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Medicine and the past. Lesson to learn about the pelvic examination and its sexually suppressive procedure

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EDITOR-- In "Lessons from medicine's shameful past"(1) the editor focus on the medical profession's repression of homosexuality only a few decades ago (2,3), using the aggressive and destructive methods so strongly criticized by the highly actual Illich (4). It is so easy to see the errors of the past and so impossible to see the errors of today. But we believe that it is more important for our patients to reflect on our methods of today than to judge the past. As is often said: "First do no harm". We have been wondering why so many young people have severe problem in their love and sex life, not being able to avoid sexually transmitted diseases and why so many people have sexual problems. About one in ten young adult woman are suffer from vulvodynia, a shameful "new" disease that only half the patients brings to their physician (5). Around every third woman seem to have sexual problems of some kind (6), and as every woman have a physician, it seems that we are generally not very good at helping. But it may be even worse. How come that the standard gynaecological procedures we use as physicians in the every-day clinical practise, like the pelvic examination, are actually repressing the sexuality of the woman? Let us take a critical look.

Is the pelvic examination a harmful and sexually suppressive procedure?

The pelvic examination is a common examination performed in general practice. Whenever a woman complains of pain in the abdomen, the general practitioner is in principle obliged to carry out a pelvic examination in order to rule out ectopic pregnancy, acute inflammation of the lower abdomen or something else that can seriously affect the patient. The patient is examined in the traditionally gynaecological position with her legs in stirrups, after which the physician can inspect, examine, explore and take samples.

When we speak to women about their experiences in this situation, a surprisingly large number of women report that they have felt humiliated and devaluated by the procedure that is normally followed. They often find it insulting to be put in positions in which their reproductive organs are exposed, without being in any way able to look after themselves. They often feel incapable of protecting themselves against an examination that may be insensitive, rushed and not leave space for them as human beings, the sole intention being to perform a physical procedure as efficiently as possible.

It is worrisome that the numerous physicians and gynaecologists around the world subject women to examinations, which may be a stressful and perhaps even traumatic experience. Part of the problem is obviously due to shortage of time, but another important part of the problem appears to be due to misunderstood respect for the woman's sexual boundaries, which means that the physician feels more secure in reducing the female patient to a pure object of examination. It is considerably easier to examine a set of organs than to relate to a living person, with feelings of shame and desire and a sexuality that can threaten to end the career of the physician, if he so much as relates to it.

Mere suspicion that the physician may assault the woman, who is placed in what is a very vulnerable position can cause the physician to entrench himself behind this clinical facade in a way that is in itself dehumanising. Instead of being present, the physician almost tries to avoid being there, and becomes an excuse for himself. Paradoxically, this gives rise to another type of violation – being rummaged around in the woman’s most delicate parts, as though one was something rather like a car engine. Pushed to its extreme, it is as though the medical profession has decided once and for all that it is difficult to show human respect and care in the situation, where the patient's reproductive organs are exposed. Instead, it is necessary to make do with showing the craftsman’s respect that a skilled clockmaker displays with a sophisticated timepiece. We have ourselves faced ethical problems in putting women or young girls, who have previously been subjected to sexual assault, through the general examination procedure, because this procedure can brings back memories of assault. Nor is it possible to solve a problem of that kind by simply passing the buck on to the gynaecologist, who although he has more experience generally has far less knowledge of the patient.

One of the emotionally most difficult aspects of the pelvic examination is the physical touch itself, which the gynaecologist tries to make less dangerous by using rubber gloves and instruments. Due to a strict professionalism with often a brusque silence (because the physician is afraid of saying the wrong thing) the women can sometimes be reminded of up-tightness, bad sexual experiences with insensitive lovers, or even insulting sexual touches, rough partners, attempted rape or in the worst case assault in childhood.

Where sexually harmless situations are concerned, the physician generally does not have any objection to calming the patient through touch, for example by putting his hand on the arm of a woman who is upset. This often causes difficulties in the gynaecological context, because if the situation is misunderstood by the woman, the entire medical career of the physician can be finished in an

afternoon. It is important that both the patient and the physician realise that instead of avoiding any human touch in connection with a pelvic examination, the physical touch can and must also be an entirely natural constituent element here too. As in any other emotionally difficult situation, supporting physical touch may help the woman to feel acceptance and support, and in that way promote her sense of security in the situation and not least her confidence in the physician and the treatment.

Many male medical students at first have serious problems with the pelvic examination (as an example one student became impotent for months, after spending a period of time in a gynaecology department). We also often encounter patients, who clearly hated the pelvic examination, because it reminded them of unpleasant things from their past. There we must consider whether it might not be possible to turn the unavoidable touching of the woman around, so that it becomes not an evil that has to be minimised, but a therapeutic resource that can be drawn on or in other words instead of masking the touch using it to express respect for and care of the woman in the examination situation.

The holistic pelvic examination

When there is an actual sexual trauma the situation is even more complex. The purpose is the healing of the patient, to re-establish the natural relationship with the body, sexuality and reproductive organs also in patients with to acknowledged or suspected sexual violations. For integration of presumed traumas following incest and sexual assaults it is recommended to carry out a slow pelvic examination, based on the holistic principles of holding and processing. On top of the normal examination in such cases all the legal aspects according to the law in the specific country must also be followed.

Due to the fact that we had a patient with a need for a considerate procedure of this type, we arranged for a very thorough, careful and well- planned procedure, which specifically tried to avoid turning the patient into an object and instead to treat the woman as a woman. The idea was to make the pelvic examination slow – very slow, in fact, so slow that the physician could be sure that the patient was entirely there at all stages of the examination, indeed in everything what was done with her. We also went through the procedure with the nurse, who approved it. We found, to our surprise, that the pelvic examination was in fact healing and therapeutic for the patient, when it was performed in this slow and attentive way. We have discovered that it was not unpleasant (as a male physician) to be present in the examination situation. The new and more relaxed attitude and new acceptance of this unavoidable physical touching of the woman's reproductive organs led to a surprising change in the patient's experience of the examination.

With this new approach women started to say that it was nowhere near as bad as it used to be. In contrast to what might have been imagined, the empathic and physically present form of examination also becomes less sexually provocative for the physician than the normal, rapid gynaecological procedure. Since that time we have allowed ourselves an extra amount of time, when we have had female patients with sexual problems, who perhaps have been subjected to sexual assault – the truth of

which, however, it is never possible to know for sure - but who have been very vulnerable, sensitive and perhaps even full of shame and self- condemnatory in relation to their sex, reproductive organs and sexuality.

If sexual assault is suspected, we use the slow procedure with preparation of the patient, where she is thoroughly informed about it beforehand, so that we can be sure of her complete acceptance and assistance throughout the procedure.

The purpose is re-establishment of the natural relationship with the body, sexuality and reproductive organs in the patient, who has problems due to acknowledged or suspected sexual violations.

Sexual violations are often forcibly repressed. It appears that the tissues that are touched during the violation often bear the trauma. It is characteristic of these patients that their love lives are often problematic and do not provide the necessary support to heal the old wounds in the soul, and therapy is therefore indicated. When this is concerned with the reproductive organs, it poses particular difficulties, as the therapy can easily be experienced as a repetition of the original violation, not least due to the risk of projection and transference. There is therefore a need for a procedure that is familiar and safe for the patient, but it involves therapeutic touching of sexual organs over and beyond what is standard medical practice. We establish the following procedure, with which the patient is familiarised and accepts, before the treatment is initiated. The procedure is carried out with a nurse and ample time allocated (three hours). The procedure includes:

· Conversation about the present condition - relationship to body, sexuality and reproductive organs, including investigation of problems in sex life such as pain and painful memories are recapitulated.
· Conversation about the concept of boundaries, so that the patient understands fully where her own sexual boundaries are in order that the examination is not experienced as an assault.
· Conversation about how the assault can be projected into the present. How do the patient and therapist act, if the patient finds the therapy a violation? It is important to say so immediately, if something feels unpleasant or wrong.
· The establishment of the therapeutic room as a safe place.
· Stopping exercise - touching of the body and reproductive organs on the outside of the clothes, where the patient says stop and the hands are removed at once.
· Contact: Physical touching of the body – from the head down to the stomach, pelvis and lower abdomen, slowly and in suitable steps, so that the patient is present and secure throughout.
· Visualisation of extended pelvic examination, where the therapist runs through the steps of the examination thoroughly, so the patient can imagine them before they are due to happen.
· Touching on the outside of the clothes with repetition of the “Stop” procedure if necessary.
· Pelvic examination paying special attention to traumatised (damaged/scarred/blocked) areas.
· Feel, acknowledge and let go of the traumatised areas. If there are areas, that appear blocked or “the patient not present”, has pains or other discomfort, we then give special attention with regard to their

integration. This is not fundamentally different for example from the treatment of growing pains in children by touching the areas that are sore, for example around the knee. If the sick areas are attended, they are also usually healed.

- Post-processing of emotions and traumas. The work with blocked places in the body often release painful gestalts from childhood and adolescence, which must be talked through, in the same way that the patient's painful feelings must be supported and accommodated by both physician and patient.
- Healing is only possible, when negative decisions are found and dropped. The patient has to come back to the present, let go of negative sentences or ideas and plan for further positive progress.
- These points above are printed out, signed and approved by the patient as a formal contract.

So we do not just need attention, respect and care – and acknowledgement of our soul – we also need something bodily, physical and down-to-earth, namely acceptance of our sex. When it is possible as a physician to meet the patient with respect and within boundaries to recognise her as a woman, then we can help her and give her our full acceptance. Many problems related to sexuality then appear to decrease, as they are probably due to self-condemnation and lack of sexual self- acceptance.

Slow pelvic examination with a therapeutic element

It is important to notice that we introduced a slow pelvic examination with a therapeutic element, relevant for a wide range of psychosomatic disturbances related to gender and sexuality, from infertility to gynaecological and sexual psychosomatic problems and the long-term consequences of child sexual abuse. On one hand this opens up for a clinical practice with many beneficial and healing qualities for the patient, because it allows a much closer and more intimate relationship between the patient and the physician that has been the traditional practice, but on the other hand this procedure has several disadvantages.

In many cultures this cannot be practiced due to cultural or religious reasons and the sexual taboo being so strong, that the female will experience the process as overwhelming or even insulting. In the United States it might be practically impossible to follow our recommendation in many cases, because of the time consumption, economics and reimbursement issues of this culture and the heavy "malpractice culture" in that country.

The most difficult problem of this procedure seems to be that is makes it very difficult to be sure that the procedure and all the involved steps are always necessary and rational. This procedure and the cultural issues involved means that it has a high potential for malpractice, but this can be minimized dramatically by the following steps: 1) Before the procedure is done, the patient must read about it with at least one case study like the one in this paper, to fully understand the emotional and existential implications of the procedure, so she has time to contemplate and make her decision of whether to accept the physicians offer or not; 2) The procedure is also orally presented by the physician to the patient before she signs the contract; 3) The physician must be in supervision to discuss the problems if

any about borders, intimacy, emotional and sexual issues. Close supervision and full inter-collegial openness is the best prevention of malpractice, as malpractice often occur with physicians without a network and without openness about what is going on in their clinic.

The ethical problem of touch and sexuality in clinical practice

Touch is a very dramatic and mutual thing for our physical and emotional being: when I touch you, you touch me (7). As many people only know touch in connection with sexual behaviour, a sexual reaction to a completely innocent touch is not rare in the clinic. If sexually aroused, the female can react as “if she has sexual organs all over her body”, making physical contact with her very electric and sexual, and this reaction can come very sudden and highly unexpected and not always convenient. If the physician retracts from her in this situation, what would be the immediate reaction of most normal people, she will experience that her body, gender and sexuality is not acceptable, which destroys intimacy and trust negatively for the patient and the professional relationship. Being there, staying in contact, takes a great deal of “spaciousness” on the part of the physician. This spaciousness should be a part of our medical training, but is often not, making so many pelvic examinations and other procedures emotionally painful and awkward for both physician and patient.

The subject of ethics has been of utmost importance for the physician, since Hippocrates and whenever the physician touch the patient the ethics of the action must be considered. The problem of touch is mostly much more of an ethical problem than it is a legal problem: Why do you touch the patient, what is the intention? If the intention is for the physician to enjoy his patient – what we do most of the time with people in private - we consider this unethically, even if this is just holding hands. The physician should have the healing of the patient as his sole focus and if the intention of the physicians is wholeheartedly and rooted in deep medical expertise to heal the patient (and in this intention touch any part of the body including the genital), this is ethical. Interestingly, the physician’s ethics seems to be proportional with his results with his patients. Only the clearest of intentions can bring us outstanding results (8).

But simply touching sensitively - the essence of manual medicine - is a much more powerful tool than many modern and bio-medically oriented physicians assume. Many pains and discomforts can be alleviated just by touching the sick area and help the patient to be in better contact with the troubled tissue and organs of the body. Lack of presence in the body seems to be connected with many symptoms that can be readily reversed simple by sensitive touch in the intention of healing. When touch is combined with therapeutic work on mind and feelings, holistic healing seems to be facilitated and many problems can be solved in a direct, easy and effective way in the clinic, without the use of drugs.

Manual medicine even in its most simple form is a powerful and often underestimated medical tool. The great power of physical contact between physician and his patient, which is even stronger in the context of the theory, practice and intent of holistic healing, is often not taken sufficiently into use in the medical

clinic today, where everything is supposed to be cured with a drug. Much suffering and money could be saved, if the physician of our time was able to discriminate more clearly between intimacy and sexuality and thus dared to be more intimate and physical with their patients. If the physician masters the art of touch he can even give the quality of holding without touching.

Conclusions

A surprisingly large number of women report that they have felt humiliated and devaluated by the gynaecological procedure or pelvic examination. They often find it insulting to be put in positions in which their reproductive organs are exposed, without being in any way able to look after themselves or control the situation. They often feel incapable of protecting themselves against an examination that may be insensitive, rushed and not leave space for them as human beings, the sole intention being to perform a physical procedure as efficiently as possible. We suspect that these experiences are harmful for the woman and suggest a more holistic approach to gynaecology and the pelvic examination.

The holistic approach seems give the woman a more safe and even sometimes a healing experience(9). We have developed a “slow” holistic pelvic examination, designed for solving gynaecological and sexual problems of psycho-somatic origin. It is a recommended alternative to the standard procedure, whenever there is a suspicion of a history of sexual assault or sexual abuse, even when that abuse took place many years ago. It is often more time-consuming and can involve strong emotions on the part of the patient, as earlier unresolved traumas are contacted during the examination. In the holistic pelvic examination this is not a problem, but quite opposite the release of suppressed emotions might be healing to the patient, if the physician knows how “to hold” (meaning to care for) the patient and how to process the problems and emotions in order for the patient to heal.

Many gynaecological problems like involuntary childlessness or infertility seem to follow problems in the woman’s relationship with her body, gender and sexuality, which might be alleviated by a holistic approach to the woman and the gynaecological procedures. It is important that the woman experience to be seen and acknowledged as a whole person, where she feels herself and all parts of her body deeply accepted. This approach can change the often quite provocative pelvic examination from a fearful to a peaceful or even healing experience. Sometimes a few hours of work can change the woman’s perception of herself, her body, her gender and her sexuality, but this is usually not done in a busy general practice.

A holistic approach in general can help the woman not to feel humiliated or devalued by the pelvic examination procedure, but instead respected, acknowledged and accepted as the woman she really is (9).

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References

1. MacDonald R. Lessons from medicine's shameful past. BMJ 2004;328 (21 February):

2. Smith G, Bartlett A, King M. Treatments of homosexuality in Britain since the 1950s--an oral history: The experience of patients. BMJ 2004;328:427.

3. King M, Smith G, Bartlett A. Treatments of homosexuality in Britain since the 1950s--an oral history: The experience of professionals. BMJ 2004;328:429.

4. Illich I. Limits to medicine. Medical nemesis-The expropriation of health. London: Marion Boyars, 2001.

5. Harlow BL, Stewart EG. A population-based assessment of chronic unexplained vulvar pain: have we underestimated the prevalence of vulvodynia? J Am Med Womens Assoc. 2003;58(2):82-8.

6. Ventegodt S. Sex and the quality of life in Denmark. Arch Sex Behavior 1998;27(3):295-307.

7. Rosen M, Brenner S. Rosen method bodywork. Accesing the unconscious through touch. Berkeley: North Atlantic Books, 2003.

8. Ventegodt S, Andersen NJ, Merrick J. QOL philosophy VI: The concepts. ScientificWorldJournal 2003;3:1230-40.

9. Ventegodt S, Morad M, Merrick J. Clinical holistic medicine: Holistic pelvic examination and holistic treatment of infertility. Accepted by ScientificWorldJournal 2004;4:00-00.

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