What influences the performance of pelvic examination in primary care: a qualitative investigation

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What influences general practitioners’ use of pelvic examination: a qualitative investigation.

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**Shortened running title**

What influences pelvic examination by GPs?
Abstract

Objective

Omission of pelvic examination (PE) has been associated with diagnostic delay in women diagnosed with gynaecological cancer. However, it is often not carried out by general practitioners.

Aim

The study aimed to determine the perceptions GPs on the role of pelvic examination and the barriers and facilitators, and their experience in practice.

Design and Setting

Qualitative semi-structured interviews. One health board in Scotland (mixed urban and rural) with an approximate population of 500,000.

Methods

Interviews were conducted face-to-face or by telephone. Framework analysis used the COM-B behaviour change model concepts of capability, opportunity, and motivation.

Results

Data was compatible with all three domains of the COM-B framework. Capability related to training in and maintenance of skills. These went beyond carrying out examination to
interpreting it reliably. Opportunity related to the clinical environment and the provision of chaperones for intimate examination. Interviewees described a range of motivations towards or against PE which were unrelated to either capability or opportunity. These all related to providing high quality care, but this was defined in different ways: “doing what is best for the individual”, “doctors examine” and “GPs as pragmatists”.

Conclusions

GPs’ reasons for carrying out, or not carrying out, pelvic examination in women with symptoms potentially indicating cancer are complex. The Capability, Opportunity, Motivation framework provides a way of understanding this complexity. Interventions to increase the use of pelvic examination, and critics of its non-use, need to consider these multiple factors.

Funding

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Keywords

Primary health care; clinical examination; pelvic examination; qualitative research; gynaecological cancer
**Tweetable Abstract**

GPs vary in their use of pelvic examination as a diagnostic aid in detection of gynaecological cancer; this study helps explain why

**How this fits in**

Not carrying out a pelvic examination (PE) is associated with diagnostic delay in gynaecological cancers; however, it is often not done by GPs. This qualitative study reveals that GPs’ reasons for carrying out, or not carrying out, pelvic examination in women with symptoms potentially indicating cancer are complex. GPs need to have the skills to do, and interpret the findings of a PE; have the opportunity to carry out the examination in terms of time and availability of chaperones and believe that it will influence the referral process

**Introduction**

Clinical examination is traditionally viewed as an essential skill for a doctor (1). Pelvic examination (PE) consists of inspection of the vulva, bimanual examination of the pelvic organs and visualisation of the cervix by speculum examination. The intimate nature of PE can make it a challenging examination for both clinicians and patients but there is evidence that lack of PE is associated with diagnostic delay (2) (3) (4). PE can provoke feelings of
awkwardness, discomfort, embarrassment around getting undressed and loss of dignity (5) (6) (7) engendering a feeling of vulnerability and some women avoid PE altogether (8).

GPs have a professional duty to manage the intimacy of PE as well as to ensure the examination is carried out when clinically required. This responsibility has been acknowledged by the General Medical Council (GMC) who have produced relevant guidance (9). One study has shown that GPs would carry out a pre-referral PE in only 37% of women who present with a gynaecological problem requiring referral to a specialist (10).

Pelvic examination requires dexterity and sensitivity. However, if a clinician does not carry out the examination frequently, the skills, or confidence in those skills, may decline along with ability to distinguish normal from abnormal findings, and willingness to undertake the procedure (11) (12).

Sensitive topics such as clinical behaviour can be explored more fully using qualitative methods. This qualitative study answered the question: What are the perceptions and experiences of GPs on the role of primary care-based PE, and the barriers and facilitators to undertaking it?

The theoretical framework used was the established COM-B behaviour change model. This model was used because it identifies what component of behaviour, capability, opportunity or motivation, needs to be modified for an intervention, in this instance, pelvic examination, to be successful (13) (14) (Figure 1). COM-B has been used previously, to understand variation in practice by GPs where social awkwardness is an issue: for instance, in relation to implementing brief alcohol interventions (15). It also links to the behavioural change wheel which aids intervention development (16).
Methods

Qualitative semi-structured telephone or face-to-face interviews were conducted with practicing GPs in one health board in Scotland between March 2019 and June 2019. Fourteen NHS Grampian GP practices that had participated in a previous linked data analysis study involving patients diagnosed with a gynaecological cancer were approached (P Williams, 2021, p. 134). An introductory email containing a letter of invitation, study information sheet and an expression of interest reply slip was sent to practice managers who cascaded it to the GPs. Reply slips were returned by post or by email.

Semi-structured interviews were conducted at a mutually convenient time and place, face-to-face or by telephone according to interviewee preference. Written consent was obtained at face-to-face interviews, or recorded verbal consent was obtained from telephone participants. Participants could withdraw from the study at any stage either during or after the interview and any collected data was deleted. Interviews were conducted until data saturation was reached (three successive interviews with no new subthemes identified (17)).

Interviews followed a semi-structured topic guide (Supporting Appendix 1, S1) based on the COM-B behaviour change model and developed iteratively as interviews progressed. All interviews were digitally recorded, transcribed verbatim then imported into NVivo Version 12. A Framework approach (18) was used. Analysis followed the steps of familiarisation, identifying a thematic framework, indexing, charting and mapping / interpreting.
However, while COM-B was the framework, we permitted the generation of additional themes outside of the framework and also over-arching themes across elements of the framework. Indexing, and charting were carried out on full transcripts by PW and CMB. Mapping and interpretation were led by PW with contributions to this in meetings with all authors. Analysis was conducted iteratively alongside interviews ((18).

Results

We interviewed 15 GPs (11 female) from nine practices. Twelve worked in urban settings and 3 in rural. Five had advanced training in pelvic examination as evidenced by holding a letter of competence in intrauterine techniques. Time since full GMC registration ranged from 9-35 years: two <10 years; three 11-20 years; eight 21-30 years and two had been practising for more than 30 years.

We identified themes in each of the COM-B components (three within capability, two within opportunity and three within motivation). In addition, we identified two overarching themes of patient choice and practitioner gender. In reporting the analysis, we recognise that some items could be described within multiple COM-B components. For instance, the delivery of much cervical screening and sexual & reproductive health by nurses in primary care reduces GPs opportunities to carry out PE and in turn leads to reduced capability through lack of continuing practice. Where this arises, factors will only be described under one heading.

Table 1 summarises the themes according to the COM-B framework.
Table 1: Summary of themes using the COM-B framework

**Capability**

Participants acknowledged that capability was dependent on training opportunities and experience as well as exposure in current clinical practice. There were three themes related to capability: learning, continuing practice, and different forms of capability.

**Learning**

Most interviewees regarded opportunities for learning PE in their undergraduate training as inadequate. Rotation through obstetrics and gynaecology as part of GP vocational training was considered a valuable component of learning although not all found it useful.

Other than one female interviewee, most did not recall any consolidation or further training of PE skills during GP registrar training. However new approaches to GP registrar training with required competences listed in an e-portfolio were regarded as beneficial, likely to produce GPs with improved skills as the following quote illustrates.

> *So I think the new trainees coming out are much better than we were, because they’ve had to prove throughout their e-portfolio that they are doing intimate examinations (...) so they’re usually examining and then the patient being re-examined by either a trainer or another colleague (GP4, female)*

Interviewees were asked whether they thought continuing education in PE should be mandatory or voluntary and there was no consensus. In terms of what learning
opportunities might be offered, suggestions included: didactic lectures; attending
gynaecological outpatient clinics and use of pelvic models.

Interviewees recognised that capability required both training and continuing practice of PE.

**Continuing practice**

All GPs described the way that changes to primary care practice (particularly nurse-led
cervical screening) had reduced their continuing practice of PE.

> I think it might be very hard to get day to day experience with gynaecology
> and you could go weeks (...) where you wouldn’t see anything (GP 15, female)

Male GPs were seen as less likely to have opportunities for continuing practice of PE.

Women were seen as more likely to choose a female GP for gynaecological problems and
some felt that practice receptionists might triage women to female practitioners (GP or
nurse) or those perceived as specialists. For example, practitioners trained to fit intra-
uterine devices were seen as more “specialised” within the practice and may gain extra
experience both by carrying out non-diagnostic PE as part of device fitting and also by more
general awareness of their expertise.

> You’ll have one person in the practice who does coils, so that even
decreases skill sets for other female GPs, never mind the male GPs (GP 14, male)

There was consensus that higher levels of exposure contributed to higher levels of
confidence in examination skills and capability and was determined partly by the gender of
the GP, as male GPs were less likely to carry out PE. The requirement for chaperones (see later section) was perceived to be more problematic for male GPs and patients were perceived to self-select female GPs when presenting with gynaecological symptoms, as in UK primary care, patients can select their clinician. Those certified to fit intrauterine devices felt more skilled and confident because of increased non-diagnostic exposure, but this impacted other GPs’ exposure levels.

**Different forms of capability**

Perceptions of capability varied across the different elements of PE. Visualisation of the cervix was considered an essential part of the examination by all interviewees, although one male GP stated using a speculum would “cause him alarm”. However several interviewees were concerned that they had insufficient capability to accurately identify cervical abnormalities. Bimanual examination was considered more difficult and subjective in interpretation. Its diagnostic value was questioned with concern about both false negative and false positive examinations. Most felt that overt changes would be correctly identified, but subtle changes were more likely to be misinterpreted or missed. No one mentioned examination of the vulva, the third component of PE.

In summary, capability in PE was seen as requiring adequate training and learning, continuing practice and the ability not just to carry out examination but to interpret it accurately.

**Opportunity**

Two themes related specifically to opportunity: chaperones and clinical environment.
Chaperones

Beliefs about the use of chaperones varied between GPs as did their actual use of chaperones; however, similar beliefs did not always result in the same behaviour.

All GPs felt the need for chaperones was an important obstacle to opportunity. All were aware of guidance from the Royal College of General Practitioners and the General Medical Council. Although most GPs routinely offered chaperones, some did not. Although the offer of a chaperone was made, some felt the guidance did not benefit patients and were happy to carry out the examination without one.

> It (using a chaperone) makes the whole thing less natural, and more awkward [...] it’s embarrassing enough for them to have me looking at their down belows, without somebody else (GP7, female)

Some female participants did not always offer a chaperone. Many said they had never had a patient request a chaperone.

> I’d say, are you okay if I examine you, and if they say yes, and they jump up on the bed, then that’s good enough for me (GP4, female)

Clear gender differences were observed regarding the belief that chaperones were essential but one male GP indicated a situation where they would not always use a chaperone:

> I’ll do it on a post-menopausal lady (...) or I’ll say if you’ve had your kids, and you’re comfortable with me doing it, and quite often they’ll say yes (...) I’m exposing myself to some risk, but I think it’s pretty low, but anybody my age or younger certainly not (GP13, male)
This behaviour was driven by assumptions the GP had about patients’ beliefs:

*Elderly ladies [...] I could be wrong, but they say this is just a procedure that needs to be done, I’m sure younger women do, but I do it, to protect myself, rather than them* (GP 13, male)

This need to protect themselves from potential litigation by offering a chaperone was also expressed by female GPs, despite some feeling that offering a chaperone was a tick box exercise.

*I think that it’s one of these tick box sentences, that feels like, it feels so stupid to ask it [...]do you want someone come in with you, they (the patient) look at you, like, what, what?* (GP5, female)

Female GPs also acknowledged not using a chaperone contradicted the guidance, but it was normal practice for several participants. This decision was influenced by familiarity with or age of the patient. The majority of those who offered, did not expect the patient to want a chaperone. Some GPs who routinely did not use a chaperone would suggest a chaperone if the patient made them feel uncomfortable, with GPs of both genders acknowledging their vulnerability when carrying out PE.

*I do offer the patient one, but if they don’t wish one [...] I should get one anyway, for my own defence [...] because I often know the patients quite well, I, I chose to take that risk* (GP 8, female)

The guidance states chaperones should preferably be a health professional and familiar with PE procedures, however participants commented that practice staff with these attributes
are often engaged in their own clinical practice and not free to chaperone. One GP’s practice had trained reception staff to be chaperones to increase availability. However, for some practices even larger obstacles were present:

*We have a, a satellite surgery in ***** where it’s just us, you know, there’s no one, no admin or anybody* (GP15, female)

Only one GP explicitly described the value of chaperones for those patients who were especially nervous about the examination.

**Clinical Environment**

Participants described a number of issues relating to the clinical environment which either facilitated or obstructed the conduct of PE. These included time and equipment such as adjustable examination couches. Interviewees gave examples of where these were absent. Routine consultations of 10 minutes were seen as insufficient for an adequate history and examination when compounded by the need to find a chaperone with no notice and ensure sufficient dignity for the patient. In contrast, designated appointments with appropriate time and equipment, especially where the practitioner had been selected for their expertise (for instance by referral within the practice between clinicians) were seen as facilitating PE. The issue of in-practice referral, especially from male GP to female was discussed by several participants and was generally felt to be appropriate.

**Motivation**

Interviewees described a range of motivations towards or against PE which were independent of either capability or opportunity. Importantly all related to providing high
quality care, but this was defined in different ways. We have categorised these broadly as three themes “Doing what is best for the individual”, “Doctors examine” and “GPs as pragmatists”.

**Doing what is best for the individual**

Some GPs made it clear that there were few hard and fast rules about when PE should be carried out and that the highest priority in clinical decisions was the patient.

> We should be tailoring the investigation to the individual, with respect for their dignity, and asking the questions, what will this investigation give me? (GP3, female)

> It’s an intimate examination, it should only be done if it’s going to add to your, to your diagnosis, or management (GP8, female)

However, some GPs assumed that patients did not want to be examined due to embarrassment. They also assumed that patients wouldn’t wish to be examined by students, resulting in reduced learning opportunities.

**Doctors should examine**

Some participants emphasised the importance of clinical examination as something that doctors do. Thus, while the intimacy of PE should be acknowledged, this should not prevent it.
I think it would be embarrassing to miss something for the want of, of their embarrassment or our discomfort at having to do it (...) because if we miss that then, you know, they’re on a completely different path (GP6, female)

Some participants acknowledged that lack of examination could lead to misattribution of symptoms.

I guess even postmenopausal bleeding for query endometrial [cancer], usually I would examine them, just to make sure if there was anything local (GP8, female)

For some, not carrying out examination before referral – even if it was unlikely to add clinical value was seen as unprofessional.

You wouldn’t put someone to cardiology, if you hadn’t listened to their chest, they would laugh at you (GP2, female)

**GPs as pragmatists**

Some GPs explicitly questioned the diagnostic value of PE by a non-specialist. For instance, several argued that imaging offered more clinical yield than clinical examination and that they would refer for ultrasound scanning (USS) rather than use clinical examination for diagnosis, especially for a patient with postmenopausal bleeding (PMB).

For many women presenting with symptoms which might be indicative of gynaecological cancer, some GPs argued that a decision to refer could be made on history alone. Once “red flag” features had been identified in the history, examination findings would not positively impact triaging of the referral by the specialist or the patient’s diagnostic journey. One GP
argued that whilst a rectal examination was clinically useful for a suspected rectal cancer a PE it was less so for at least some types of suspected gynaecological cancer.

In the past couple of months, two women with post-menopausal bleeding, I didn’t even bother to examine them (...) they need referred (...) I’m not going to find anything of value (...) I can see the utility of the, the rectal exam, in you know, for rectal cancer, because if you feel the tumour (...) that’s going to potentially change the initial management (GP14, male)

This argument was often seen in GPs who described low capability and opportunity (and thus, for whom the probability of a well conducted and interpreted examination was likely to be lower).

While GPs recognised clinical guidelines for urgent referral of patients with suspected cancer they described their limitations, especially when advice changed.

I just have a gut feeling there’s something not right, they don’t necessarily fit a guideline, but they need referred (GP2, female)

Pragmatic GPs also saw limitations to the value of providing extra information at the time of referral.

My referral letters tend to be quite short and to the point, so maybe mine are read more, but I know I’ve signed letters for some people who just write screeds of stuff, and think what’s the point, because who’s going to read this at the end? (GP7, female)
Integrating findings

While the analysis has been presented by deconstructing interviews into the COM-B framework, it is clear that a number of different factors influence GPs’ approach to carrying out pelvic examination. These are presented in table 2 which summarises the findings in a set of conditional statements, each of which makes pelvic examination more or less likely in the GP consultation. This has value in two ways: increasing understanding and planning service innovation. In terms of understanding it makes it apparent why factors (such as male gender of the GP) may have effects at multiple levels of this integrated model. In terms of service innovation, it suggests that action at a single level is unlikely to have a substantial impact without addressing others.

Table 2: Summary of conditions which make GP pelvic examination more or less likely

Discussion

Summary

The reasons why GPs do, or do not, use pelvic examination in assessing gynaecological symptoms which might indicate cancer are complex. The COM-B model provides a way to understand GPs behaviour which shows how contrasting views about the value and practice of examination depend on factors relating to all three components: capability, opportunity, and motivation. A framework which integrates these findings allows these factors to be considered together and could be used both in understanding individual decisions and in planning training or innovation in the way services are delivered.
**Strengths and limitations**

This is the first study of its kind, to our knowledge, which explores GPs’ perceptions of PE using the COM-B behaviour change model as the analytical framework. Analysis was carried out by all researchers: three GPs, a pharmacist and a consultant gynaecologist. Preconceptions of researchers can be a challenge, but the multi-disciplinary approach helped to mitigate this.

There were however some limitations. Study participants knew the interviewer, PW, was a GP, potentially influencing enquiries. As with all exploratory studies the results are not intended to be generalizable, but interviewee selection should aim to recruit a range of characteristics likely to affect views and experiences. Undertaking the study in a one Health Board in Scotland, and the self-selection of GPs agreeing to be interviewed may mean there are other views that have not been identified.

**Comparison with existing literature**

Existing literature is limited. Paluska presented data in 2000 confirming doctors are more comfortable examining patients of their own gender (19) They assumed this was because male doctors felt patients would be embarrassed. However, questioning patients has revealed that despite feeling nervous about PE, patients regard it as necessary (20).

Although patients report being exposed during the examination, they also describe how clinicians can influence this discomfort. Good communication during the examination, a trusted relationship with the clinician and a comfortable environment can reduce patient distress (20–22) Clinician discomfort can increase patient’s distress (22). Clinician discomfort can also influence their use of chaperones. Reflecting our findings, discordance between
clinical practice and guideline recommendations has been observed previously and has been quantified; while 72% of clinician’s thought patients should be offered a chaperone, only 27% of the study population used chaperones (23)Another study suggested that guidance on the use of chaperones should be flexible, taking into consideration the relationship between patients and their doctors while considering practice staffing and space (24); this pragmatic approach was observed in this study.

Chaperone use was acknowledged as a barrier in terms of resource. But there was also recognition of clinical vulnerability, potential litigation while acknowledging that patients generally did not want chaperones. The use of chaperones to alleviate feelings of vulnerability to false allegations or to sexualisation of the examination by the patient has been reported by Hine and Smith (25)

**Implications for research and practice**

Our identification of important factors in all three elements of the COM-B framework indicates that Interventions to change practice either through training or service delivery innovations need to address multiple components. As we suggest in table 2, changing one element without addressing others, is likely to have limited effect. It is thus important to consider all three components.

Increasing capability could involve more skills training with the use of pelvic mannequins. However, these are not anatomically representative of many women and do not allow the development of communication skills which are key in reducing patient concerns. An alternative could be gynaecological teaching associates (GTA). A GTA is a non-doctor woman who has been trained to teach PE using their own bodies (26). They are able to develop a
patient centred approach while removing the homogenous depictions of women in mannequins. Their value in improving medical student education is well established (27) but it is not clear how effective they are for maintaining skills after initial training.

Several practices described ways of delivering care which addressed opportunity, for instance supporting patient choice of, or explicitly directing patients to GPs with greater experience. Further consideration is required to determine how patients access those confident GPs at the earliest possible opportunity. Ten-minute consultations and difficulties in locating appropriate chaperones clearly reduce opportunity. Increased length of consultation has also been highlighted by the Royal College of Obstetricians and Gynaecologists report ‘Better for Women’ which proposes 15-minute GP consultation (28). Additionally, primary care has changed its consultation model because of the Covid-19 pandemic. We do not know in what way this has affected how clinicians carry out pelvic examination.

Motivation factors about PE are clearly complex. GPs remain unsure of how valuable examination findings are to a good gynaecological referral. This could be addressed in further database studies, but as a starting point, gynaecologists should be asked whether they value PE carried out in primary care. More research is also needed to understand how much GPs assumptions about what women prefer to match the reality.

The unheard voice in this research is of women themselves. While we have knowledge of patients’ views on PE, we do not know how this influences their help seeking behaviour. Delayed help seeking is associated with poorer outcomes (29). We need to understand how PE influences patients’ help seeking behaviour.
Conclusion

GPs reasons for using, or not using, pelvic examination in women with symptoms potentially indicating cancer are complex. The Capability, Opportunity, Motivation framework provides a way of understanding this complexity. Interventions to increase the use of pelvic examination, and critics of its non-use, need to consider these multiple factors.

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Disclosure of interests

There were no conflicts of interest.

Contribution to authorship

PW contributed to the conception and design of the work, acquired and interpreted the data for the work, drafted the manuscript and revised it for important intellectual content, provided final approval for publication and agreed to be accountable for all aspects of the work. PM, CMB and CDB contributed to the conception and design of the work, drafted the manuscript and revised it for important intellectual content, provided final approval for publication and agreed to be accountable for all aspects of the work. MEC interpreted the data for the work, drafted the manuscript and revised it for important intellectual content,
provided final approval for publication and agreed to be accountable for all aspects of the work.

Details of ethics approval

The study was approved by the North of Scotland Research Ethics Committee on the 26th September 2017, reference 17/NS/0094, and by NHS Research and Development on 18th October 2017, reference NRS17/213808.

Funding

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Supporting Information

Supplement 1 Topic guide

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## Table 1: Summary of themes using the COM-B framework.

<table>
<thead>
<tr>
<th>COM-B Component</th>
<th>Theme</th>
<th>Theme Details</th>
</tr>
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<tbody>
<tr>
<td>Capability</td>
<td>Learning</td>
<td>Early training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Further training</td>
</tr>
<tr>
<td></td>
<td>Continuing practice</td>
<td>Limited opportunities</td>
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<td></td>
<td></td>
<td>Loss of capability</td>
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<td></td>
<td>Different forms of capability</td>
<td>Procedural skill</td>
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<td></td>
<td></td>
<td>Confidence in interpretation</td>
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<tr>
<td>Opportunity</td>
<td>Chaperones</td>
<td>Patient preference</td>
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<td></td>
<td></td>
<td>Practical availability</td>
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<td></td>
<td>Clinical environment</td>
<td>Enhanced vs generic</td>
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<tr>
<td>Motivation</td>
<td>Doing the best for the individual</td>
<td>Prioritise patient over rules</td>
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<td></td>
<td>Doctors examine</td>
<td>Importance of checking</td>
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<td></td>
<td></td>
<td>Professional reputation</td>
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<td></td>
<td>GPs as pragmatists</td>
<td>Question added value of PE</td>
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<td></td>
<td></td>
<td>Referral as acceptable alternative</td>
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<tr>
<td>Conditions</td>
<td>Pelvic examination in the GP consultation MORE likely</td>
<td>Pelvic examination in the GP consultation LESS likely</td>
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<tr>
<td>------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>GPs who ...</td>
<td>are well trained in PE</td>
<td>have not had detailed training in PE</td>
</tr>
<tr>
<td>... and who ...</td>
<td>have a substantial PE caseload to maintain confidence in their skills</td>
<td>have a limited PE caseload &amp; less confidence in their skills</td>
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<tr>
<td>... who practice in ...</td>
<td>a clinical environment which has been enhanced to provide PE</td>
<td>a generic clinical environment</td>
</tr>
<tr>
<td>... where chaperone needs ...</td>
<td>are easily met</td>
<td>are at best hard to meet</td>
</tr>
<tr>
<td>... and where patients with gynaecological symptoms ...</td>
<td>choose, or are directed, to see them because of their expertise</td>
<td>have little choice in who they see</td>
</tr>
<tr>
<td>... and who believe that by carrying out PE ...</td>
<td>they commonly add important value to the clinical process before or at the time of referral</td>
<td>they commonly add no value to a decision to refer either for imaging or specialist assessment</td>
</tr>
<tr>
<td>Outcome</td>
<td>GP is more likely to offer and conduct PE before referral</td>
<td>GP is less likely to offer or conduct PE, but, instead to either bypass PE (by direct referral) or to arrange for PE a practice colleague</td>
</tr>
</tbody>
</table>
Figure 1: COM-B behavior change model representation