for PE teaching; they were more likely to have pathologies, when the goal was for medical students to identify ‘normal’ anatomy (1997). As well, moral concerns arose in these institutions from the continued employment of sex workers (Godkins, 1974).

Another early PE teaching technique was known as the modelling method. This is where a clinician demonstrated the PE to a group of students on a patient in an exam room. The students would then perform the exam on the same patient under guidance of the instructor (Scheibel, 1996). Like the use of sex workers, the modeling method was deemed problematic; reports detail students repeating PEs on a chosen patient, one after another, while an attending observed (Kapsalis, 1997). Feminist findings also suggest that the modelling method – and even contemporary practices of medical students performing PEs that must be watched or repeated by attendings – are disproportionately borne by lower-income and racialized patients. These populations are more likely to seek care at teaching hospitals and outreach clinics and are arguably less vocal in the faces of authority due to positionality and/or historical trauma within medical systems (Hall, 2012; Wilson, 2005).

### **c. The introduction of the anesthetized PE**

The rise of the use of anesthesia provided another opportunity for PE learning. Like many forms of early PE teaching, it is also unclear when the phenomenon of non-consensual exams for patients under anesthesia emerged as it is widely undocumented and under-researched (Friesen, 2018). However, the practice was seen as a way to alleviate the fears medical students may have towards performing the exam for the first time on a patient (Kapsalis, 1997). Reports have detailed anywhere from one to more than a dozen medical students performing a PE – one after the other – on an unaware patient who had been anesthetized for gynaecological surgery (Scheibel, 1996). The practice is and was widespread throughout Canada, the United States, and the United Kingdom. As cited in the *American Journal of Obstetrics and Gynaecology* (Beckmann et al., 1988), 23 percent of Canadian medical schools reported using anesthetized patients to teach PEs in the early 1980s with that number growing to 37 percent in the 1990s (Beckmann et al., 1992; Wilson, 2005). In 2007, an informal poll by a McMaster University medical student demonstrated that 72 percent of students had performed anaesthetized PEs without consent (Picard, 2010).



Clinicians and medical institutions publicly defended anesthetized PEs stating that patients had “an obligation to participate in the teaching process” (Wilson 2005, p. 242). Others argued that public outcry against the practice was merely “the sexual mores of society” placing restrictions on the ability of clinicians “to care for the whole patient” (Goedken, 2005, p. 236). But by the early 2010s, even medical students began pushing for an end to the practice (Barnes 2012; Wainberg et al, 2010). As well, qualitative studies emerged showing 72 percent of patients wanted to know in advance if an educational PE under anesthesia was to take place (Wainberg et al, 2010). While anesthetized PEs without consent have been banned in Canadian guidelines since 2010 (Liu et al., 2010), there remain concerns that the practice may still be occurring due to vague wording in the revisions (Friesen, 2018; Gibson and Downie, 2012).

#### **d. Our bodies, ourselves: gynaecological teaching associates**

Women’s healthcare – including the PE – shifted in the 1960s and 1970s with the rise of second-wave feminism and the push for legal abortion. The publications of *Our Bodies, Ourselves* by the Boston Women’s Health Collective and the *Birth Control Handbook* by McGill Students’ Society brought health information to women by women and highlighted “shortcomings in communication between female patients and their physicians” (Silverman, 2014; Sethna, 2016). With the invention of the more affordable plastic speculum, radical feminists at various clinics in the U.S. even began teaching people how to perform a vaginal self-examination (Murphy, 2004). Out of this ‘self-help’ women’s health movement, came a new approach towards the PE in medical education: gynaecological teaching associates (GTA).

One of the first GTA programs arose in 1975 from a group of feminist medical students at Harvard University (Silverman, 2014). The students were disappointed with their training and approached the Boston Women’s Health Collective about creating a PE teaching program using simulated patients (Silverman, 2014). While the results of the first program were mixed (the simulated patients felt they were given little control over the exam), the role of the GTA has since improved dramatically (Silverman, 2014). They are trained, paid, and provide step-by-step feedback to students, focusing specifically on communication and sensitivity training. Research demonstrates GTAs’ effectiveness in medical education (Beckmann et al., 1988; Fairbank, 2009;

Shain et al., 1983; Waangren et al., 2010), and a randomized control trial recently concluded GTAs improve medical students' confidence and competence with PEs (Janjua et al., 2017).

Narratives from GTAs themselves show mixed experiences with the profession; some found the work incredibly satisfying and feel like they are making a difference (Steer, 2003; Underman, 2011). Others reported feelings of powerlessness during negative student interactions, heavy burdens of emotional labour, physical pain, and a dependency on the money the job provides (Silverman, 2014, Kapsalis, 1997; Hall, 2012; Underman, 2011). Others have raised issues with the objectification of their healthy bodies, as GTAs typically have to be pathology- and abnormality-free to participate (Hall, 2012). Some GTAs have even stated that they feel obligated to participate to ease gender discrepancies in medical education and to help any future patients who have experienced sexual trauma from having a negative experience with an improperly trained physician (Underman, 2011). And critiques have emerged suggesting that GTAs are predominantly white, questioning how well the programs truly represent the communities clinicians may serve (Underman, 2020).

## **II. Contemporary Review**

### **a. Patients' experiences of the PE**

The PE has long been known to be an uncomfortable and challenging procedure for those assigned female at birth. By the 1970s, likely due to the awareness brought on by the women's health movement, researchers began investigating patients' experiences with PEs, and this research continues to this day (Yanikkerem et al., 2009). Studies have demonstrated that patients report a wide range of physical and emotional responses to this sensitive procedure. Common emotions included fear (of both the exam and its results), anxiety, vulnerability, shame, embarrassment, degradation, overexposure, and loss of control (Areskog-Wijma, 1987; Bates et al., 2011; Oscarsson and Benzein, 2002; Wendt et al., 2004; Wijma et al., 1998; Yanikkerem et al., 2009). Physical experiences ranged from discomfort to descriptions of the exam as "very painful" (Wijma et al., 1998, p. 424).

Beyond these embodied reactions, many patients also reported that they do not understand the purpose of the PE and/or of cervical cancer screenings (Bush, 2000; Norrell et al., 2017; Williams and Williams, 2013). Research findings have shown that a majority believe

routine PEs are necessary before receiving prescriptions for contraception (Kling et al., 2017). A UK study that interviewed 35 women on their experiences with routine PEs and cervical cancer screenings<sup>1</sup> provided some alarming conclusions that suggested medical coercion; not only did they think the PE was required for renewal of contraception prescriptions but participants also reported that clinicians did not present the exam as optional (Bush, 2000). Studies have highlighted that clinicians need to better communicate with patients about PEs to truly achieve shared, informed decision making on this sensitive procedure (Norrell et al., 2017). Discussions have suggested that these practices can lead to barriers in care for access to birth control (Henderson et al., 2010).

While the above represents literature related to the general patient experience, it is important to note that responses to the PE can vary widely based on patient identity. Research related to PE experiences in vulnerable and/or marginalized populations does exist, but it is sometimes restricted to survey data and statistics on related health inequities. Though limited, this research does provide perspective on the importance of recognizing different positionalities and is therefore summarized next, by patient group.

#### *Adolescents, youth, and first timers*

For young patients or for those who are having their first PE, the procedure has been shown to elicit high anxiety, which is also correlated with the experience of a painful exam (Bodden-Heidrich et al., 2000; Gupta et al., 2001; Wijma et al., 1998; Yanikkerem et al., 2009). A negative first experience of a PE is known to influence future experiences and present barriers to wanting or receiving subsequent exams (Wijma et al., 1998). Though not specific to previous experiences, one study interviewed young women who had never had the procedure about what their ideal first PE would be; researchers identified that many adolescents lacked information about the exam and thought it was mandatory (Freyens et al., 2017). Participants identified that they would prefer to have a third party present during an exam, privacy to get undressed, and information about what would happen during the exam. In other studies, younger patients as well as those with lower socio-economic status and from religious backgrounds have also reported preferences for female providers (Bodden-Heidrich et al., 2000; Schmittiel et al., 1999).

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<sup>1</sup> This study was conducted at a time when routine PEs were performed alongside routine cervical cancer screenings; thus, its findings relate to the patient experience of both.

### *'Different' Bodies*

Patients with bodies or abilities that fall outside the medical definitions of 'normal' or 'standard' are also known to have challenges with PEs, though few studies examining their unique care experiences exist. As noted in case studies and demographics, patients who are obese not only have difficulties having an accessible PE – with tables, gowns, and even speculums standardized to patients with average body-mass indexes – (Ahmed et al., 2002; Bates et al., 2011) but also have higher rates of cervical cancer and lower screening rates (Wee et al., 2000). Few studies have examined PE experiences of patients with physical disabilities, though one survey of Canadian patients with physical disabilities showed barriers to care. These included difficulties getting onto the exam table and the clinical belief that persons with disabilities do not need a PE and/or cervical cancer screening (Cooper and Yoshida, 2007). Patients with intellectual disabilities have their own challenges with care, though again, literature in this area is restricted to case studies and ethical discussions among clinicians. It is widely known that patients with intellectual disabilities have low rates of cervical cancer screening and clinicians often forego screening in non-sexually active patients (Wilkinson and Cerreto, 2008). When a PE is necessary, literature points to proxy consent from surrogate decision makers or caregivers as well as the use of restraints, benzodiazepines, or sedation for the procedure to take place (Corey and Bulova, 2016; Prevatt, 1998; Wilkinson and Cerreto, 2008).

### *2SLGBTQ+ Community*

Research related to 2SLGBTQ+ patients and the PE is more focused on health inequity than on the lived experience of this community. Trans men and lesbian and bisexual women are significantly less likely to be up to date on Pap-tests (Peitzmeier et al., 2014; McCune and Imborek, 2018). A handful of studies have specifically investigated trans men's experiences of the PE and/or cervical cancer screenings; this population reported mis-gendering from clinicians and staff; feelings of heightened body dysmorphia during the exam; and inappropriate, excessive, or invasive questioning about their bodies irrelevant to the issue at hand (Dutton et al., 2008; Peitzmeier et al., 2017).

A 2019 PhD dissertation out of the United States found no studies to date that explored 2SLGBTQ+ patients' experiences at the gynaecologist. The researcher then conducted qualitative interviews with 19 members of the community and found participants had negative

and positive experiences, though nearly all positive experiences had occurred at either Planned Parenthood or an 2SLGBTQ+ specific clinic. When asked to describe negative experiences, participants reported feelings of discrimination from providers, feeling out of place due to a “hyper-feminized” environment, changes in quality of care after disclosing their sexuality, misgendering, and a lack of consent during the exam itself (Richi, 2019).

### *Racialized Groups and Ethnic Minorities*

Research about racialized minorities’ experiences with the PE – like that of the 2SLGBTQ+ community – is limited and focuses on healthcare inequities related to cervical cancer screenings and cancer rates. In the United States Black and white women have similar PE and cervical cancer screening rates; however Black women undergo lower quality screening and poorer follow-up of abnormal results (Eichelberger et al., 2016). In Canada, Indigenous women have lower self-reported screening rates and vastly higher incidences of cervical cancer (Demers et al., 2012). The one qualitative study on racialized patients’ experiences with PEs also intersects with identities of trauma, a theme to be explored next.

### *Trauma Survivors*

The difficulty for survivors of sexual trauma to receive gynaecological care has been well documented in both scientific and popular literature and has been known among clinicians for decades (Huber et al., 2009; Robohom and Bутtenheim, 1997). Survivors overwhelmingly rate their experiences of PEs more negatively than non-survivors. Survey data show that survivors can experience discomfort at every stage of the exam as well as triggering and/or trauma-like responses to the procedure (Robohom and Bутtenheim, 1997; Gunes and Karacam, 2017). Surveys of survivors who have experienced childhood trauma showed that 82 percent do not disclose their history to healthcare providers (Robohom and Bутtenheim, 1997). Other findings have shown that clinicians have a high rate (75 percent) of false-negative screens for trauma history (Stevens et al., 2017). Survivors have also been shown to require more PEs than their peers due to a higher rate of health complications (Stevens et al., 2017).

As mentioned above, a 2012 qualitative study took an intersectional approach to trauma and the PE. African-American women with a history of interpersonal trauma were interviewed

about their experiences with routine Pap-tests.<sup>2</sup> Nearly all participants did not understand the reason for the exam nor did they disclose their histories to providers. As well, 93 percent reported an emotional or triggering response to the exam, including flashbacks, disassociation to get through the exam, and even direct comparisons of the exam (particularly the bimanual portion) to the abuse they experienced (Ackerson, 2012).

### *Patients in teaching hospitals and clinics*

Any of the above patient groups may also find themselves involved in a teaching hospital or clinic for their PE, meaning a medical student may be asked to be involved in the procedure. Research has demonstrated that gynaecology patients are less likely than others to accept student involvement in their care, particularly when it calls for a PE (Mavis et al., 2006; Marwan et al., 2012). Patients in obstetrics and gynaecology are more likely to accept medical-student involvement if the student is female (Mavis et al., 2006; Marwan et al., 2012). Surveys also showed that patients who are racialized are more likely to refuse medical-student participation in their care (Abdulghani et al., 2008; Thurman et al., 2006; Vaughn et al., 2015).

One study examining medical-student participation for obstetrical/gynaecological visits in out-patient settings found that the majority of patients (86 percent) want a non-physician and non-student to ask permission for student participation, regardless of the visit purpose, student gender, or previous experience with students. The study's authors concluded that physician and student requests could put "undue pressure on the patient to accept the student as part of their visit" and may even be considered coercive (Berry et al., 2003, p. 637).

## **b. Medical student perspectives on the PE**

### *Anxieties and Fears*

Like research on patients' experiences with PEs, that on medical students' perspectives emerged in the 1970s. A ten-year prospective cohort study which interviewed medical students identified five common fears they have around PEs: fear of hurting the patient, fear of being judged inept by attendings, fear of not recognizing pathology, fear of being sexually aroused by performing the procedure on a patient, and fear of finding the examination unpleasant,

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<sup>2</sup> Though the study specifies 'Pap-test,' reference is made throughout to the bimanual exam, implying that in these cases, the Pap-test included a routine PE.

particularly related to smell (Buchwald, 1979). Fear is such a common response to learning the PE that there now exists a standardized questionnaire for medical students, the Fear of Pelvic Examination Scale (F-PEXS), to assess fear in this context (Siwe and Wijma, 2015).

Contemporary studies continue to contextualize these fears, with medical students often reporting anxieties about the ‘sexual’ nature of the exam and making an already vulnerable patient uncomfortable (Sörensdotter and Siwe, 2016; Siwe et al., 2012). Students who have had a PE before have been shown to be more anxious than their peers to provide the examination (Abraham et al., 2003). In qualitative interviews across multiple studies, male students have stated that they link sexuality and female genitals and struggle to “deal with the notion of the non-sexual” when learning to perform PEs for the first time (Giuffre and Williams, 2000; Kapsalis, 1997; Sörensdotter and Siwe, 2016, p. 1301). Some even compared the bimanual portion of the exam to sexual intercourse (Sörensdotter and Siwe, 2016). However, findings have shown that these associations dissipate in students as they get used to performing exams (Sörensdotter and Siwe, 2016). GTA programs alongside mannequin simulations have been known to decrease fear and anxieties in medical students (Ronn et al, 2012; Pugh, 2009).

### *Clinical Frustrations and Coping Mechanisms*

While male students have an awareness of the sensitivities of the exam in educational settings, this awareness shifts in clinical settings. Several studies detail frustrations from male medical students and the difficulties they face learning the exam on patients in clinical settings. Common complaints include their increased likelihood of patient refusal and ‘gate-keeping’ targeted at male students practicing the exam by other healthcare professionals (Bhoopatkar et al, 2017; Chang et al., 2010; Wallbridge et al, 2018; Zahid et al, 2015). Findings have suggested that as medical students advance in their clinical training, they suffer “an erosion in their attitudes about telling patients that they are students” (Silver-Isenstadt and Ubel, 1999, p. 481). They find innovative ways to ask patients for PE consent including approaching patients in waiting rooms before they are seen by a nurse or doctor, referring to themselves as ‘student doctors’ instead of ‘medical students,’ and employing the use of ‘spin’ to frame the request more favourably (Carson-Stevens et al., 2013). Discussions have suggested that these are coercive practices resulting in misrepresentation and in denying individual freedom to patients (Carson-Stevens et al., 2013). Other studies have called this learning discrepancy between male and

female students ‘gender bias’ or ‘gender discrimination’ in medical education (Akkad et al., 2008; Zahid et al., 2015).

### **c. Medical school culture and #MeTooPelvic**

Though difficult to quantify, cultures within medical schools play a large role in how the PE is presented to, interpreted, and ultimately performed by medical students. Research has consistently shown that medical students lose empathy for patients when they transition from the classroom to clinical practice, and this is particularly true for rotations involving obstetrics and gynaecology (Sheikh et al. 2013; Ubel et al., 2003). It has been suggested that decreased empathy levels can be considered part of the professionalization process; medical students have been shown to rapidly develop identities as future doctors in their first year of clinical contact (Pitkala and Mantyranta, 2003; Sheikh et al., 2013). This involves shifting their identities away from the patient perspective and instead aligning with the authority and professionalism exemplified by medical doctors (Sheikh et al., 2013).

But theorists and certain medical students have linked this trend towards decreasing empathy to issues within medical-school culture – namely, the acceptance among students and staff of aestheticized PEs without patient consent (Barnes, 2012; Friesen, 2018). Research has drawn attention to online medical forums where students have defended the practice of anaesthetized PEs without patient consent and rejected its characterization as a violation (Friesen, 2018). As mentioned, clinicians have also endorsed the practice in scientific journals stating how students are “trained to see the genital organs as part of the entire human anatomy” without “the taboo and different feelings elicited in the general population” (Carugno, 2012, p. 1480; Goedken, 2005). Though now banned in Canadian guidelines, the practice continues to spark public outcry in American media and has led to the #MeTooPelvic movement, which equates unconsented anaesthetized PEs to sexual assault (Friesen, 2018; Goldberg, 2020). As one medical student noted in the journal *Obstetrics & Gynaecology*, a disconnect exists between “a culture of medicine” that considers unconsented PEs a nonissue and “those outside the world of medicine who were repulsed by the thought of it” (Barnes, 2012, p. 941).



#### **d. Medical education curricula**

In my understanding, no one has directly studied PE depictions in medical-school curricula, representing a knowledge gap in this area. Analyses of medical textbooks have explored other related topics such as gender and bodily representations. Qualitative findings have shown anatomy textbooks to be dichotomous in their depictions of female genitals; either they were vivid photographs portraying fully exposed genitals on cadavers, or they were computer-generated graphics “negating any sense of corporeality” or diversity (Moore and Clarke, 1995, p. 289). Other analyses have shown that women were often depicted as homogenous (toned, abled, and white) (Parker et al., 2017); heterosexuality was assumed (Moore and Clarke, 1995); decisions on contraception and abortion were laced with medical paternalism (Elder et al., 1988); and women were constructed as having a reproductive destiny to fulfill (Carson, 2018).

Critiques of patient representation in curricula often point to a lack of both diversity and socio-cultural awareness (Garden, 2013; Sharma, 2019; Taylor, 2003; Wear and Aultman, 2005). Broadly speaking, medical education has been referred to as “a culture of no culture” (Taylor, 2003), one that homogenizes patients’ identities and lived experiences. Cultural competencies are seen as secondary to the ‘real’ competence of medical knowledge (Taylor, 2003). This sanitization of the patient experience has been aptly called a form of neocolonialism by Malika Sharma (2018) which she states silences marginalized perspectives. She has also suggested that these deficiencies in the curriculum render medical students – and thereby eventual medical professionals – ill-equipped to serve certain patient populations (Sharma, 2019).

Diverse representations are not the only element missing from medical-school curricula; research has pointed to deficiencies in trauma-informed approaches as well (Ali, 2017; Dichter et al., 2018). Trauma-informed care (TIC) is a model of care specifically for patients who have experienced physical, sexual, or emotional violence. It highlights principles such as shared decision-making, peer support, avoiding unnecessary procedures, and patient choice and voice (Elliott, 2005; Reeves, 2015). TIC has been identified as a particularly important model of care during the PE, as the exam itself can mimic dynamics of abuse or violence (Elliott, 2005; Reeves, 2015).

Despite this importance, medical students and practicing clinicians report a lack of training in trauma-informed care, specifically in the fields of obstetrics and gynaecology (Farrow et al., 2018; Goldstein et al., 2018). A 2017 policy paper by the Canadian Federation of Medical

Students called for the development of a formal guideline on the teaching of trauma-informed gynaecological care at Canadian medical schools and subsequent implementation of the guideline in clinical practice (Ali, 2017, p. 5). It appears this recommendation has yet to be implemented. Patient-centred research has been done on how to make the PE more trauma-informed, to be discussed in subsequent sections. However, it appears this research may not be reaching medical-school curricula, given how ill-prepared students and clinicians report feeling in providing such care (Ali, 2017; Farrow et al., 2018; Goldstein et al., 2018).

#### **e. Screening guidelines and DIY cervical swabs**

Public health recommendations and clinical guidelines continue to greatly influence clinical practices surrounding the PE and cervical cancer screenings. Routine PEs – those done on asymptomatic patients – are no longer recommended by nearly all North American health agencies and regulatory bodies (Evans et al., 2019; Tonelli et al., 2016). This change came after a 2014 systematic review on the topic from the American College of Physicians and Surgeons; it demonstrated that not only were routine PEs ineffective at identifying cancers and treatable conditions in asymptomatic patients but also that the harms of the procedure (false positive findings and physical/psychological harms to the patient) outweighed the benefits (Qaseem et al., 2014). Explicit in the update is that patients presenting for routine cervical cancer screenings (typically, every three years) no longer require a bimanual exam (Qaseem et al., 2014). Despite this clear, evidence-based recommendation, certain regulatory bodies are still taking an ambiguous approach. For instance, the Society of Obstetricians and Gynaecologists of Canada suggests clinicians may consider performing a routine PE in tandem with a routine cervical cancer screening if he/she sees fit, if the patient requests it, or if regional guidelines suggest it (Evans et al., 2019). The American College of Obstetricians and Gynaecologists maintains that patients should see their gynaecologists yearly for care, determining together if a routine PE is needed (Committee on Gynaecologic Practice, 2018).

More recent developments in cervical cancer screening may do away with the need for a clinician-administered speculum altogether. HPV self-sampling kits allow patients to insert a small device – about the size of a tampon applicator – into their vaginal canal themselves and obtain a cervical sample to be sent to a lab (Eve Kit, 2019). It has been demonstrated that self-sampling reduces burdens on patients, allowing for a greater sense of privacy and autonomy

(Gupta et al., 2018). Moreover, studies show that HPV self-samples are as accurate as clinician-collected samples, improve patient participation in cervical cancer screening, are preferred among trans and Indigenous patients, and result in increased follow-up in under-screened populations when a positive result is found (Arbyn et al., 2018; Cerigo et al., 2012; Gupta et al., 2018; Reisner et al., 2018). Regulatory bodies in both Canada and the United States refuse to take positions on their use (Dickinson et al., 2013; US Preventative Services Task Force, 2018). And while the kits have been available for use in Canada since 2017, they are not covered by any provincial public health plan (Fedyanova, 2018).<sup>3</sup>

The aforementioned updated guidelines (Qaseem, 2014) and the emergence HPV self-sampling kits should perhaps imply that patients are receiving less pelvic and speculum exams; however, research demonstrates that this is not the case. Studies show that clinicians are still unnecessarily performing both PEs and cervical cancer screenings as part of a routine, annual exam or as a prerequisite to prescribing hormonal contraception (Stormo et al., 2012, Henderson et al., 2014, Gabzdyl et al., 2015). Most recently, findings from a cross-sectional study in the *Journal of American Medicine* showed that clinicians have provided millions of unnecessary routine PEs and Pap-tests to adolescents under the age of 20 (Qin et al., 2020). A recent journal editorial stated that this practice serves as an example of the harms endured by vulnerable populations (young women and girls) when clinicians do not adhere to guidelines (Simon, 2020). Researchers have concluded that more effective strategies are needed to inform providers about up-to-date PE practices to reduce these harms (Henderson et al, 2014, Gabzdyl et al., 2015; Qin et al., 2020; Stormo et al., 2012).

## **f. Patient-centred improvements**

Amidst a growing awareness of problems related to the procedure, research from the past two decades has investigated how the PE experience can be improved from a patient-centred perspective. Qualitative interviews with and surveys from patients have identified simple

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<sup>3</sup> It must be noted that HPV self-sampling kits cannot replace a PE. Again, a PE is a procedure to be performed on a symptomatic patient, and cervical cancer screenings (including HPV self-sampling kits) are recommended routinely and on asymptomatic patients. However, I am including a discussion of these self-sampling kits because they do reduce patient contact with speculum exams, which are a noted component of the PE. Moreover, as discussed in the next paragraph, the PE is still frequently performed routinely and in tandem with cervical cancer screenings. As such, self-sampling kits – if used – may inadvertently reduce patient contact with the PE and are therefore relevant to the discussion.

practices to improve the patient experience. These include using a disposable wrapped skirt as opposed to a drape, allowing for chaperones during the exam (particularly when the provider is male), forgoing the use of footrests,<sup>4</sup> warming the speculum in advance, offering self-insertion of the speculum, offering a mirror so the patient can see the exam, and having the clinician ask for permission for each step of the exam (Fiddes et al., 2003; Neuhaus et al., 2016; Seehusen et al., 2006; Williams and Williams, 2013).

Some studies have suggested more radical approaches to the exam: a speculum redesign to make the device more patient-centred and less intimidating (Taylor et al., 2017), having a psychiatrist on site for patients who have a history of trauma (Ades et al., 2019), and even allowing patients to perform the exam on mannequins before having one themselves (Siwe et al., 2013). And while only relating to speculum exams done for cervical cancer screening, as mentioned, research has confirmed that certain populations prefer HPV self-samples to clinician-administered sampling (Arbyn et al., 2018; Cerigo et al., 2012; Gupta et al., 2018; Reisner et al., 2018). To my knowledge, research has not explored the uptake of these suggestions in medical education, presenting another knowledge gap that I aim to fill.

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<sup>4</sup> Here, I am choosing to use the term ‘footrests’ over ‘stirrups.’ Recent feminist practices have identified the objectifying nature of the term stirrups given its connotations to horse-back riding. I have used the term ‘stirrups’ in the findings chapter when that was the language used within the documents.

## CHAPTER 3: CONCEPTUAL FRAMEWORK

### Introduction

This study is guided by three conceptual frameworks including: 1) a post-structuralist approach to discourse theory; 2) phenomenological representations of the body; and 3) feminist perspectives on bioethics and autonomy. This chapter provides an overview to these foundational frameworks and explains how each informed the research process.

### I. Discourse and Discourse Theory

#### a. Discourse

Discourse is a broad concept that can loosely be defined as a form of communication. It encompasses language, conversation, gestures, as well as text-based communication such as written words or visuals (Prior, 2008). Discourse communicates information and/or knowledge among or between groups of people. Within specific professional fields, discourse can refer to a set of codified linguistic usage, for instance: legal discourse, religious discourse, or – of specific relevance to this study – medical discourse.

Medical discourse covers a range of communication occurring in settings such as medical records and charts, health journals, conversations between professionals and with patients, and words and images used in medical textbooks and training materials (Lupton, 1994; Wilce, 2009). It has been noted that discourse plays an important role in biomedicine and that medical discourse has “profound anthropological significance” in shaping both medical institutions and practices (Wilce, 2009, p. 199). As Lupton (1994) has noted, analyses of medical discourse have the potential to demonstrate the process by which biology and culture interact. For instance, discourse theories in biomedicine have brought forward notions on the social construction of diseases, pathology, and disability, as well as feminist perspectives on the medicalization of the female body, the medical gaze, and authoritative medical knowledge (Lupton, 1994; Morgan, 1998).

#### b. Discourse theory

Philosophers and scholars have spent decades developing theories related to discourse – the role discourse plays in our lives and how it has the power to shape ideas, thoughts, beliefs, values, and identities. Out of these reasonings emerged the field of discourse theory. Existing

predominantly within the social sciences, discourse theory is the study of how people communicate about individuals, social organizations, and other phenomena and why the way we construct and use discourse matters (Torfing, 2005; Sociology Group, 2019). The field of discourse theory can follow many traditions, disciplines, and ontologies, spanning positivist and critical paradigms (Hesse Bieber and Leavy, 2011; Torfing, 2005). For instance, one approach to discourse theory might be to note frequencies of words in certain texts, whereas another may analyze the use of these words and what their meanings tell us about a text (Hesse-Biber, 2011).

Situated in a more critical paradigm, scholars such as Michel Foucault and Jacques Derrida, as well as the more recent Norman Fairclough and Lindsay Prior have moved discourse theory beyond basic analyses of semiotics and into the realm of a social theory (Blommaert and Bulcaen, 2000; Licqurish and Seibold, 2011; Torfing, 2005). These more post-structuralist approaches to discourse link semiotic concerns surrounding the structure, form, and established meanings of language with the notion that language is embedded in social and political settings and used for certain purposes (Lupton, 1994). Most seminally, the works of Foucault and Derrida have highlighted how dominant discourses contain the power to construct what is ‘normal’ and ‘real’ in our society (Parker et al., 2017; Moore and Clarke, 1995), as well as how accessing subjugated knowledges of individuals and groups in discourse can challenge these oppressive power relations and ideologies (Hesse-Biber and Leavy, 2011).

Building off of Foucault and Derrida, Fairclough (1992) and Prior (2008) have constructed social theories of discourse that focus predominately on the written. Fairclough’s three-dimensional framework for critical discourse analysis acknowledges the importance of not just linguistic choices, but also the use of discursive practices (i.e. – the production, circulation, distribution, and consumption of texts), as well as the ideological effects and hegemonic processes prevalent in discourse (Blommaert and Bulcaen, 2000). Prior’s work on document analysis encourages researchers to see how documents shape “political, economic, medical, and scientific activities just as much as humans do” (Prior, 2008, p. 833).

A post-structuralist approach to discourse theory informed my study. Naturally, a certain level of understanding of discourse theory was necessary to embark upon my research, as my data (PE learning materials) are made up of text and visual-based documents, and the content within them can be characterized as medical discourse. Beyond this obvious application of discourse theory, I have employed an approach to my study that recognizes discourse as a social

practice. Through this perspective and as characterized by Prior (2008), these PE learning materials are not merely containers for words, images, information, and instructions but are ‘active agents.’ The discourses in them have the power to maintain normative notions of the body, to create ‘ideal’ patients for examination, and to silence or marginalize certain groups, experiences, or choices. Moreover, their discursive practice – that is their use as introductory training materials on how to perform the PE – can influence medical students’ attitudes, beliefs, and behaviours (Parker et al., 2017). Viewing these PE learning materials as a social practice acknowledges them as living documents that may have very real impacts on both the patient experience and continued health disparities related to the PE in medical practice.

## **II. Representations of the Body**

### **a. The body**

In line with a social practice of discourse, theories and concepts on representations of the body – both generally and in biomedicine – have also informed my study. Notions of the body hold tensions between traditional philosophy and feminist theories. Western political and philosophical thought from Descartes on has drawn attention to ‘mind-body dualism’ – the concept that one’s mind is separate from one’s physical body. Within this tradition, the rational self was represented as the masculine, whereas the embodied self was identified with the feminine (Lennon, 2019). Women, it was said, could not escape their embodied existence – from puberty, menstruation, sexual objectification and/or violence, childbirth, breast-feeding, and menopause – making the attainment of rationality questionable (Gadow, 1994; Lennon, 2019). This enmeshment in corporeality has also been attributed to colonized bodies, to those of lower socio-economic statuses (Lennon, 2019), and to the continued objectification of the female body in mass media. As Bayer and Malone (1998) have characterized it, society is surrounded by images of the female body: the maternal body, the racialized body, the vulnerable body, the victimized body, the hysterical body, the body with no desire of its own, the regulated body, the rebellious body, and the thin body. Some of these representations are idealized, others are rendered powerless (Chrisler and Johnston-Robledo, 2018).

Naturally, critiques of both mind-body dualism and representations of the female body have spanned decades and philosophical perspectives. This includes the works of Simone de Beauvoir – who studied the patriarchal regulation of the female body and social constructions of

gender – and those of the aforementioned Foucault, highlighting how politics and biopower are exercised over and through the body (Turner, 2007). Trauma theorists in particular have challenged notions of the mind-body dualism, noting that the intermingling of the mind and body is apparent in traumatic memories (Brison, 2002). More recent interpretations of the body have increasingly moved towards these inclusive perspectives of embodiment, including contributions from disability and critical race theories (Lennon, 2019; Turner, 2007). These accounts work to make visible the “variable experiences of gendered, raced, classed, differently abled and differently aged bodies” and to reflect how such experiences “mediate social positionality” and constitute one’s sense of self (Lennon, 2019). As Lupton states, in the wake of post-structuralism, the human body can no longer be considered a biological fact but instead as the product of certain kinds of knowledges, shaped by social relationships and limited by historical, cultural, and political factors (Lupton, 1994).

#### **b. The biomedical body**

Theories on bodily representation have been extended into a variety of fields, perhaps most prominently in biomedicine. Both social and feminist theories have highlighted how, within biomedicine, the body is characterized as biologically determined: a universal, stable entity outside of history, culture, geography, and language (Chrisler and Johnston-Robledo, 2018; Lupton, 1994). The work of Foucault – particularly around his concepts of the medical gaze and bodily surveillance – was seminal to these schools of thought, bringing to light how, in medicine, the body is rendered an object to be prodded, tested, and examined (Lupton, 1994). As Gadow (1994), Malterud (1993) and others have noted, medical representations separate the relation between the objective scientific body and the subjective person to whom the body belongs.

It has been noted that representations of the body in science and medicine arguably carry the most powerful influence on constructions of the female body and on what it is to be a woman (Chrisler and Johnston-Robledo, 2018). Women are frequently constructed as deficient, uncontrolled, inherently diseased, and “failing to meet the norms of the male (white/middle-class/fit) body” (p. 145). Moreover, in medical representations, social theory has taught us that the female body is reduced to its reproductive potential; menstruation is failed production, menopause is regression/decline, and pregnancy and birth is one’s bodily destiny (Carson, 2013; Gadow, 1994).



Second-wave feminist theories and activism centred on women taking back control of their own bodies and on challenging the “hegemony of the masculinist medical profession” (Chrisler and Johnston-Robledo, 2018, p. 146). Though these movements brought about great social change and improved medical practices, subsequent feminist theorists such as Hadd (1991) have argued that the notion of being able to control one’s body exists within a discourse that accepts the concept of mind-body dualism; representations of the body remain as an object upon which forces of biomedicine act and of which women must struggle to regain control (Chrisler and Johnston-Robledo, 2018; Hadd, 1991). More recent post-structuralist theories call for a rejection of the biomedical model. Instead they argue for localized and contextual feminist knowledges of the body that understand the body as representation, medicine as political practice, and disease as language (Chrisler and Johnston-Robledo, 2018, p. 146). In doing so, as Malterud (1993) states, entrances for female voices into medical discourse can be found so that reconstruction of medical knowledge can occur.

These more inclusive perspectives of embodiment and the body in medicine informed nearly all aspects of my study. In applying them, I grounded my worldview with an awareness of the varied lived experiences of the body – including the female body, the racialized body, the colonized body, the queer body, the differently-abled body, the traumatized body, and intersections thereof – and how social, historical, cultural, and political factors shape the body both generally and in biomedicine. By doing so, I recognize that inclusive discourse and practices must include an awareness of patients as experts on their own bodies and experiences.

### **III. Autonomy**

#### **a. Normative autonomy and feminist critiques**

The idea of personal autonomy generally refers to the capacity to be one’s own person and “to live one’s life according to reasons and motives that are taken as one’s own and not the product of manipulative or distorting external forces” (Christman, 2018, p. 5). It features as a central value in Kantian moral philosophy and in John Stuart Mill’s version of utilitarian liberalism (Christman, 2018). The concept of personal autonomy reaches into multiple disciplines from moral and political philosophy to policy, law (rights and freedoms), and bioethics (Christman, 2018). Nearly all theories view two conditions as essential for autonomy:

liberty and agency (Beauchamp & Childress, 2009). Autonomy has traditionally been thought to reflect values of independence and individuality (Christman, 2018; Stoljar, 2018).

In the field of bioethics, the principle of respect for autonomy has been said to follow this atomistic narrative. Normative definitions rest on those established by Thomas Beauchamp and James Childress in their seminal work *Principles of Biomedical Ethics*. Patients' decisions are considered autonomous if the individual is competent to make the decision, has adequate information and understanding about the available options, and is free from coercion toward these options (Beauchamp & Childress, 2013; Sherwin, 1998). Informed consent can be viewed as a subset to autonomy in that autonomous patients are able to give their informed consent to clinicians for treatments, procedures, and other interventions (Beauchamp & Childress, 2013).

Autonomy has played a crucial role in feminist theory and feminist bioethics. First- and second-wave feminisms have regarded autonomy as a fundamental condition for women to overcome patriarchal control (Neyer & Bernardi, 2011). Beauchamp and Childress' concept of autonomy was initially well-aligned with the individualistic nature of the reproductive rights and women's health movements, where it has been said that women cannot be free and equal if they do not autonomously control their bodies (Tong, 1996). But in the last twenty years, feminist (re)interpretations of autonomy in philosophy and bioethics have led to critiques of these traditional definitions.

As mentioned, traditional definitions of autonomy apply what is often called an individualistic approach, highlighting the importance of self-governance over one's body and one's choices (Beauchamp & Childress, 2013; Stoljar, 2018). Feminist theorists have noted, as with representations of the body, that the rational self – that is, the one that is autonomous – is identified with the masculine, whereas the embodied self – the one that feels and cares for oneself and others – is more identified with the feminine (Brison, 2002). The nature of the rational self is abstracted from “the social relations in which actual agents are embedded” (Stoljar, 2018). Traditional autonomy therefore ignores the relationships of care and *interdependence* an agent may have that play a part in her decisions (Stoljar, 2018).

In the context of healthcare, individualistic notions of autonomy have also been deemed inadequate. Feminist bioethics criticizes the principled approach for encouraging patients to see their healthcare decisions in isolation from others, thereby increasing their vulnerabilities and dependences on medical authority and/or paternalism (Sherwin, 1998; McLeod & Sherwin,

2000). Patients do not make healthcare decisions in a “social vacuum” nor are all patients equally placed due to factors such as oppressive social conditioning and power differentials (gender, race, class, education, and ability) that usually fall in favour of clinicians (Dodds, 2000, p. 219). Feminist critiques of normative autonomy in both philosophy and bioethics lead to a richer and socially situated definition of autonomy, titled relational autonomy.

### **Relational autonomy**

Relational autonomy is an umbrella term encompassing a number of different and sometimes even dissenting views (MacKenzie, 2008; Stoljar 2018). Unlike the individualistic self of normative theories, relational selves are social beings that are shaped and modified within “a web of interconnected (and sometimes conflicting) relationships” (Sherwin, 1998, p. 35). Broadly speaking, the theory recognizes 1) the ways in which “our practical identities and value commitments are constituted in and by our interpersonal relationships and social environment” and 2) that autonomy can be impaired by “abusive or oppressive interpersonal relationships and by social and political environments characterized by oppression, injustice, and inequality” (MacKenize, 2008, p. 519). Relational theories attempt to answer how both oppressive social conditions and internalized oppression can undermine – or completely negate – an agent’s autonomy (Stoljar, 2018).

Debate continues among relational theorists as to how or if decisions made under oppressive conditions can be judged as autonomous ones, often characterized as the procedural versus substantive debate. However, more recent feminist approaches to relational autonomy have focused less on the question of whether individuals are autonomous and more on how autonomy may be diminished at an institutional level and what work can be done to alleviate these restrictions. The works of Susan Brison (2002) and Uma Narayan (2002), for instance, have called for policies that provide women and vulnerable populations not just with choice but with adequate and more empowering options. Bioethicist Susan Dodds (2000) has highlighted how discussions about patient autonomy ignore systemic issues such as discriminatory healthcare funding practices that may impact what alternatives are available to patients. Further to this point, Heather Widdows (2013) has argued that the number of choices offered to individuals is almost irrelevant; it is the quality of their content that requires ethical attention (Widdows, 2013).

Given that the PE has long been fraught with issues of patient consent and autonomy, it would be illogical to exclude notions of autonomy from my conceptual framework. As demonstrated in the literature review, autonomy remains a crucial component to the PE procedure – particularly in medical education settings – and continues to generate ethical discussions among scholars, medical students, patients, and clinicians (Barnes, 2012; Friesen, 2018). In particular, the feminist perspective of relational autonomy informed my study. To my knowledge, adopting this feminist framing of autonomy to a PE study is novel; ethical analyses on autonomy during the procedure mainly focus on the practice of PEs under anaesthesia through normative lenses. But as medical schools work to build more inclusive practices such as cultural competencies and shared decision making into curricula (Sharma, 2019; Taylor, 2003), it seems imperative that a more comprehensive view of autonomy be embraced.

The perspective of relational autonomy grounded my research in both an awareness of medical authoritative knowledge (Morgan, 1998) and the forces of oppression that disadvantage patients in the clinical encounter (Sherwin, 1998). Widdows' (2013) work on choice quality provided me with an awareness of the multitude of choices that are available regarding cervical-cancer screenings and PEs and the ethical importance that these choices and alternatives be offered to patients. As Sherwin has stated (1998), a relational approach provides a more inclusive lens from which to view autonomy – one that helps restructure healthcare in ways that renegotiate the practices around informed consent and physician-patient interactions.

## CHAPTER 4: METHODOLOGY

### **Introduction:**

As identified in the literature review, two pervasive knowledge gaps persist in my field of inquiry. First, depictions and representations of patients receiving the PE in medical-school curricula have not been analyzed or studied. Secondly, medical-school curricula have not been evaluated to see if they reflect updated PE and cervical cancer screening guidelines or if they include contemporary patient-centred preferences. These knowledge gaps persist in tandem with findings that demonstrate on-going issues of the PE in educational and clinical practices: overperformance and/or unnecessary performance of the PE, medical students' attitudes towards patient autonomy during the PE, and patients' reported lack of understanding of the exam's purpose. With this in mind, my research question is as follows:

- **How are patients represented in PE learning materials used by Canadian medical students?**

In this chapter, I will explain the methods I used to answer this question. This includes a description of my research design and the approach I took to sampling and data collection. I will also provide a summary on my contemporary approach to data analysis: Situational Analysis (Clarke, 2005). I will justify my use of this method and its postmodern epistemologies over more conventional qualitative analyses. Finally, I will explain how I used Situational Analysis to approach the project.

### **Research Design**

In this study, I employed a cross-sectional, multiple case-study design. Cross-sectional designs explore and/or describe the characteristics of “a specified sample at one point in time or over a short span of time” (Drisko & Maschi, 2016, p. 32-33). As I aimed to analyze learning materials currently in use at Canada's five largest medical schools (i.e. for the 2019-2020 school year), a cross-sectional research design was appropriate. Longitudinal designs would yield results about how depictions of patients in materials have changed over the years; however, by

exploring this specific moment in time, my research aims to shed light on current issues in medical learning, patient care, and clinician-patient encounters.

A multiple case-study approach was chosen as the most efficient and effective way to address the research question. Case studies provide researchers with “a holistic understanding of a problem, issue, or phenomenon within its social context” (Hesse-Biber & Leavy, 2011, p. 256). In particular, a multiple case study aims to describe the quintain or larger group of cases. For the purposes of my research, studying only one case (i.e. learning materials from one university) would be limiting; institutions are likely to have different approaches to teaching the PE, and the research would not be generalizable. Studying multiple cases provided the breadth of knowledge I sought with my study and allowed for comparison between cases.

### **Sampling Strategies**

Qualitative purposive sampling was employed to obtain the most informative and appropriate sample for my research purposes (Drisko & Maschi, 2016). In particular, I applied critical-case sampling, as defined by Michael Patton (1990). Critical-case sampling involves strategically seeking out cases that “yield the most information and have the greatest impact on the development of knowledge” (Patton, 1990). Because the selected cases are information rich, logical generalizations can often be made from the evidence produced in studying critical cases (1990). Critical-case sampling is also useful in qualitative research where resources may limit evaluation of larger data sets. As this is a master’s thesis to be completed over the course of one year, critical-case sampling provided a data set that was rich with information but also manageable for my research purposes.

### **Inclusion/Exclusion Criteria**

The sampling frame I chose for my data had specific inclusion and exclusion criteria. Inclusion criteria were as follows: the segments of required textbooks or in-house learning materials that 1) describe how to perform a PE and 2) are currently required reading for undergraduate medical students at Canada’s five largest medical schools. Based on the number of undergraduate medical students, the five largest schools are: McGill University, McMaster University, University of British Columbia, University of Toronto, and Western University. Exclusion criteria were materials that depicted portions of the PE as a precursor to a larger

procedure or as cervical dilation checks during labour, and materials that were optional for medical students and/or that came from the remaining 12 medical schools in Canada. I will now justify these criteria.

Required materials (as opposed to optional) were chosen as inclusion criteria for obvious reasons. Undergraduate medical students are much more likely to be exposed to required readings than optional ones. This focus ensured that my research reflected the materials that are currently being used and read by medical students. Undergraduate programs were selected over residency programs simply because physical learning materials are much more prevalent in classrooms and, therefore, in undergraduate programs; residency programs concentrate on an application of skills in hands-on settings.

Moving onto the second inclusion criteria, materials describing solely how to perform a PE were chosen for varied reasons. First, the scope of this project meant that exploring all gynaecological procedures that contain portions of the PE (IUD insertions, colposcopies, and cervical dilation checks, etc...) would result in an untenable amount of data. Secondly, as per the literature review, findings have demonstrated that there are challenges specifically related to the PE in educational and clinical settings that should be explored. And thirdly, to my knowledge, no one has examined PE educational materials, representing a knowledge gap in this area. These documents illustrate how a large percentage of PEs have and will continue to be performed and what options are being presented to patients. For all these reasons, they deserve careful analysis.

Finally, the five largest medical schools in Canada were chosen as inclusion criteria for the sample for multiple reasons. Canada was selected as the country of focus because my research is situated in Canada. The five largest schools were selected to maximize the breadth and scope of the project; these institutions train the largest numbers of doctors moving onto clinical practice in Canada. By focusing on these critical cases, my research aims to have the largest possible impact on patient care.

## **Data Collection**

Data collection took place from September 2019 through to January 2020. I began with searching each school's website for an administrator or faculty member in charge of curriculum development and emailing and/or calling that identified person. I asked for: 1) a list of any required textbooks for undergraduate medical students and 2) any internal materials used for

learning clinical skills and/or the teaching of the PE. I also reached out to bookstores and medical librarians at the institutions for any lists of relevant required texts that they may have had. While waiting for responses, I searched online for publicly accessible and recent student handbooks, course listings, and bookstore websites. This proved fruitful with several textbooks being identified as required reading for current students through bookstore websites.

Responses from institutions were varied. One institution responded almost immediately with a copy of an internal clinical skills guide. Others responded with names of different contacts who they stated would have the information I requested. After reaching out to this second wave of contacts, I received a clinical skills guide and a list of required texts from a second institution. By November, if I had not heard back from an institution or had been passed off to too many contacts, I began reaching out to Privacy Information Officers. Officers at two of the remaining institutions put me in contact with relevant faculty and staff members, who then sent related materials including textbook lists, clinical skills guides, and a PowerPoint presentation. An officer at the remaining institution instructed me to seek out any other methods of finding the materials, as he knew the institution itself would be too challenging to deal with. I then reached out to the Medical Students' Society, who gave me access to their entire reproductive class modules as well as a PowerPoint presentation on the PE. I confirmed with the identified author(s) of these materials via email that I had permission to use them in my study. Data collection was completed by early January 2020.

After eliminating materials that did not contain depictions of the PE and removing duplicates (for instance, multiple schools use the same textbooks), a sample of 10 educational materials remained, listed in table 1. Textbooks were accessed via McGill University Library, either online or in physical copy. Below is a list of the publicly available and used textbooks (five total) and the internal documents (anonymized) consisting of two PowerPoint presentations and three clinical skills guides/manuals.



Table 1: Educational Materials

Title	Author/Editor (if applicable)
Bates' Guide to Physical Examination (12th edition, 2017)	Lynn S Bickley and Peter G Szilagyi (Authors)
Essentials of Clinical Examination Handbook (8th edition, 2017)	Yuhao Shi (Editor)
Essentials of Clinical Obstetrics and Gynecology (6th edition, 2016)	Neville Hacker et al (Editor)
Essentials of Family Medicine (7th edition, 2019)	Mandy A Smith et al (Editor)
Obstetrics and Gynecology (7th edition, 2014)	Charles Beckmann (Author)
Clinical Skills Guide 1	Internal Document
Clinical Skills Guide 2	Internal Document
Clinical Skills Guide 3	Internal Document
PowerPoint Presentation 1	Internal Document
PowerPoint Presentation 2	Internal Document

## Data Analysis

After an exploration of various methods of analysis, I landed on a contemporary approach for analyzing this visual and textual data: Situational Analysis, developed by social-science researcher Adele Clarke (2003). As this method is perhaps a less well-known approach to data analysis, in this section I will define Situational Analysis, including its epistemological background and methods, before moving onto my justification and application of this method.

### *Situational Analysis: Background and Paradigm Shifts*

According to Clarke, Situational Analysis can be defined as a “theory/methods package” that is an extension of the conventional qualitative methodology of Grounded Theory (Clarke et al., 2016, p. 12). Unlike traditional applications of Grounded Theory, however, Situational Analysis contains flexible research designs and methods and is rooted in post-structuralist epistemologies. As such, Situational Analysis has been referred to as a ‘re-grounding’ of Grounded Theory through updated analytic approaches that are relevant to the postmodern turn in research (Clarke, 2003).

Grounded theory is an iterative methodology. It begins with a question or even with the collection of qualitative data. The data is inductively coded for repeated themes and/or concepts, which inform what further sampling strategies must be taken. The cycle repeats until data saturation is reached, with codes being grouped into categories. Throughout the process, a theory – one that is *grounded* in the empirical data – emerges (Glaser & Strauss, 1999; Green & Thorogood, 2014). During its beginnings in the 1960s, Grounded Theory had been aligned within a more positivist paradigm alongside quantitative research. Some focus has shifted within

the methodology to include epistemologies rooted in social constructionism (Clarke, 2003). Certain researchers have been instrumental in adapting Grounded Theory to this more constructivist paradigm while also bringing forward practices such as researcher reflexivity (Charmaz, 2014).

Despite this epistemological shift, Grounded Theory has not been without its critics – Clarke among them. These critiques have included the methodology's trend towards oversimplification, its inadequacy of addressing heterogeneity or complexities in the data, and its lack of analysis of power (Clarke et al., 2016). By its very nature Grounded Theory leaves data analysis reliant on a sort of quantification of the most prevalent themes or categories. Clarke has argued that these notions of universality work to silence divergent groups and positions that are present in the data but not prevalent (Clarke, 2005). Moreover, she states that Grounded Theory focuses too heavily on the human action (or interaction) within the data but not the situatedness of said action; methodological attention must be paid to implicated or less powerful actors and the consequences of others' actions for them (Clarke et al., 2016).

In the postmodern era of research, the acceptability of conventional methods has diminished; values have shifted towards methodologies that embrace awareness of power, hierarchies, contradictions, as well as understandings of multiple ways of knowing (Clarke, 2003). Clarke's Situational Analysis aims to update Grounded Theory under this new set of values. Like Grounded Theory, Situational Analysis focuses on analyzing discourse – be that documents, ethnographies, transcribed interviews, or news media. But where Grounded Theory uncovers the basic social process occurring strictly within the data, Clarke's analyses are meant to incorporate an awareness of the overall situation of concern (Clarke, 2003). Researchers using Situational Analysis go beyond the hard data to situate their topic individually but also within social structures, collectives, institutions, and histories/present-day realities (Clarke, 2003). Drawing on Foucault's post-structuralist theories involving discursive power, Clarke's analyses aim to displace hierarchies; positions within the data that are at the margins are as relevant as those that are dominant (Clarke et al., 2016).

In addition to the above, Situational Analysis allows for more flexible research designs than the systematic approaches of Grounded Theory. It can be applied as a methodology that influences entire projects or solely as a method for data analysis alongside other methodological

approaches, as I have employed it in this study (Grzanka & Mann, 2014; Karley, 2009; Martin et al., 2016; Pauly et al., 2019).

### *The Methods of Situational Analysis*

A situational analysis is accomplished through the making of three kinds of maps and following through with analytic work and memo-making (Clarke, 2003). Researchers may choose to use one or a combination of the maps, depending on their project. The first of these maps – situational maps – are created early on in the research project to help discover pathways to new data sources and/or to lay out what has already been collected (Clarke, 2003). The goal is to list all the human and nonhuman elements in the situation of concern in both an abstract/messy map, followed by a structuring of these elements in an ordered map (Clarke, 2003). The researcher then analyzes relations among them. These maps are intended to capture the messy complexities of the research topic or data and work against “the usual simplifications so characteristic of scientific work” (Clarke, 2003, p. 559). They also can help the researcher decide which relations – or stories – are worth pursuing during data analysis.

The second analytic tool used in situational analyses is called a social worlds/arenas map. These maps can be used to aid research design or entry ways into data analysis. Whereas situational maps bring to light individual elements within the research, social worlds/arenas maps lay out the collective actors and arenas of commitment within which they operate (Clarke, 2003). To create these maps, researchers plot out relevant collective actors and arenas in their situation of concern. Porous circles on the map represent open boundaries between these groups and circle size represents hierarchies between or among them. During the mapping process, the researcher creates memos, analyzing different discourses, actions, and boundaries within these groups. Clarke refers to this process as a meso-level interpretation – one that focuses on the sites of collective action both organizationally and institutionally. This process is distinctly postmodern in its approach; it takes into account notions of heterogeneity, power, and collective action of groups within the research topic (Clarke, 2003).

The third analytic tool is called positional maps. These maps incorporate some tenants of Grounded Theory and are mainly used for analysis of collected discursive data. Researchers immerse themselves in the data – as is done in Grounded Theory approaches – but here, the primary aim is to uncover contested issues. Previously created social worlds/arenas maps assist

as a way to enter into the data, having laid out some of these broader issues in the situation of inquiry. The data can then be coded – again, as in Grounded Theory. But rather than focusing on emergent themes, the researcher pays attention to positions taken and other silences in the discourses. Finally, these positions and/or silences are plotted on coordinate (X, Y) maps, with the axes representing contested issues and the location of the plot point representing the position's prevalence. Rather than resulting in a theory, these maps allow for multiple positions and even contradictions and silences within the data to be fully articulated (Clarke, 2003; Clarke et al., 2016).

### **Justification of Method**

Situational Analysis is a beneficial tool of data analysis for my study for multiple reasons. First and most evidently, the method has a strong history in the social sciences, particularly related to feminist health research and equity issues in public health (Clarke et al., 2016; Licqurish & Seibold, 2011; Martin et al., 2016). At a base level, this method aligns with my research design, which is situated within a social science/qualitative analysis of medical learning materials.

Secondly, a situational-analysis approach to my study allows me to build on previous findings in the literature and on theories related to the PE and medical curricula. Deficiencies have been demonstrated in medical school textbooks and curricula in the fields of patient representation and trauma-informed care. By conducting a Situational Analysis in my study, I can note any “exclusions and erasures of individuals, groups, concepts, knowledges, and perspectives” (Perez & Cannella, 2016, p. 99). But more than that, the PE has long contained notions of clinical power – be that its beginnings in medical bondage, anaesthetized exams without patient consent, or current practices that force patients to undergo unnecessary exams. Systemic power is also at play in the PE when one considers the on-going health disparities linked to the procedure in vulnerable and marginalized populations. Situational Analysis and its post-structuralist groundings provide for an awareness of the power that dominant discourses hold (Licqurish and Seibold, 2011). Whereas conventional qualitative analyses would result in mere descriptions of how patients are depicted in these materials, a situational analysis *situates* my data in the problematic medical histories and realities of the PE. Alongside my conceptual

framework, it brings to light how dominant discourses in these documents can shape the exam for students, clinicians, and patients (Licqurish and Seibold, 2011; Martin et al., 2016).

### **Pre-Data Analysis: Situational and Social Worlds/Arenas Maps**

Before immersing myself in the data, I first made situational maps – both abstract and ordered – to lay out my project and to open up the situation of inquiry. The ordered map identified and categorized elements that would have otherwise gone unnoticed: sex workers who served as early standardized patients and the non-human elements of the exam (the table, drape, footrests), for instance. The elements on the ordered map were then analyzed relationally using a mapping tool in a qualitative data-analysis software called *NVivo* until analytic sufficiency was reached. This process brought to light relationships between elements that had not been previously evident, such as the correlation between the women’s health movement and newer PE technologies. Both the abstract and ordered map aided in refining my research question and identifying what themes to explore in the literature review chapter.

Upon completion of the situational maps, I began the social worlds/arenas maps and extensive memo-making of this process. *Microsoft Word* was used to create the maps. Multiple revisions and consultations with my supervisor took place throughout their making. These consultations were key in identifying silent actors and elements that existed in social worlds and arenas which had previously gone unnoticed. For instance, while I initially had left patients out of the medical education arena due to their presence in the patient voice arena, my supervisor informed me that – perhaps though silent or disempowered – patients existed in this realm. During the process, Clarke’s detailed approach to memo-making for the social worlds/arenas maps was applied (Clarke et al., 2016). This involved answering multiple questions for each social world and arena such as: what is the work of this world/arena? what are its commitments? how do participants believe they should go about filling them? how does the world describe its present self in its discourse? and several others defined by Clark (Clarke et al., 2016).

This map and memo process took approximately two weeks. Again, while this did not constitute data analysis, the social worlds/arenas maps provided a meso-level interpretation of broader notions of the PE; they aided in identifying the sites of collective action such as clinical regulatory bodies, medical schools and medical school culture, and patient narratives in scientific and popular media. Like the relational analysis of the situational maps, this meso-analysis aided

in structuring the literature review and theory chapters and provided an entry into the data. As both situational and social worlds/arenas maps were used for project design and not data analysis, they will not be included in the findings chapter; however, a sample of them can be found in Appendices 1-2.

### **Data Analysis: Positional Maps**

Data analysis was approached through a combination of Grounded Theory coding and Clarke's positional mapping. The ten PE documents were imported into *NVivo*. Primary and then secondary codes were applied to the data. As per the methods of Situational Analysis, these codes focused on positions present in the data rather than on themes. Previous analyses done during the making of the situational and social world/arenas maps aided in identifying these positions. An awareness of discourses surrounding medical-school culture, for instance, helped bring to light positions around medical professionalization and the role of the clinician as an expert and a decision maker. Memos were taken throughout the coding process which allowed for comparison between documents and for an identification of silences within the data.

When new positions were no longer emerging from the data, I exported the codebook from *NVivo* to a *Microsoft Excel* spreadsheet. These were then organized into thematically related groups, noting the full range of positions in the data. From this, I began conceptualizing titles and axes for the position maps. Here, as Clarke states one should do, I identified the key issues at stake in the broader situation of inquiry to aid in designing the maps. Though this will be elaborated on in the findings chapter, key issues were identified as 1) The PE presents multiple challenges in interactions between clinicians and patients and 2) Decisions about the overall procedure are made by the clinician. Evaluation of which positions belonged on which maps and which axes took approximately one week. The maps were completed in *Microsoft Word* using templates available from Clarke (Clarke et al., 2016). Maps were created until analytic sufficiency. Positions and silences that were relevant to my research question were included on the final two position maps, to be discussed in the subsequent chapter.

## CHAPTER 5: FINDINGS

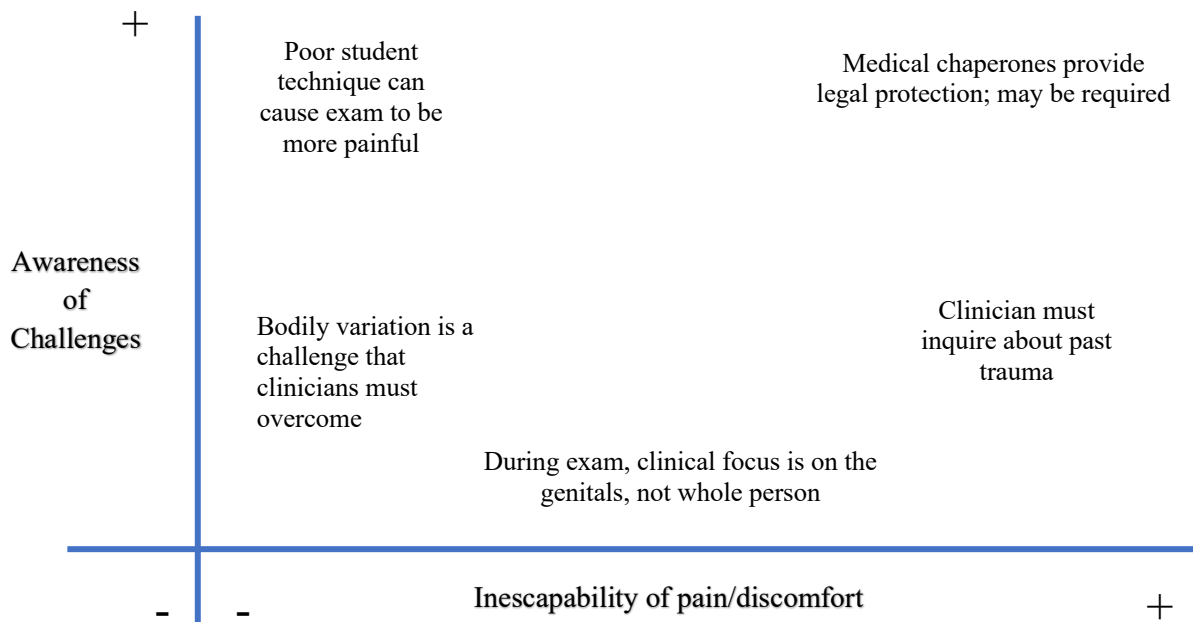
### Introduction

This chapter presents results of a situational analysis of my collected data. The positional maps provided are a visual representation of the findings, and discursive themes and positions that emerged from the data will be discussed individually. Of note, throughout this chapter, the term “documents” refers to the complete data set; the term “textbook” refers to the five public textbooks within the data set; and the term “internal documents” refers to materials that are internal to and were provided by each medical school (including three clinical skills guides and two PowerPoint presentations).

### I. Positional Map 1

Positional Map 1 illustrates the most significant issue that emerged from discourses in the data: that the PE poses multiple challenges in interactions between clinicians and patients, more so than other physical examinations. The positions within this issue were plotted along two axes: 1) clinician awareness of these challenges and 2) the inescapability of pain/discomfort of the PE for the patient. Below is the positional map itself, followed by descriptions of the five positions.

**Position Map 1: The PE presents multiple challenges in interactions between clinicians and patients**



*a. Poor student technique can cause exam to be more painful*

An awareness of patient pain and discomfort during the exam was common throughout the documents. Discourses highlighted that an inexperienced clinician or student learner may cause more pain for the patient with improper PE technique, be it psychological (saying the wrong thing) or physical (doing the wrong thing). Emphasis was placed on using desexualized and/or non-violent language in front of the patient, with three textbooks and two internal documents containing lists of these linguistic do's and don'ts. Words and phrases to be avoided included insert, pulling out, looks good, feel/touch, spread your legs, bed (for exam table), and blades (for bills) of the speculum. Discourses in the documents implied that neutral language would be less triggering for patients. Despite this emphasis on patient-friendly language, several documents went on to use non-neutral language when describing how to perform the exam clinically; the speculum still had blades and the medical student still had to 'insert it.'

In terms of physical techniques to minimize pain, emphasis was placed on 'what not to do' during the speculum portion of the exam. Two clinical skills guides provided examples of this:

Any turning of the speculum as it first enters the vagina **can catch hair or skin**.... When the speculum is removed, it is very important to slightly open the bills to loosen the cervix so the speculum can be brought out **without pulling down on the cervix** (Clinical Skills Guide 2, p. 7)

**DO NOT TOUCH CLITORIS** while inserting **re painful**. (Ask patient to breathe in, as breathes out insert speculum). (Clinical Skills Guide 1, p. 94) (emphasis added; capitalization present in original text)

Here, discourses focus on how missteps in speculum technique can not only physically injure a patient but can also sexualize the exam; the statement to not touch the clitoris is heavily underscored in the above example. Medical students are told they have the opportunity to improve patient experience by avoiding these gaffes.

This emphasis on minimizing pain and emotional distress implies that these factors can be controlled by the clinician. A PowerPoint presentation discussed how the exam – when performed correctly – can be empowering for the patient (PowerPoint 2, p. 10-11). While this may be accurate, it could be interpreted that clinical perfection of technique will inevitably result in positive experiences for patients. Only one document – a clinical skills guide – illustrated that the exam may be uncomfortable or traumatizing regardless of what the clinician does (Clinical



Skills Guide 3, p. 2). None suggested patients be made aware that allowing medical students to perform the PE can result in a more painful exam.

*b. Medical chaperones provide legal protection; may be required*

Discourses related to chaperones existed in the majority of the documents (60 percent). Medical chaperones (i.e. those not related to the patient) were heavily recommended not just for students but for clinicians in general. These recommendations carried contractual tones. One clinical skills guide stated that a third party must be present to hear a patient refusal of a chaperone. It also went on to say that, when used, the chaperone must be able to verify what the clinician did “medicolegally” and that family chaperones do not offer this legal protection (Clinical Skills Guide 1, p. 93). When mentioned, family chaperones were constructed as optional emotional support for patients; no instructions were given as to how to include them in the PE process. Certain textbooks stated that female chaperones were mandatory for male clinicians, regardless of patient preference (Bickley and Szilagyi, p. 23; Smith et al., p. 328). Only one document reminded students that an attending had to be present at all times during a student-performed PE (Clinical Skills Guide 3, p. 4).

Few discourses suggested that the patient may need protection from the clinician, despite historical and recent controversies where this has been the case. In fact, only one document – a PowerPoint presentation – mentioned cases of PE abuse and solely in the context of them occurring historically (PowerPoint 2, p. 6). There was also no mention of how a forced third party – be it an attending or a required chaperone – may affect patients.

*c. Clinician must inquire about past trauma*

Discourses in both textbooks and internal documents recommended that clinicians inquire about possible trauma either during patient history or when they witness an adverse reaction during the exam (e.g., Bickley and Szilagyi, p. 22; PowerPoint 2, p. 17; Clinical Skills Guide 2, p. 2). In certain instances, these adverse reactions were constructed as part of a mystery that the clinician must solve:

The woman’s response to the pelvic examination **may reveal clues** about her feelings about the examination and her sexuality. If she pulls away, adducts her thighs, or reacts negatively to the examination, you can gently comment, “I notice you are having some

trouble relaxing. Is it just being here, or are you troubled by the examination?...Is anything worrying you?" ... Adverse reactions **may signal** prior physical or sexual abuse and **should be explored** (Bickley and Szilagyi, p. 22, emphasis added).

Here, patient reaction is constructed as ‘clues’ to possible past traumas and not as a reaction to the known discomfort of the procedure. This text also instructs clinicians to inquire about the patient’s reaction and explore any prior physical or sexual abuse. No mention is made about the burden of disclosure that is placed on the patient in such a situation or the potential discomfort of disclosing to a healthcare professional.

Only two documents (20 percent) overtly referred to trauma-informed practices for the PE. The first – a PowerPoint presentation – stressed that clinicians must have an awareness of possible institutional and personal trauma related to issues of class, gender, ability, race, and sexuality and their own positionality within this trauma (PowerPoint 2, p. 13). It went on to emphasize a gender-inclusive approach for trans patients (p. 20-23). The second – a clinical skills guide – dedicated two pages to principles of trauma-informed care, the recognition of provider positionality, as well as contextualizing Canadian Indigenous and LGBTQ+ histories and realities and their impact on care and healthcare disparities (Clinical Skills Guide 3, p. 11-12). Both highlighted relevant issues; however, neither discussed how to actively make the PE trauma-informed.<sup>5</sup> The two pages dedicated to trauma-informed care in the internal guide, for instance, are completely divorced from the steps of the PE. Harm-reducing PE strategies such as self-swabbing or referrals to counselling services are not mentioned.

*d. During exam, clinical focus in on the genitals, not the whole person*

Discourses throughout the documents shifted between representing the patient as a person and the patient as their genitals. Before and after the exam, patients were often constructed as sentient, engaging in conversations with clinicians. Once patients were undressed and the procedure had begun, they were almost completely reduced to their genitals. Distinct examples of this in the following texts include:

With introduction of the speculum it is important to have control of the speculum bills at

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<sup>5</sup> Some mention is made in the PowerPoint about communication and patient choice as a trauma-informed approach, which will be discussed in the subsequent map under the position *Patient choice is the customization of the actual PE*.

all times. If the upper bill is not secured **it can pop up and hurt the anterior structures of the vestibule** (Clinical Skills Guide 2, p. 8, emphasis added).

Palpate the cervix, noting **its** position, size, shape, consistency, regularity, mobility and **tenderness**. **Normally the cervix can be moved somewhat without pain**. Feel the fornices around the cervix. Cervical motion with **adnexal tenderness** suggests pelvic inflammatory disease (Clinical Skills Guide 3, p. 8, emphasis added).

Here, the description of the subject experiencing pain is a body part. The ‘anterior structures of the vestibule’ may be hurt by improper speculum technique, and the ‘cervix’ may be tender or experience pain if moved too much. These demonstrate how patients – once undressed and receiving an exam – are no longer present as a whole person; their body parts – not their selves – experience the exam’s discomfort.

Broader notions of patient disembodiment were present in visual data as well. Only two documents – both textbooks – contained an image of a whole patient. These are copied below; *Image 1* shows a faceless patient with her head turned away, and *Image 2* shows a patient with her eyes closed. Both are emotionless, undressed, covered with a sheer drape, and compliantly awaiting their PEs. While they may be physically whole, they do not appear involved, present, or perhaps even awake for their PE experience.

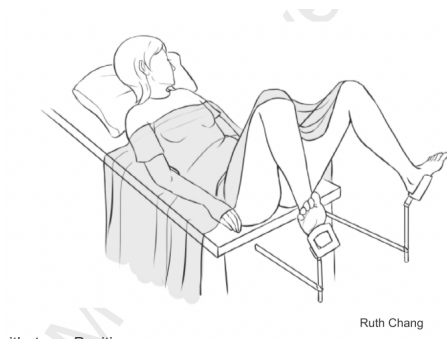


FIGURE 1.4. Lithotomy position during a pelvic examination.

*Images 1-2: The sole images of whole patients in the documents Shi, p. 268 (left); Hacker et al., p. 12 (right)*

The remaining visuals were anatomical and educational in nature, containing either cross-sections of internal organs or closeups of external genitalia or cervixes. Computer-generated graphics were predominantly used. All were detached from physical bodies; for instance, legs would be spread displaying the labia and vaginal entrance, but the graphic faded into nothingness beyond the legs. Very few depicted clitorises; when the clitoris was present, it was not labeled

(Bickley and Szilagyi, p. 28; Beckmann, p. 12; PowerPoint 2, p. 29). Real photographs also left the patient as a whole person out of the shot; they mainly portrayed closeups of external genitals with a gloved finger inside (PowerPoint 1, p. 7; Bickley and Szilagyi, p. 29). One document – a PowerPoint – depicted a real patient on the table with a clinician about to insert a speculum, but it fell short of including anything above the patient’s waist (PowerPoint 2, p. 3). This framing was possibly due to offering the model anonymity, as there are historical precedents for this in medical texts (Clarke and Moore, 1995). Both real and computer-generated images were suggestive of white, cis-gendered patients; no racial, ability, or gender diversity was present or discussed in the visuals.

*e. Bodily variation is a challenge that clinicians must overcome*

As mentioned above, present in nearly all documents – visually and discursively – was a homogeneous notion of the body: one that identifies female and is white, abled, and of child-bearing age. If variation was mentioned, it was in reference to how certain bodies can make the PE more challenging for the clinician once the exam begins. Obese, multiparous, virginal, tense, and elderly bodies all made the clinical steps of the exam more difficult, as demonstrated in the following examples:

Many **virginal vaginal orifices** admit a single examining finger. Modify your technique so as to use your index finger only. A small Pedersen speculum may make inspection possible. When the vaginal orifice is even smaller, an adequate bimanual examination can be performed by placing one finger in the rectum rather than in the vagina, but warn the patient first! Similar techniques may be indicated in **elderly women** if the introitus has become **atrophied and tight**. (Bickley and Szilagyi, p. 30, emphasis added).

The Graves speculum has blades that are wider, higher, and curved on the sides; it is more appropriate for most parous women. Its wider, curved blades keep the **looser vaginal walls of multiparous women** separated for visualization. (Beckmann, p. 13, emphasis added).

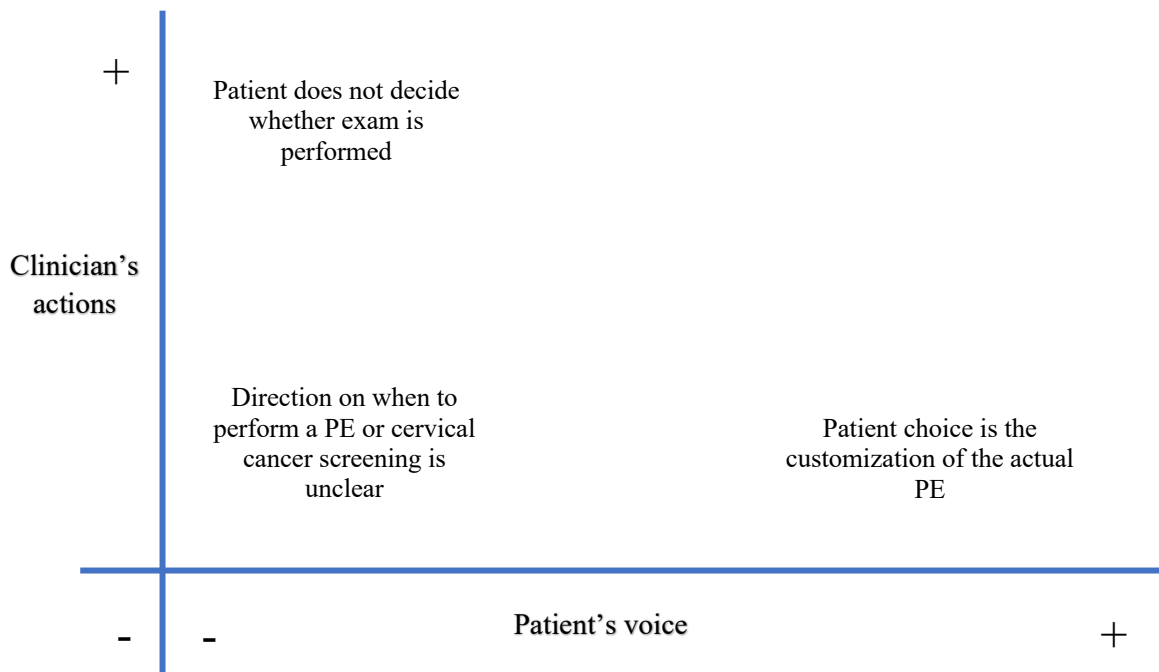
Ovaries are **difficult** to palpate in **obese or poorly relaxed women** (Clinical Skills Guide 3, p. 8, emphasis added)

‘Different’ bodies were consistently constructed as difficult bodies, presenting problems that a clinician must overcome. Words and phrases such as “tight,” “more appropriate,” “looser,” “difficult,” and “poorly relaxed women” implied a comparison to bodies that are preferable for examination. Here a young (but not too young), non-parous woman, with no fear of the exam is held as the ideal for examination.

## II. Position Map 2

Position Map 2 illustrates a less overt theme within the cases: that decisions about the overall PE procedure are more likely to be made by the clinician than patients themselves. The positions within this issue were plotted along the axes 1) clinician's actions and 2) patient's voice. Below are elaborations on the three positions present in the data and the one identified silent position.

**Position Map 2: Decisions about the overall procedure are made by the clinician**



Silenced position:

HPV self-sampling kits are available, effective, & may increase screening uptake in vulnerable populations

*a. Patient does not decide whether exam is performed*

Underscored in all documents was that patients were not in control of deciding whether the PE was to be performed. The clinician was framed as the ultimate decision-maker; that is to say, if the clinician had determined that a PE was indicated, it was to be performed. The following examples from two textbooks and one internal guide demonstrate this authority:

Explain to the patient **your plans** for the exam (Smith et al, p. 328; emphasis added).

Everything **that is going to happen** during the pelvic examination should be explained **before it occurs** (Beckmann, p. 11; emphasis added)

[Obtain] permission from the patient to proceed (Clinical Skills Guide 2, p. 3).

Here, the exam has been decided before or completely independent of patient input. Though patient consent – or ‘permission’ as it was sometimes phrased – is mentioned, it is within the construct of the exam already being in motion or decided on; clinicians merely must dictate their plans, obtain permission, and begin the procedure.

Moreover, in the mere 50 percent of the documents that mentioned patient consent, few detailed what the process of obtaining it entailed. Some suggested explaining the procedure in segments (the visual, bimanual, and speculum exam) and offering the patient the opportunity to ask questions. No mention was made of describing the physiological or psychological experiences that the patient may have. One document – the second PowerPoint – suggested that clinicians specifically not use the word ‘pain’ when describing the exam (PowerPoint 2). Discourses framed clinicians as experts and professionals whereas patients were framed as uneducated about their bodies (the exam represented a ‘learning opportunity’). This notion of the clinician’s authority was so prevalent that none of the documents suggested what to do if a patient refused; no alternative courses of actions were suggested for apprehensive patients.

*b. Patient choice is the customization of the actual PE*

When patient choice was discussed in the documents, it occurred with respect to how the patient could customize details of the procedure. Examples of this choice included adjusting the position of the exam table (PowerPoint 2) holding a mirror to see the procedure (Clinical Skills Guide 2 and PowerPoint 2), the option to be given non-verbal cues for adjustment (PowerPoint

2) wearing shoes during the procedure (Bickley and Szilagyi) and using phones or other electronic devices as a distraction during the procedure (Clinical Skills Guide 3). Discourses in the documents described this customization of the exam as “patient inclusion,” “empowerment” (PowerPoint 2), and allowing women “to feel more in control of what is being done during the examination” (Clinical Skills Guide 2, p. 8). Absent recommendations of patient choice during the exam included self-insertion of the speculum and forgoing the use of footrests, with every document referencing the use of footrests throughout the procedure.

*c. Direction on when to perform a PE or cervical cancer screening is unclear*

The majority of the documents (60 percent) made no reference as to when a PE or cervical cancer screening was to be performed. One textbook and one internal document – a PowerPoint – stated that PEs and cervical cancer screenings were to be performed “routinely” at patient check-ups or when clinicians feel they are indicated (Bickley and Szilagyi, PowerPoint 2). Nearly all documents linked the PE with a cervical cancer screening; a Pap or HPV test was to occur during the speculum portion of a PE.

Only two documents – both clinical skills guides – made reference to public health recommendations for cervical cancer screenings, both referring to the Canadian Task Force on Preventive Health Care (CTFPHC). The first dedicates an entire page to Frequently-Asked-Questions medical students may have about cervical cancer screenings, including why the task force now recommends the exam from age 25 and not annually. Some examples of questions include:

Will women forget to come in for their annual check-ups if they do not need to attend for an annual pap test?

Why is the CTFPHC increasing the age at which screening is recommended to 25?

Why does the CTFPHC recommend a screening schedule of every three years? (Clinical Skills Guide 3, p. 9)

Discourses in these questions are constructed as though medical students naturally lean towards over-screening and over-examination. The first question challenges patients’ ability to attend to their own healthcare needs if they are not strongly prompted to have a Pap-test every year by clinicians. The second clinical skills guide was the only document to make the distinction between the PE and cervical cancer screenings; it overtly referenced that patients attending for a

routine Pap-test do not require the bimanual portion of the exam and suggested that the harms of the bimanual exam outweigh the benefits for asymptomatic patients (Clinical Skills Guide 2).

*d. Silenced position: HPV self-sampling kits are available, effective, & may increase screening uptake in vulnerable populations*

No documents made reference to contemporary options available to patients such as HPV self-sampling kits. The kits have been available in Canada since 2017, and each internal document – which had been updated for the 2019/2020 school year – did not reflect this information. As mentioned in the literature review, research has demonstrated that HPV self-samples improve patient participation in cervical cancer screening, are preferred among trans and Indigenous patients, and result in increased follow-up in under-screened populations when a positive result is found (Arbyn, 2018; Cerigo et al., 2012; Gupta et al., 2018; Reisner et al., 2018). Of the two documents that focus on healthcare disparities and providing trauma-informed care for Queer and Indigenous patients, neither made mention of the possibility of self-sampling (Clinical Skills Guide 3 and PowerPoint 2).



## CHAPTER 6: DISCUSSION

### Introduction

This chapter presents a discussion on the study's findings and on my situational analysis of the data. As the findings were extensive, the discussion will be centred on four themes related to patient representation that are relevant to both my research question and the conceptual framework: embodiment, identity, choice, and autonomy.

#### I. Embodiment

In terms of embodied experience, the documents provided little guidance on what a patient may physically or psychologically feel during a PE. Many discussed how providers should explain to a patient what to expect during the procedure, but none explained what the experience of the exam entails from a patient perspective. Some emphasis was placed on providing patient comfort, including techniques to avoid pain and modified language to avoid any sexual or violent connotations. However, for the most part, discourses and visuals ignored the patient perspective. Body parts – not patients – were described as feeling sensitivities or pain, for instance. And while it was mentioned that adverse physical reactions to the exam may occur, attribution rested on previous sexual or physical assault and not on the exam being uncomfortable. Perhaps most notably related to this omission of patient embodiment were the results of the visual analysis; only two documents (both textbooks) contained images of whole patients, which were either faceless or asleep.

These results build on previous sociological interpretations of and theoretical discussions on the PE. Feminist theories have long drawn attention to notions of patient disembodiment and medical objectification during the procedure (Giuffre and Williams, 2000; Henslin and Biggs, 1978; Kapsalis, 1997; Underman, 2011). Kapsalis (1997, p. 3) has suggested that the framing of genitals in gynaecology textbooks exists to reduce the patient to a de-personalized object for medical gaze. Moore and Clarke (1995) have similarly stated that computer-generated graphics of genitals represent a gross negation of corporeality. Earlier interpretations of the PE in clinical practice have theorized that patients transition from being seen as a whole person by providers to “just the exposed genitals marked off by the drape sheet” during the exam (Henslin and Biggs, 1978 p. 133). And more recent analyses have suggested that clinicians lean on bodily objectification of patients as a coping mechanism during sensitive, physical examinations

(Giuffre and Williams, 2000). My findings indicate that the way patients are portrayed in these documents adhere to concepts of medical disembodiment and objectification present in existing literature; narratives about patients' embodied experiences are deficient.

The question remains as to whether this patient perspective should be included in medical education. The documents do thoroughly present the clinical skills required of medical students to perform the PE, and an awareness of the embodied experience of the procedure may be considered to be an acceptable sacrifice in an already overloaded curriculum. As Taylor (2003) has noted, priorities in medical education often focus on the attainment of 'real' medical knowledge – such as anatomy, clinical skills, and disease diagnostics – and less on an awareness of the patient perspective. However, there are multiple arguments for its inclusion.

First and most evidently, feminist ethicists and health activists have suggested that the PE's intimate nature awards it special dispensation in medical education and practices. Friesen (2018) characterizes this as 'the vagina is different than the mouth' argument when discussing why explicit consent matters in the context of anaesthetised exams. Underman (2020) has also pointed out that the combination of the vagina being a 'private part' and the reproductive organs being internal to the body makes the examination "unique among those that medical students must learn" (p. 4). Moreover, in what other examination are medical students required to have a female chaperone present for "medico-legal purposes," as one document phrased it? And while decades of studies have explored the physical and psychological reactions patients have to the PE, few – if any – have paid this level of attention to the embodied experience of a routine ear examination, for instance. Whether the medical institution recognizes it or not (Goedken, 2005), the PE is an exceptional procedure for patients and as such requires an exceptional teaching process. I argue – as do Larsen et al (1997) – that technical guidelines on how to perform the PE are not enough; the exceptional nature of the procedure calls for an educational approach in which medical students can acknowledge the patient perspective.

Secondly, not only is the PE an exceptional procedure, it also contains the power to influence health outcomes for patients. It has been well established in the literature that negative PE experiences can present barriers to wanting or receiving subsequent exams (Wijma et al., 1998). As such, findings have emphasized the importance of clinicians learning to provide a patient-centred PE (Fiddes et al., 2003; Neuhaus et al., 2016; Seehusen et al., 2006; Williams and Williams, 2013). Given the implications of a negative exam (i.e. avoidance or refusal of future

clinically necessary exams), I argue that knowledge of the patient experience during a PE is as important as clinical technique and as such, requires a prominent position in the curriculum.

## **II. Identity**

In terms of patient identity, my analysis has shown that these documents in sum present a homogenous and/or normative view of patients undergoing PEs. While there were two outliers in this category (to be discussed at the end of this section), the majority of the documents represented patients receiving PEs as white, fluently English-speaking, female-identified (she/her pronouns), able-bodied, and with no history of sexual violence. No mention was made of cultural competencies, language levels, or socioeconomic status. Both real and computer-generated visuals were suggestive of racially white and abled-bodied patients. When identity was mentioned, it was in reference to those who had bodies that fell outside the perceived norm including overweight, multiparous, virginal, tense, and elderly bodies. Discourses implied that examination for these ‘different’ bodies was difficult and required adjustments. This suggests there was an ideal patient for examination – one who was young (but not too young), non-parous, and held no fear of the procedure.

My overall findings are consistent with and add to previous research detailed in the literature review both on the lack of diversity in medical textbooks (Carson, 2018; Moore and Clarke, 1995; Parker et al., 2017; Scully and Bart, 1973) and the lack of trauma-informed care approaches in medical curricula and training (Ali, 2017; Dichter et al., 2018; Farrow et al., 2018; Goldstein et al., 2018). These training materials have continued to exclude representations of race, gender, sexuality, and trauma history despite findings demonstrating the influence these identities have on the patient experience of the PE (Ackerson, 2012; Ahmed et al., 2002; Bates et al., 2011; Bodden-Heidrich et al., 2000; Dutton et al., 2008; Freyens et al., 2017; Huber et al., 2009; Gupta et al., 2001; Peitzmeier et al., 2017 ; Robohom and Buttenheim, 1997; Richi, 2019; Wijma et al., 1998). And in line with previous research, my findings demonstrate that trauma-informed approaches to gynaecological care appear to be lacking in medical school curricula (Ali, 2017; Goldstein et al., 2018).

As with patient perspective, here, I argue for the inclusion of diverse patient identity in these training materials. As has been noted by Whitney (2019), lack of patient representation carries particular weight in PE and other gynaecological depictions; medical and technological

advances in this field were only made possible by women of colour, vis-à-vis the troubling and problematic history of gynaecology. But more than that, the documents as they stand are failing to provide medical students with cultural competencies to adequately serve marginalized populations with respect to the PE. It is these marginalized populations precisely who are underserved in gynaecological preventative care and overrepresented in health disparities linked to PE access (Demers et al., 2012; Eichelberger et al., 2016; Peitzmeier et al., 2014; McCune and Imborek, 2018; Wee et al., 2000; Whitney, 2019). As such, these homogeneous representations of patients could be interpreted as a form of neo-colonialism (Sharma, 2018) and what Whitney (2019) calls “a logic of eugenics,” perpetuating practices that are designed to serve some bodies and not, or even at the expense of, others. While diversification of patients in the curriculum will not erase all disparities linked to the PE, identity representation has the potential to humanize collective practices and to teach future doctors to provide better care to their patients (Sharma, 2019).

Despite the sum of the documents negating notions of patient identity, two outliers emerged in my analysis: Clinical Skills Guide 3 and PowerPoint 2. As mentioned in the findings, both these documents made efforts to include references to diverse patient groups, Canada’s colonial legacies, and some trauma-informed approaches. However, these references and approaches – particularly in the clinical skills guide – were featured independently of the PE itself, almost as a footnote to the procedure. And as will be discussed in the subsequent section on choice, neither included strategies that have been identified as harm reducing for certain identities including self-swabbing techniques, self-insertion of speculum, or disuse of footrests.

It is unknown why these two documents stood out among the others. Both are internal documents, and perhaps some effort has been made at these institutions towards more inclusive educational practices and developing curricula based on the contemporary research findings previously mentioned. The PowerPoint in particular was content created by an organization independent of the university, one that develops the Gynaecological Teaching Assistant program. The incorporation of this community practice could be the reason behind this outlier status. Still, even within the topic of patient identity in these documents, efforts could be made towards improvements, as discussed above and to be expanded upon in the conclusion of this thesis.

### III. Choice

As revealed in the findings chapter, patient choice was often framed as the option to customize the PE procedure with minor adjustments. This customization included modifying the position of the table, the use of a mirror to see the procedure, wearing shoes during the procedure, and the use of electronic devices as distractions. Certain documents depicted these choices as an act of patient empowerment and a way to give patients a ‘sense of control.’ While the inclusion of these choices aligns with scientific recommendations to improve the PE experience for patients (Fiddes et al., 2003; Neuhaus et al., 2016; Seehusen et al., 2006), my analysis has demonstrated that certain options were missing. Forgoing the use of footrests and offering speculum self-insertion have both been shown to demonstrably decrease patient vulnerability and improve patient comfort (Williams and Williams, 2013; Wright et al., 2005). Neither were mentioned in any document. Other excluded options that reflect more recent recommendations include offering counselling support post-exam and HPV self-sampling kits. Both have been demonstrated to improve the PE and cervical cancer screening experience for vulnerable populations (Ades et al., 2019; Arbyn, 2018; Cerigo et al., 2012; Gupta et al., 2018; Reisner et al., 2018).

It must be noted that both counselling support and HPV self-sampling kits are often not covered by any provincial health care plan in Canada, and it could be argued that this is the reason for their omission in the documents. However, feminist analyses have called for medical practices to consider incorporation of material resources that could improve healthcare and address inequities (Dodds, 2000; Elliott et al., 2005; Kapsalis, 1997; Sherwin, 1998; Whitney, 2019). As Dodds (2000) has argued, clinicians can use their privileged positions to advocate for resource funding, but only if they are aware of its existence and need. And with respect to the PE specifically, it has been noted that medical education must include training, materials, and environments that support alternative practices (Kaplasis, 1997, p. 167). Therefore, the exclusion of information about HPV self-sampling and counselling services in the documents could be interpreted as depriving future clinicians with information to fulfill an advocacy role in patient care.

The incomplete range of options for the provision of PE also speaks to notions of quality and choice. As mentioned in the conceptual framework, contemporary feminist theorists (Brison, 2000; Narayan, 2002) have called for policies and practices that provide those assigned female at

birth not just with choice but with adequate and more empowering options. The number of choices offered to individuals is almost irrelevant; it is the quality of their content that require ethical attention (Widdows, 2013). The exclusion of alternative PE practices from these documents could be interpreted through this lens. While the documents allowed for accommodations of the exam itself, they failed to include established, up-to-date, and patient-centred choices of a certain *quality* including speculum self-insertion, disuse of footrests, HPV self-sampling, and counselling referrals. These options need to be included so that clinicians can advocate for care that could improve health inequities and patients can be informed of all their choices, even those that may be fee-for-service or available on extended private healthcare plans.

#### **IV.    Autonomy**

As mentioned, few if any studies have examined how patients are depicted in PE learning materials and this includes representations of their autonomy. The notion of patient autonomy as it relates to the PE is a substantial topic, and it must be noted that not all possible components can be covered in this thesis or discussion section. For brevity's sake, I will discuss two specific concepts related to autonomy that emerged from the data: consent and knowledge/control.

##### *Consent*

My analysis has shown that these learning materials do not present a thorough picture of patient consent. Consent (or 'permission' as it was sometimes called) was referenced in only 50 percent of the materials. Discourses often framed it as a box for clinicians to check – sometimes in an actual checklist – rather than a discussion with the patient in which refusal of the procedure was a real option. Patients' concerns about the exam were described as 'obstacles' that a clinician must overcome; one document stated that descriptions of the exam's painful nature were to be avoided, bringing into question whether patients were truly being informed of the risks of the procedure. Moreover, none referenced that educational PEs (those performed by medical students) were medically unnecessary for patients and that care should be taken in obtaining consent for them.

The deficiencies surrounding representation of patient consent are obvious; at a base level, even when it is mentioned, consent was rarely depicted as free, expressed, and/or informed (Evans, 2016). For medico-legal reasons alone, representations of patient consent in these

materials should be a) included where they are not and b) explained more thoroughly where they are. But does representation of patient consent matter beyond these legalities?

What we know from previous qualitative findings and ethical discussions in popular media is that consent for PEs both in practice and in educational settings matters deeply to patients (Bush 2000; Friesen, 2018; Norrell et al., 2017; Wainberg et al., 2010). The right to refuse both medical student involvement and the exam itself, as well as the ability to understand the reason for the PE have been highlighted as important issues by patients and feminist scholars alike for decades (Berry et al., 2003; Friesen, 2018; Norrell et al., 2017). It could be argued that the learning materials I analyzed merely serve as a ‘how to’ manual on the technical portions of PE; patient consent is likely covered more thoroughly in other portions of the curriculum. But this is once again perpetuating what Taylor (2003) has referred to as the prioritizing of medical skill over patient perspective. Medical students may be ‘forgiven’ for failing to take these perspectives seriously so long as their ‘real competence’ (i.e. technical skill of the PE) is acquired (2003). Research findings demonstrate that medical students still fail to grasp the importance of consent during the PE (Barnes, 2012; Carson-Stevens et al., 2013; Friesen, 2018), and part of this could rest on either deficiencies in the curriculum or the divorcing of patient perspective from technical skills. If medical education is to evolve beyond its problematic past and on-going reality with patient consent and the PE, the curriculum requires a centering of patient voice in teachings on the procedure, even at the base level of technical manuals.

### *Knowledge and control*

Conversations about autonomy in biomedicine tend to concentrate on concepts of informed consent. But underneath this basic requirement for procedures and treatments exists deeper notions that have bearing on patient autonomy: epistemic hierarchies (i.e. – whose knowledge is valued in the clinician-patient interaction), medical paternalism, and control. Here I will discuss some of these themes in relation to my analysis and how patients were portrayed in the data.

One result that emerged from my analysis was that clinicians were framed as – what I call – the ultimate decision makers. That is to say, decisions about whether the procedure was to be performed and which components were made solely by the clinician without patient input. In most documents, once the clinician had decided the exam was necessary, the process of

performing it was put into motion; as several texts framed it, the patient merely need to be informed about the clinician's 'plans.'

My research question is not how clinicians are represented; however, by analyzing this characterization, we can see how patients are represented, by omission. In framing clinicians as ultimate decision makers on the PE, the texts diminish notions of patient autonomy. Patients are set up as unqualified and uninformed to make a health decision. This theme was echoed in certain discourses that suggested clinicians must 'educate' patients about their bodies and that the PE presents a perfect opportunity for this lesson. Here, my analysis of the texts is in line with scientific findings and conclusions on the PE that validate this diminished autonomy. Wood et al (2018) have noted that providers do not view routine gynaecological procedures as a decision for patients to make. And Larsen et al (1997) have indicated that women may have an unrealistic belief in the diagnostic validity of the PE and may be accepting the procedure based on false trust in medical knowledge, perpetuated by providers.

Overall, the texts created what Ho (2011) calls an epistemic hierarchy and what Morgan (1998) similarly refers to as authoritative medical knowledge. This occurs when clinical expertise is valued over an individual's knowledge about their own body and is a frequent critique of clinical encounters from feminist theorists and ethicists (Crosthwaite, 1998; Dodds, 2000; Gadow, 1994; Mackenzie, 1998; Sharma, 2018). Malterud (1993) has specifically noted that common patterns in the patient-clinician interaction coupled with medical expert power are strong agents that obstruct and suppress the voices of female patients. Similarly, Morgan (1998) has argued that genuine patient disagreement with physicians is often not seen as "a real, respected option when weighed in the balance with the epistemic authority and institutional power of the physician" (p. 92).

Here, we can see these themes reflected in my analysis; in their representations, patients are not accorded the basic ability to decide whether they will undergo the PE. Perhaps more alarmingly, however, is that even though the documents set up clinicians as the ultimate decision makers, nearly all do not provide the corresponding knowledge on when a PE is necessary, with some even incorrectly referencing that the procedure should be performed 'routinely.' These deficiencies in the texts are unacceptable, especially given scientific findings demonstrating the overperformance of these invasive exams and nearly a decade of recommendations suggesting



that effective strategies are needed to inform providers about up-to-date PE practices (Henderson et al, 2014, Gabzdyl et al., 2015; Qin et al., 2020; Stormo et al., 2012).

But more than that, if the PE is to truly be trauma-informed, patients need to be centred as the decision makers of the procedure. Research and theories on trauma-informed approaches to gynaecology have shown that clinicians must recognize the patient as the expert on whether the procedure can be performed that instant or whether it should be deferred to another day (Ades 2019; Reeves, 2015). Moreover, procedures like this require “constant analysis of the health benefits versus [their] emotional costs” and their necessity should be evaluated on an individual basis and in “a collaborative manner that supports patient autonomy” (Reeves, 2015, p. 702). This should occur at all levels of medical education and practice, including representations of patients and their decisions in technical skills guides.

Again, even though these documents are not a comprehensive representation of the education medical students receive, they still matter. Discourses such as these have the ability to shape beliefs and values of medical students (Parker et al., 2017; Torfing, 2005). And given the problematic issues of the PE in medical education both historically and currently, medical institutions should have an obligation to rectify patient representation at all levels of training. Patient autonomy is central to gynaecological procedures, and this must be reflected in medical education if the medical institution is to work towards systemic change in how PEs are performed by clinicians and more importantly, experienced by patients.

## CHAPTER 7: CONCLUSION

### Introduction

This chapter presents the conclusion of my study. I will begin by discussing study limitations and possibilities for future research. Finally, I will discuss the implications my findings have for medical education and practice. This includes suggestions for improved patient representation in the curricula, inclusions of alternative PE practices, as well as clarity on when the PE is to be performed.

### I. Limitations and Future Research

The findings of this study – though significant – do have some limitations in their interpretation. First, and as mentioned, the documents sampled and analyzed represent only a portion of the Canadian medical school curricula that students receive. Medical students learn the PE both in the classroom and in clinical rotations. Certain deficiencies present in this discursive data may be addressed elsewhere in medical education training. Secondly, the scope of the project allowed for a critical-case sampling of these materials. Canada has 17 medical schools. While there is standardization among learning objectives given the national nature of medical board examinations, school curricula will still vary. Generalizability of the data is still possible, but it must be noted that distinctions across curricula may exist within the U-17.

Further research into this subject could examine curricula on the PE more extensively, both from a breadth perspective (i.e. – more documents and observations of rotations) and a sample perspective (i.e. – more schools). Another research opportunity would be an ethnographic study of medical school classrooms when the PE is learned; this would allow for more in-depth analysis about what is discussed between teachers and learners alongside discursive learning materials. And finally, future studies could interview medical students on their experiences learning the PE with respect to their knowledge and awareness of patient perspectives. While many studies have explored medical students' experiences of learning the PE, to my knowledge, none have specifically investigated their knowledge of patient experience.

### II. Implications for Practice

The findings of this study have far-reaching implications for those interested in medical education. This study identified several opportunities to diversify and expand upon learning

materials related to the PE in Canadian medical schools. Persons involved with curricula development, educational policies, training, and textbook publishing in particular may find these opportunities for improvements useful. This section details these areas for exploration below.

*a. Clarity on PE guidelines and contemporary choices*

My findings have demonstrated a need for clarity on PE and cervical cancer screening guidelines in medical education that could easily be implemented. The ambiguities present in all but one of the internal documents and textbooks cannot be justified given that guidelines for the PE and cervical cancer screenings have been stable for the better half of a decade (Committee on Gynecologic Practice, 2014; Government of Canada, 2017; Qaseem et al., 2014). Current research continues to demonstrate that clinicians are overperforming these procedures (Qin et al., 2020) and that these procedures do come with established harms to patients (Ackerson, 2012; Ahmed et al., 2002; Bates et al., 2011; Bodden-Heidrich et al., 2000; Dutton et al., 2008; Freyens et al., 2017; Huber et al., 2009; Gupta et al., 2001; Peitzmeier et al., 2017; Robohom and Bittenheim, 1997; Richi, 2019; Wijma et al., 1998). Given this, information on when to perform these exams should be included at key opportunities and especially should not be divorced from source material on the PE.

In addition, my findings have shown that the description of contemporary options for PE provision is deficient in the documents and their inclusion in medical education may be lacking more generally. Inclusion of options such as self-insertion of speculums and disuse of footrests would be simple, given their well-established benefits in the literature, and not require much effort on behalf of curricula developers and administrators. Other options such as HPV-self sampling would require more nuance including discussions on access to care and patient advocacy. However, as research continues to show the benefits of HPV self-sampling particularly for vulnerable populations and as lobbyists continue to push for coverage of this technology in Canada (Arbyn et al., 2018; Cerigo et al., 2012; Fedyanova, 2018; Gupta et al., 2018; Reisner et al., 2018), medical students and future clinicians need to be aware of these patient-centred developments.

### *b. Acknowledgement and inclusion of patient experience*

The above leads to another recommendation suggested by my findings: the inclusion of patient's embodied experiences in PE learning materials. My analysis has revealed that patient experience of the PE – be that in discourses or visuals – is deficient in the documents. At the most basic level, effort could be made to include images of whole patients with faces, rather than fragmented genitals and/or faceless graphics, to work towards more patient-centred perspectives.

But beyond visuals, PE learning materials could aim to include embodied experiences and narratives as part of curricula and training. It appears medical students are heavily informed about the clinical process of the PE and less so about the patient experience or the cultural competencies needed to improve this experience for patients. Though limits have been noted in the use of narrative medicine in educational settings (Wear and Aultman, 2005), efforts can still be made to “traverse the distance” of scientific discourse and allow students the opportunity to “imaginatively experience another's embodied subject position” (Garden, 2013).

Outside of medical education, this traversing has included the use of ‘radical empathy,’ allowing people (namely, cis men) to experience a PE through exercises in graphic, first-person narration (Yona, 2017). While this was implemented more as a social experiment, the practice has potential to influence and shape how medical students learn about the PE and the patient experience thereof. Though medical schools may have limits and time constraints on what can be included in the curricula, this technique could be a potential option to more fully discuss PE experiences. While certain documents emphasized how medical students must explain to patients what to expect during the exam, they did not equip them with knowledge of the patient perspective. Radical empathy and other narrative techniques could work to bridge this gap.

### *c. Improved representation*

Another clear area for improvement within these documents, and one that could translate to medical education more broadly, is the inclusion of diverse patient identities. As established in research (Moore and Clarke, 1995; Parker et al., 2017; Taylor, 2003), medical education textbooks and training materials lack diverse patient representations, and my findings on the PE were in line with this previous work. Given that patient identity – be that as a racial, gender, or sexual minority, as a trauma survivor, as an adolescent, as a person with disabilities, or as any intersection thereof – greatly impacts one's experience of the PE, inclusion of this information

seems necessary to provide appropriate patient-centred care. As mentioned in the discussion, the homogeneous representations of patients in these documents could be interpreted as a form of neo-colonialism and what Whitney calls “a logic of eugenics” serving to amplify white, privileged voices and silence or marginalize others (Sharma, 2018; Whitney, 2019). And again, this is particularly relevant to gynaecological procedures like the PE where there is not only a troubling history involving vulnerable and marginalized populations but also persistent health disparities linked to the exam in these populations (Whitney, 2019). It has been noted that incorrect or insensitive inclusion practices may run the risk of tokenizing certain populations (Whitney, 2019). However, much has been written about how to adopt an ethic of inclusion in medical education through community consultation, patient involvement, and engagement (Sharma, 2018; Whitney, 2019).

#### *d. Discussions about patient autonomy*

As mentioned in the findings and discussion, my analysis demonstrated that the notion of patient autonomy was lacking in the documents. This is despite the fact that ethical challenges related to autonomy have long been tangled up with the teaching of the PE in medical schools and affiliated institutions (Friesen, 2018; Hall, 2012; Godkins, 1975; Kapsalis, 1997; Kearney et al., 2018; Silver-Isenstadt and Ubel, 1999). Given this lasting legacy, efforts should be made to include more discussions around patient autonomy relating to the uniqueness of the PE procedure.

First, medical student involvement in the PE could be addressed. As has been noted in the literature, medical education relies on patient cooperation to provide students with training to become competent doctors. Yet it is widely recognized that the PE represents an “extreme case” in educational practice due to patient vulnerability and feelings of violation (Carson-Stevens, 2013, p. 676). While nearly impossible to solve in a single lesson, discussions surrounding this ethical challenge could be encouraged and addressed; provider positionality, historical context of exams under anaesthesia, and the specific (and perhaps unrealistic) burden placed on patients to train medical students in PE techniques are just some possible topics of discussion.

Second, efforts could be made in the documents to centre patients in the PE decision-making process, ultimately highlighting and promoting patient autonomy. Shared-decision making – whereby providers and patients work jointly to make healthcare choices based on

clinical evidence and patient values and preference – has been emphasized in healthcare policy and education in Canada (Haesebaert et al., 2019). Yet in these documents and their discussions on the PE, the concept appears to be lacking. A shared-decision making model would tie together previously mentioned implications for practice by including representations of patients and patient experience and contemporary choices that may align with unique patient-preferences or values. It would position patients as experts in their own bodies and work to dismantle notions of epistemic hierarchies currently present within the documents.

### **III. Conclusion**

The teaching of the PE has posed and continues to pose ethical issues in medical education related to patient care. Text and visual-based curricula may represent just one facet of how medical students learn about and how to perform the PE; however, these medical discourses matter. For too long, medical curricula have excluded vulnerable and marginalized identities, and theories suggest that this practice perpetuates health inequities in certain populations while also maintaining the interests of hegemonic groups (Wilce, 2009). Moreover, the historical and even current silencing of patient autonomy during the PE in both education and practice cannot be overlooked. It is for these reasons that – even at the basic level of technical skills guides – patients, their voices, and their experiences must be centred and respected.

It must also be recognized that medical education related the PE has come a long way, and efforts are still being made to improve its teaching, as reflected in this study’s outlier cases. But progress towards more diverse and inclusive practices is never finite, and biomedicine is no exception. Curricula need constant observation and analysis, and depictions of the PE – with its problematic history and sensitive standing in patient experience and the clinical encounter – require special attention.

The ‘quandary of the sacred vagina’ (Posner, 2015) and its place in medical education may never fully be solved, just as the PE may never be empowering for all those who must undergo it. And while we can work to alleviate health disparities linked to the procedure, they too may never fully vanish. However, by representing identities, experiences, and alternative choices and centring patient autonomy, these documents can begin – as Underman (2020) puts it – to wrestle with structurally embedded discrimination in medical education and reconceptualize meanings of true patient representation, individual knowledges, and choice.

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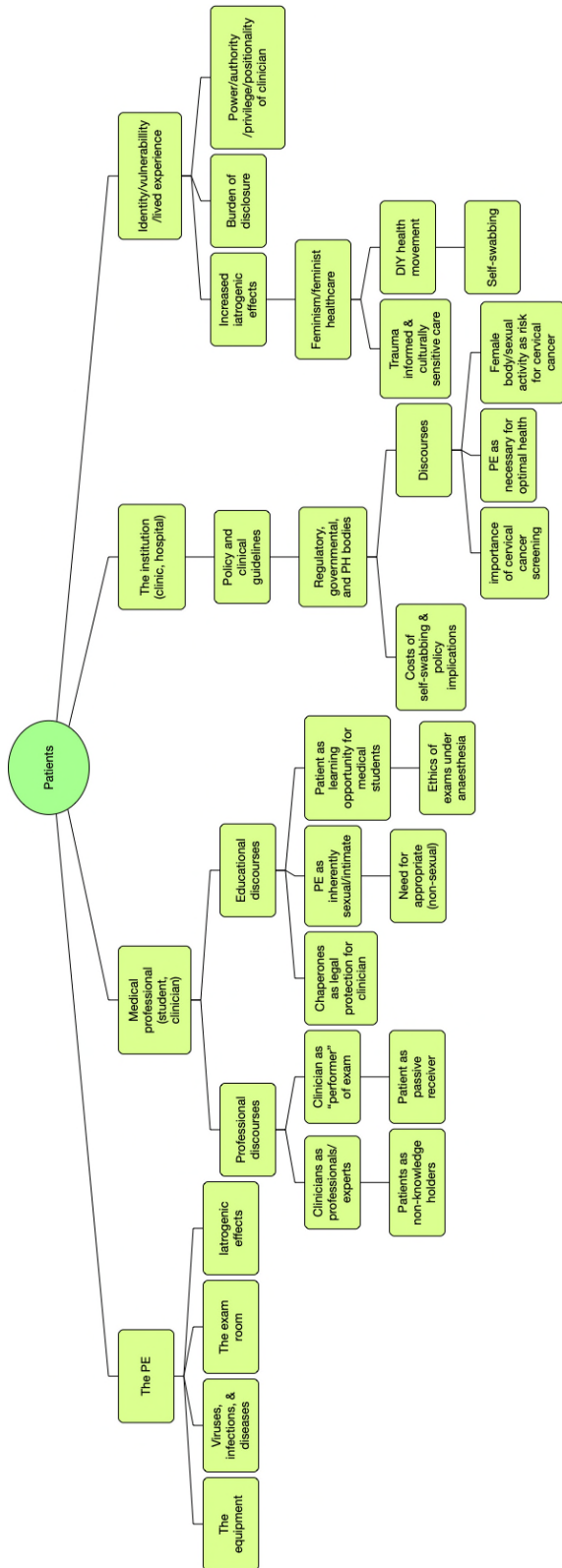
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# APPENDIX 1 : Relational Analysis (sample)



**APPENDIX 2: Social Worlds/Arenas Maps 1-3**

