AMA Journal of Ethics®
February 2025, Volume 27, Number 2: E86-90

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

# How Should a Physician Respond to a Patient's Unexpected Pain During a Pelvic Examination When There Is Clinical Indication of Infection?

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**Abstract**

This commentary on a case considers how to navigate a pelvic exam in the context of a patient's personal experience and suggests the clinical and ethical importance of thoughtful, intentional action and consistent, clear communication in these clinical encounters.

## Case

Dr B sees CC, who is 16 years old and presents with persistent, foul-smelling vaginal discharge despite finishing antibiotics prescribed by another clinician for a presumed sexually transmitted infection (STI). Dr B explains, "I need to perform a pelvic examination and get a swab sample for the lab to test. Do you understand what that means?" CC responds, "Yes," and nods agreement. Dr B returns with a chaperone. Upon inserting and opening a lubricated speculum in CC's vaginal canal, CC screams, "This hurts too much!" Dr B slowly withdraws the speculum and does not complete the examination.

Given CC's recent health history, Dr B needs an accurate diagnosis to inform appropriate treatment. "Maybe I should have just quickly inserted the swab to get a sample," Dr B wonders.

## Commentary

*Pelvic exam* is used as an umbrella term for one or more potential evaluations: cervical cancer screen, STI screen, speculum exam, bimanual exam, visual inspection, and more.[1] However, patients—especially patients of color—might associate a pelvic exam with anxiety, fear, discomfort, and pain.[1,2,3] Throughout history, people of color and vulnerable populations have been used gynecologically to advance the goals of others: from Dr J. Marion Sims, lauded as the "father of modern gynaecology," who performed pelvic surgeries on slaves without analgesia despite its availability,[4] to physicians threatening to withhold medical care unless people were sterilized and legislative proposals that financially incentivize women of low income to choose contraceptive implants.[5,6] Patients bring experiences of not only systemic racism but personal trauma to the exam room.[7] In surveys of predominantly White and of diverse adult respondents, 64% and 83%, respectively, reported having experienced at least one category of adverse childhood experiences, including sexual abuse.[7] Examinations can trigger

emotions associated with these experiences and retraumatize patients.[7,8] Clinicians thus must actively seek to provide trauma-informed care, especially given the historical context of reproductive injustice.

While many areas of medicine leave an individual vulnerable, seeking help, and placing trust in their clinician, a pelvic exam by nature asks even more of patients by putting them in an even more vulnerable position. Preparing for and conducting pelvic exams are not skills gleaned from a textbook or during clinical skills sessions in medical school. Such sensitive patient care harkens back to the general principles of medical ethics (nonmaleficence and beneficence) and relies heavily on a trusting patient-physician relationship. Knowing when to perform an exam, preparing for an exam, and navigating patient-specific challenges that might arise, such as unexpected pain, are vital to centering a patient's experience and gaining both the most information and a patient's trust. Let's break down our case line by line.

### Assessing Pelvic Exam Utility

In the first line, we discover that CC is a 16-year-old who has persistent foul-smelling vaginal discharge after finishing antibiotics for a presumed STI. Pausing here, the first question is whether a pelvic exam is necessary within this context. Pelvic exams are performed to evaluate symptoms such as pain, vaginal bleeding, or discharge and used as a screening tool for cervical cancer and STIs.[8] CC is reporting a concerning symptom for which it would be reasonable to proceed with a pelvic exam for evaluation, with patient consent. However, for an asymptomatic person, the utility of the routine pelvic exam has been called into question when weighing the potential risks we now more openly acknowledge that the exam can carry.[9] According to the American College of Obstetricians and Gynecologists, the screening pelvic exam leads to harms "such as fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%)."[3] These concerns about potential harms[3,8,10] are also relevant for symptomatic patients, who might experience more pain and, as such, should be appropriately informed of expected pain. Although an exam might be deemed worthwhile by the clinician, the patient might not share that opinion. After adequate counseling, the patient is in the best position to weigh the personal risks and benefits of the exam and to come to a conclusion, for whatever reason, for themselves.[3,11]

Dr B decides that a pelvic exam is warranted, then tells CC they need to perform the exam to get a swab sample for a test. Framing this as a decision already made instead of a point for shared decision-making can perpetuate negative associations and a lack of control surrounding the exam for the patient.[11] Dr B does ask if CC understands what a pelvic exam means, but phrasing the question as a yes/no question is less likely to elicit what concerns and preferences CC brings to the experience.[11] For example, CC is only 16—is this their first pelvic exam? Which components of a pelvic exam would be acceptable to CC? What is Dr B planning to perform? There are ways to explain what exactly the exam entails, taking into account the age and health literacy of the patient, and to assess true understanding when obtaining consent through means like the teach-back method, all of which help maintain the patient's sense of safety and build trust.[12] Another key element of consent is the right to refuse treatment as long as the patient is aware of the potential risks.[13] Telling patients before starting a pelvic exam that they have the right to discontinue the exam at any point for any reason, pain related or not, can restore patients' agency and sense of security.[13] Acknowledging that the exam is sensitive and can be painful, as well as asking about prior exam experiences, might open the door to communication that better prepares the patient for—and

individually tailors—the exam while building rapport.[1] Although a formal signed consent is not required for a pelvic exam, good practice requires tailored counseling prior to performing such an exam.

### Managing Pain

In the next paragraph, Dr B returns with a chaperone, which is a point to applaud in the case. Patients are encouraged to bring support persons, and a chaperone can provide both the support and reassurance a patient needs during an exam.[1] Dr B then places a lubricated speculum—at which CC screams, "This hurts!"—and Dr B ends the exam by removing the speculum. Dr B deserves credit for using a lubricated speculum, which has been shown to decrease discomfort and does not affect results of infection tests.[8] But speculum size, voiding prior to procedure, and patient positioning can also make a difference in ensuring that a patient is comfortable prior to and during the exam, and it is unsaid in the scenario whether these factors were addressed.[8] Regardless, once the speculum is in place, CC reports pain. Instead of immediately removing the speculum, Dr B could have asked CC what hurts or where it hurts, which might reveal that resolving the pain is as simple as releasing an area of pinched skin or repositioning the table and footrests. In the same vein, asking CC if they want to continue the exam centers CC and shows that they are still in control rather than assuming that CC wants to discontinue the exam and deciding for them. Some individuals might react initially or experience pain but still deem the answers from the exam worthwhile and prefer to continue, whereas others might not. However, that determination is up to the patient, not the clinician. This case illustrates why adequate counseling, obtaining patient consent, and reviewing potential challenges and solutions beforehand are helpful to prevent further harm, optimize the chances of a successful exam, and ensure a positive patient experience.

### Alternatives to a Pelvic Examination

CC's exam was not satisfactory for obtaining an adequate sample for STI testing, which is important in providing adequate care, given CC's presentation. Fortunately, there are less invasive, yet still effective, means to obtain samples through vaginal self-swabs or even testing from a urine sample. Data have shown that vaginal self-swabs for STIs are just as accurate as those performed by a clinician and that urine samples, while slightly less accurate, are still recommended over no sample.[3,14,15] Either alternative could be an option for those unable to complete a pelvic exam and gives patients control. Additionally, offering a digital exam with one finger might be better tolerated and still adequately assess cervical motion tenderness. These alternatives further emphasize the importance of determining the extent and utility of a pelvic exam for each patient. A downside in a setting of high concern for infection is the inability to assess other potentially important components of the exam (eg, discharge, cervical or vaginal lesions). However, if the patient is aware of these downsides and their impact, deferring the exam and evaluating possible infection by other means in order to tailor treatment is a viable option.

### Managing Pain With Communication

The final sentence gets at the heart of the issue throughout CC's entire visit: lack of adequate, open communication. Dr B might wonder what went well or wrong and what could have been done differently, but Dr B's best resource for figuring out that answer is the patient. Dr B could have obtained additional history to assess for risk factors and counseled CC on the exam beforehand, but, even after the exam, Dr B had the opportunity to ask CC how they could have made the exam more comfortable.[10,12]

Medicine and pain unfortunately often coincide. Although we try to standardize it, pain is a personal experience unique to each individual. If pain is personal, the medical care to understand and combat it should also be made personal. Just as we are now learning more about Anarcha, Betsey, and Lucy—the women upon whom Dr Sims experimented without consent—and recognizing their contributions to the field of medicine, so, too, should we respect and support our patients in seeking the care and experience that best suits their needs. Truthfully conveying the details of the exam and placing the patient as the one in control are essential to changing the narrative of the pelvic exam. Including the patient in the decision-making process reinforces autonomy and affirms the pelvic exam not as "a threshold experience for women" but as a judiciously used tool to advance health and reproductive justice.[9]

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### Editor's Note
The case to which this commentary is a response was developed by the editorial staff.

### Citation
*AMA J Ethics*. 2025;27(2):E86-90.

### DOI
10.1001/amajethics.2025.86.

### Conflict of Interest Disclosure
Authors disclosed no conflicts of interest.

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ISSN 2376-6980