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Importance of demographic characteristics and nurses' role in women's perceptions and experiences of gynaecological examination

Pomen demografskih značilnosti in vloge medicinske sestre pri doživljanju žensk ob ginekološkem pregledu

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Key words: nursing; empathy; patients' rights; reproductive health; gynecology

Ključne besede: zdravstvena nega; empatija; pravice pacientov; reproduktivno zdravje; ginekologija

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ABSTRACT

Introduction: Gynaecological examination is crucial for protecting the reproductive health of women. The purpose of the study was to explore the perception of women towards gynaecological examination, the importance of some demographic characteristics and the role of a nurse.

Methods: A quantitative methodology was used for study purposes. A structured web questionnaire was applied on a non-random, convenience sample of women (n = 476). The questionnaire was published on the most popular Slovenian web forums. Prior to the main research project, a pilot study was conducted on a sample of 10 women. The statistical analysis included descriptive statistics, t-test, Pearson's and Spearman's correlation coefficient.

Results: Results of the study show a statistically significant correlation between the respondents' residential environment (t = -2.436, p = 0.015), the level of educational attainment (r_s=-0.153, p = 0.001) and the presence of discomfort and fear before the gynaecological examination. The role of a nurse in reducing the level of discomfort and fear before (t = -0.931, p = 0.352) and during (t = -0.888, p = 0.375) the gynaecological examination was not proven statistically significant.

Discussion and conclusions: Besides the demographic characteristics, a number of personal and societal factors influence women's attitudes towards gynaecological examination and the associated discomfort and fear. The study suggests that further qualitative studies are needed to gain a deeper understanding of how women experience a pelvic examination.

IZVLEČEK

Uvod: Ginekološki pregled je ključnega pomena za varovanje reproduktivnega zdravja žensk. Namen raziskave je bil razložiti doživljanja žensk ob ginekološkem pregledu in pomen nekaterih demografskih značilnostih ter vlogo medicinske sestre.

Metode: V raziskavi je bila uporabljena kvantitativna metoda dela. Na nenaključnem, priložnostnem vzorcu žensk (n = 476) je bil uporabljen strukturiran spletni anketni vprašalnik, ki je bil objavljen na najbolj obiskanih slovenskih spletnih forumih. Pred uporabo je bila opravljena pilotna študija na vzorcu desetih žensk. Podatki so bili obdelani z uporabo deskriptivne statistike, t-testa, Pearsonovega in Spearmanovega korelacijskega koeficienta.

Rezultati: Rezultati kažejo statistično pomembno povezanost med bivalnim okoljem (t = –2,436, p = 0,015), stopnjo dosežene izobrazbe (r_s = –0,153, p = 0,001) in prisotnostjo nelagodja in strahu pred ginekološkim pregledom. Vloga medicinske sestre pri zmanjševanju nelagodja in strahu pred (t = –0,931, p = 0,352) ali med (t = –0,888, p = 0,375) ginekološkim pregledom se ni izkazala za statistično značilno.

Diskusija in zaključek: Poleg demografskih značilnosti številni osebni in družbeni dejavniki oblikujejo odnos žensk do ginekološkega pregleda ter s tem povezanega nelagodja in strahu. Raziskava nakazuje, da so v bodoče potrebne kvalitativne raziskave, ki bi omogočile poglobljen vpogled v ozadje doživljanja ginekološkega pregleda pri ženskah.

The article is based on the diploma work of Dušanka Zaić entitled *Women's experience of gynaecological examination* (2013).

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Introduction

Vaginal speculum is one of the oldest instruments in the technology of obstetric surveillance and diagnosis around which history echoes loudly. In her outline of historical development and use of the instrument, Sandelowski (2000, p. 73) points out that vaginal speculum has never been just a medical instrument that allows clinicians to see into women's bodies. For women, the vaginal speculum has loomed large and has long signified a kind of scrutiny and intrusion they have found aversive and have feared. Nurses' role in teaching women about the use of the speculum in gynaecological examinations was of paramount importance. They helped them understand the structure and functioning of their bodies by the use of mirrors, specula and other instruments, and what is most important, to alleviate fear and discomfort, often accompanying even present-day gynaecological examinations. Clearly, women attribute additional meaning to vaginal speculum, mainly in relation to a gynaecology visit and the perception of gynaecological examination. Accordingly, several questions related to the women's body (Prosen & Tavčar Krajnc, 2013) and social control (Foucault, 2009), culture and ethics (Stewart, 2005) are emerging.

The gynaecological examination is an essential part of gynaecological care and is the most commonly performed procedure in gynaecological practice. A large number of women in the world will have a gynaecological examination at some time in their lives, and some may undergo several examinations during their lifetime. This intimate physical examination may provoke many negative feelings, such as embarrassment, shame, anxiety and awkwardness (Yanikkerem, et al., 2009). The first pelvic examination in adolescent years and the attitude of health providers may lay the foundation for subsequent pelvic exams (Ricciardi, 2008). Similar results were obtained in the research by Starešinič and Mihelič Zajec (2014) who affirmed that embarrassment and fear are the most commonly experienced feelings during the first pelvic examination. Swahnberg and colleagues (2011) established that women in adulthood experience strong discomfort during pelvic examinations, but find it necessary to confirm their health.

Apart from the physical discomfort, the psychological factors are important as gynaecological examination involves exposure of intimate parts of the body in a vulnerable situation with loss of control. Women experience many feelings, such as embarrassment about undressing, worries about cleanliness, qualms about vaginal odour, concern that the gynaecologist might discover something about sexual practices, fear of discovery of a pathological condition, and fear of pain (Hilden, et al., 2003, p. 1030), or even the history of psychological, physical or sexual abuse (Swahnberg, et al., 2011). Cold instruments, lack of information about the procedure and lack of gentleness from the examiner are also perceived as factors contributing to discomfort (Hilden, et al., 2003). An important factor in the perception of the exam is also the gender of the examiner. Racz and colleagues (2008) conclude that increasing experience with intimate examinations over time results in greater comfort with these examinations and a greater willingness to be examined by doctors of either gender. One final factor to be considered in association with a patient's perceived level of discomfort is the premises and technical equipment used in gynaecology. Drife and Magowan (2004) therefore caution that the examination room should ensure intimacy and sense of safety during the examination. A separate place must be provided to prepare for the examination. The metal instruments should be warmed up before insertion to alleviate discomfort. A qualitative study on women's experiences of pelvic examination conducted by Grundström and colleagues (2011) identified three general themes: (1) relinquishing and regaining control, (2) facilitation of the situation by the examiner, and (3) pelvic examination is an unpleasant necessity. The authors explain that women experienced pelvic examination as an intimate situation, which they associated with their sexuality. They felt exposed both bodily and mentally and were placed in a vulnerable situation. Pelvic exam was considered as unpleasant, but necessary to confirm their health. During the examination, the women felt that they lost control of the situation by exposing their intimate parts. To regain control, the women felt a need for continuous information from the examiner (Grundström, et al., p. 59).

Wendt and colleagues (2004) observe that women still get insufficient information about how the examination is performed and what it involves. The provision of information on the procedure may moderate many negative feelings like fear of illness, pain, and the feelings of embarrassment and awkwardness. The authors also recommend that information be provided in advance, or preferably, during the examination what tones down the feelings of tension and fear. According to Oscarsson and colleagues (2007), women most commonly receive information on the procedure from midwives or district and hospital nurses, while information from a gynaecologist is provided only in 4.1 %. Similar expectations are observed in Slovenian girls who rely on nurses to provide them with adequate information on pelvic exam (Starešinič & Mihelič Zajec, 2014). Results of the mentioned studies validate the important role of nurses and midwives in the provision of facts about and on the procedure. Women who undergo a gynaecological examination for the first time should be treated with special considerations as their level of discomfort is usually high (Ricciardi, 2008). All women, and especially those who visit a gynaecologist for the first time should be offered adequate information about the procedure in advance and asked to give their consent to perform the examination (Drife & Magowan, 2004). Hilden and colleagues (2003) emphasise that discomfort during the gynaecologic examination is strongly associated with a negative emotional contact with the examiner, therefore it is important to establish a rapport, offer a sense of safety, express empathy and build a trusting professional relationship to diminish the discomfort of

the situation. According to Lewin and colleagues (2005), sociodemographic characteristics of women have a bearing on their contentment with information provided. Women with higher educational level and those working in health care sector usually demand more detailed information in comparison to less educated ones.

Pelvic examination presents a special challenge to women with disabilities who often encounter multiple obstacles accessing gynaecological health services. Barriers can include physical and structural obstacles, the inability to get into the required position or onto the examination table, and the absence of modified examination devices. One of the common obstacles is the personnel's behaviour in the situation of gynaecologic examination which may result in poor or ineffective communication. If the health personnel do not obtain the necessary information to tailor their approach to the woman's needs and preferences, the procedure may be even more unpleasant for the examinee. Women with disabilities might not inform nurses of their fears or concerns because they have been socialized to "please" Therefore, active listening is important to assess and to respond to women's needs and fears prior to and during pelvic examination so that discomfort and anxiety can be alleviated (Sudduth & Linton, 2011, pp. 141-142).

Purpose and objectives

As the research into women's perceptions during gynaecological examination in Slovenia is scarce, the paper attempts to critically examine the issue focusing on women's demographic characteristics and the implications for nurses. On this basis the following hypotheses were tested:

Hypothesis 1: Demographic characteristics of women (age, place of residence, educational attainment) influence their experience of pelvic examination prior to and during examination.

Hypothesis 2: The contribution of nurses in diminishing discomfort and fear before and during examination is noteworthy.

Methods

For this study, a quantitative research method was employed. A non-experimental, observational research was conducted. The data were collected using a web-surveying technique.

Description of the research instrument

The data were collected through a structured survey questionnaire. Due to the lack of domestic reports and publications, the survey questionnaire was designed mainly on the basis of relevant foreign literature review (Hilden, et al., 2003; Wendt, et al., 2004; Grundström, et al., 2011). The questionnaire consisted of 21 questions, divided into three categories. The first category was related to demographic characteristics of the respondents and the second to the respondents' perception and feelings with regard to undergoing gynaecologic examination. In the third part the respondents were asked to give their opinion on or describe their experiences. The introductory part of the questionnaire explained the nature and purpose of the study along with detailed instructions on how to fill in the questionnaire. The questionnaire was pre-tested in a pilot study performed on a sample of ten women to validate the clarity and comprehensibility of questions and internet-based survey method. Results of the pilot study confirmed the suitability of the research instrument. The estimated time to complete the survey was ten minutes. The questionnaire was designed with a web survey tool 1KA (www.1ka.si).

Description of the sample

A random sample consisted of women who had previously undergone a gynaecological examination. The survey was completed by 476 women aged 15 to 55 years. The mean age of the respondents was 32 years. Detailed demographic data are given in Table 1.

Table 1: *Demographic data of the study participants*
Tabela 1: *Demografski podatki udeleženk raziskave*

Demographic data/Demografski podatki	***n = 476***	***%***
Place of residence		
Urban area	316	66.39
Rural area	160	33.61
Social status		
Employed	326	68.49
Unemployed	70	14.71
Undergraduate student	58	12.18
High school student	4	0.84
Other	18	3.78
Education		
Primary	5	1.05
Secondary	161	33.82
College	21	4.41
Higher professional	95	19.96
University	155	32.56
Masters degree	25	5.25
PhD	9	1.90
Other	2	0.42
Not answered	3	0.63
Age		
≤ 14	/	/
15–20	11	2.31
21–26	93	19.54
27–32	163	34.24
33–37	112	23.53
38–42	60	12.61
43–47	23	4.83
48–53	11	2.31
≥ 54	3	0.63

Legend/Legenda: n –number/število; % – percentage/odstotek

Data collection and processing

The survey was conducted from June 24 to July 22, 2013. The questionnaire was available on the internet forums to which a large number of women were expected to respond, namely, www.medover.net, www.bibaleze.si in www.ringaraja.net. The access to the questionnaire was offered also on the social network www.facebook.com within the author's profile. The survey was conducted in accordance with the Declaration of Helsinki and anonymity of the respondents was secured.

The data management and analysis was performed using the SPSS statistical software version 17.0 (SPSS Inc., Chicago, IL). Descriptive statistics were used to describe and calculate the following features of the data in a study: percentage, the mean, minimum and maximum values and standard deviation values. The hypothesis was tested by the Student's *t*-test, Pearson's correlation coefficient and Spearman's correlation coefficient.

The following independent variables were tested within the frame of the first hypothesis: age, place of residence and educational attainment, with which the dependent variables were explained (the level of discomfort and fear prior to and during gynaecological examination). The testing of the second variable included the response of nurses to the perceived level of discomfort and fear in women prior to and during their gynaecological examination. The level of $p < 0.05$ was taken into account in determining the statistical conclusion validity.

Results

Descriptive statistics

The data presented in Table 1 lead to a conclusion that most of the respondents ($n = 318$, 66.81 %) describe their experiences taking place within the last six months prior to the study. 66.31 % ($n = 307$) of women with a chosen gynaecologist expressed preference for a female doctor. Their choice was affected by the experience and advice of other women ($n = 157$, 26.79 %), the feelings of shame and embarrassment to expose their intimate parts to a male doctor ($n = 73$, 12.46 %), and because they believed that women doctors are more empathetic and better listeners ($n = 42$, 7.17 %). In contrast, 4.95 % ($n = 29$) of women with a chosen gynaecologist believe that male doctors are more empathetic and better listeners or that they possess better professional knowledge ($n = 21$, 3.58 %).

The study found that the majority of surveyed women (77.52 %, $n = 369$) are always offered information about the procedure while one fifth of women (21.01 %, $n = 100$) state the contrary. Most of the respondents (86.55%, $n = 412$) receive information from a gynaecologist and a smaller number from a nurse (3.36 %, $n = 16$). Almost half of the respondents (49.65 %, n = 70) who stated that nurses do not respect their privacy and do not consider their feelings and personal data protection, experience also the feelings of discomfort, shame, anger and loss of power and the feeling that all the patients in the waiting room are staring at them. Nearly one third of the respondents

Table 2: *Selected questions about gynaecological examination*
Tabela 2: *Izbrana vprašanja o ginekološkem pregledu*

Questions/Vprašanja	***Answers/Odgovori***	***n = 476***	***%***
When did you last visit a gynaecologist?	In the last six months	318	66.81
	In the last year	97	20.38
	In the last two years	35	7.35
	More than two years ago	22	4.62
	Not answered	4	0.84
Do you have a chosen gynaecologist?	Yes	463	97.27
	No	12	2.52
	Not answered	1	0.21
Are the patients allowed privacy to undress and dress?	Yes	447	93.91
	No	23	4.83
	Not answered	6	1.26
Are you troubled by cold gynaecological instruments?	Yes	173	36.34
	No	296	62.18
	Not answered	7	1.48
Does your gynaecologist stop the procedure when you feel pain or discomfort?	Yes	317	66.60
	No	80	16.81
	Other	75	15.76
	Not answered	4	0.83
Do nurses respect your privacy and protect your personal data?	Yes	330	69.33
	No	141	29.62
	Not answered	5	1.05

Legend/Legenda: n – number/število; % – percentage/odstotek

(27.66 %, n = 39) have positive attitudes towards pelvic examination and were not concerned with or troubled by the nurses' behaviour. The respondents' answer to the control question whether nurses observe their anxiety prior to examination and ask them about their feelings was affirmative in 32.98 % (n = 157) and negative in the remaining 64.92 % (n = 309). As regards the support in coping with their feelings of fear and discomfort before the examination, the respondents chose the following answers: "Nurses respond to my question by listening and counselling" (25.03 %, n = 183); "Nurses facilitate the situation by taking time to listen and by being open and sincere" (17.92 %, n = 131); "Nurses use humour to help relieve my tension and stress" (13.68 %, n = 100), and "Nurses help me relax with adequate non-verbal communication" (12.68 %, n = 94). The respondents claim that nurses offer no support (14.23 %, n = 104), that they are not actively involved in the communication process and just listen passively (13.95 %, n = 102).

Figure 1 presents the level of discomfort and fear before and during the pelvic examination on one to ten rating scale. Number one indicates the absence of discomfort and fear and number ten the highest degree of discomfort and fear. The mean values before and during examination were $\overline{x}$ = 3.56 (s = 2.66) and $\overline{x}$ = 4.59 (s = 2.609), respectively.

Testing of hypotheses

Spearman's correlation coefficient was used to test the statistically significant difference between the age of respondents and their level of discomfort and fear before and during pelvic examination. It was established that the age of women is not statistically significantly associated with the level of discomfort and fear either prior to examination (r = –0.075, p = 0.106 or during the examination (r = –0.070, p = 0.132).

An independent samples t-test was used to test statistically significant difference between residential area of the respondents and their level of discomfort and fear before and during pelvic examination. The results indicate that the rural residents exhibit higher mean values of the dependent variable assessing their level of discomfort and fear during pelvic examination ($\overline{x}$ = 4.82, s = 2.76) in comparison to urban residents ($\overline{x}$ = 4.48, s = 2.53), but these differences are, however, not statistically significant (t = –1.345, p = 0.179). On the other hand, statistically significant difference was established in the level of discomfort and fear before the examination (t = –2.436, p = 0.015). The respondents from rural areas experience higher level of discomfort and fear than those from rural areas.

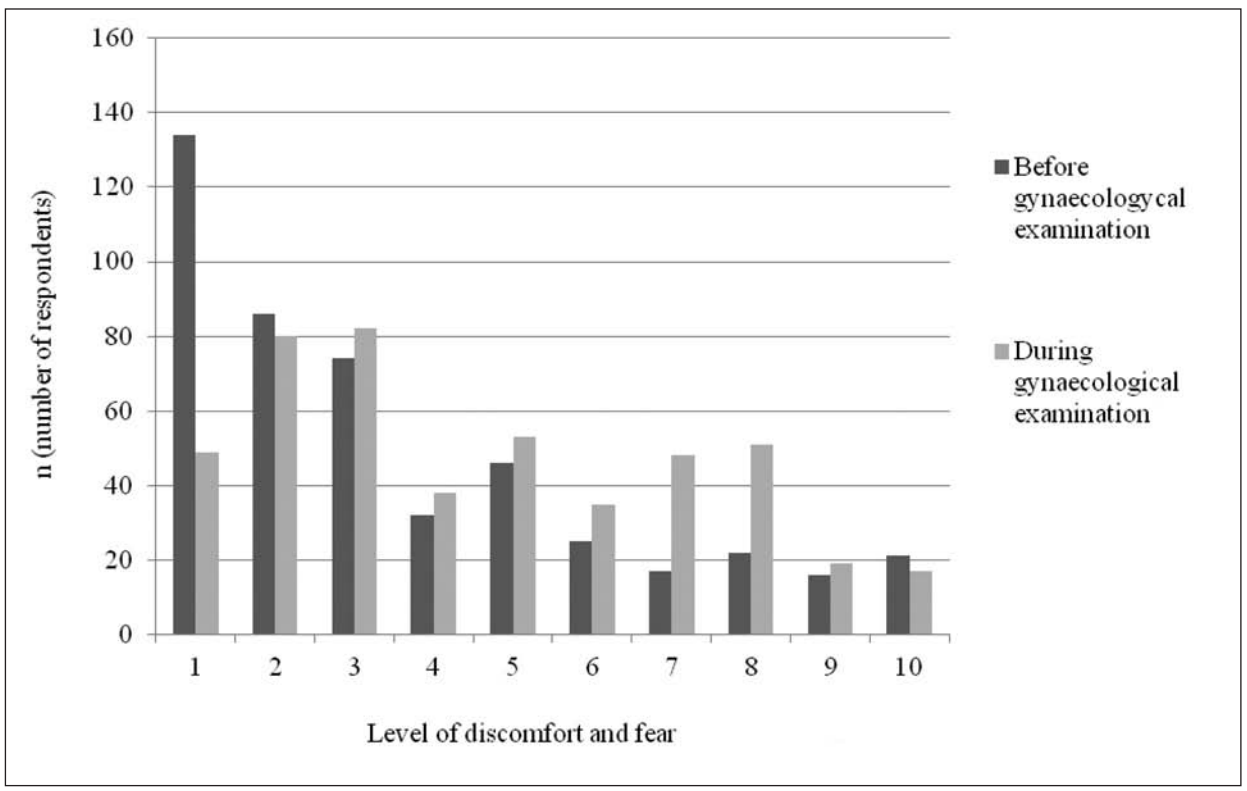


Figure 1: *Comparison of levels of discomfort and fear before and during gynaecological examination*
Slika 1: *Primerjava stopnje nelagodja in strahu pred in med ginekološkim pregledom*

The Spearman's correlational coefficient was used to test the statistically significant difference between the respondents' educational attainment and their level of discomfort and fear before and during pelvic examination. It was established that the level of discomfort and fear before the examination is weakly but still statistically significantly negatively associated with the respondents' educational attainment ($r_s = -0.153, p = 0.001$). The results indicate that the respondents with higher educational attainment experience lower levels of discomfort and fear before the examination than those with lower educational attainment. According to the results, no relationship exists between the level of discomfort and fear during pelvic examination and the respondents' educational attainment ($r_s = -0.068$, $p = 0.144$). The first hypothesis can therefore not be fully confirmed as the perception of examination is only partly related to the respondents' educational attainment and their residential area, while there is no correlation with the respondents' age.

An independent samples *t*-test was used to confirm the second hypothesis that the level of fear and discomfort prior to or during pelvic examination is dependent on the nurses' perception of and response to women's fear and discomfort. It was established that women whose feelings were observed by nurses (n = 156, 32.8 %), experienced lower levels of fear and discomfort prior to or during pelvic examination ($\overline{x}$ = 3.37, s = 2.58 and $\overline{x}$ = 4.44, s = 268, respectively) in comparison to those women whose feelings were not perceived and responded to by nurses. The latter group of women reported relatively higher levels of fear and discomfort prior to and during pelvic examination (n = 309, $\overline{x}$ =3.61, s = 2.64) and (n = 308, $\overline{x}$ = 4.66, s = 2.55, respectively). The differences between the two groups were not statistically significant at two different points in time, i.e. before and during examination (t = -0.931, p = 0.352 and t = -0.888, p = 0.375, respectively). Accordingly, the second hypothesis therefore could not be confirmed.

Discussion

The current study found that women's place of residence and educational attainment are significant factors in the perception of fear and discomfort before pelvic examination while they are of no consequence during examination. The rural residents experience higher level of fear and anxiety before the examination seen against urban residents. Women with higher educational attainment experience a lesser degree of fear and discomfort before the examination in comparison to less educated women. The demographic factor of age was found to have no significant impact on women's experience of the examination. Contrary to the results produced in this study, Hilden and colleagues (2003) observed that the degree of discomfort during the gynaecologic examination was associated with a number of factors, including the age of the examinees. The highest level of discomfort was identified in women aged 15 – 20 years. A study conducted among Swedish women (Fiddes, et al., 2003) further reveals that young women (under 25) and nulligravid women are more likely to find pelvic examinations distressing. Similar results were obtained by Yanikkerem and colleagues (2003) indicating that embarrassment levels during the examination were significantly higher for younger women under the age of 25 years, for women with completed primary education only, the unemployed and those with lower incomes. These groups of women usually also express a gender preference for a female physician which accords with the findings of Starešinič and Mihelič Zajec (2014). It seems that women prefer a female provider for their routine gynaecological care. These preferences are mostly based on the providers' attributes in terms of communication ability, empathy and the ability to understand women's concerns. According to the results of the current study, two thirds of women prefer female physician for the reasons given above and the remaining third would prefer a male professional. Some other studies exploring factors associated with gender bias (Racz, et al., 2008; Yanikkerem, et al., 2009) reported that religion and cultural tradition may also influence the preference for a female physician. In their study conducted in the United Arab Emirates, Rizk and colleagues (2005) determined that most women prefer female providers because of embarrassment during pelvic examination and reproductive counselling, religious beliefs, and sociocultural values. Yanikkerem and colleagues (2009) also noted that most women who regularly undergo gynaecological examination would probably choose a male over a female physician. In the majority of cases, the choice of a gynaecologist is not a woman's conscious decision and is oftentimes influenced by the popular media. Kincheloe (2004) performed an analysis of the best-selling print media in the U.S. (some of them are also available in the Slovene language) to determine whether gender bias against male obstetricians and other male physicians is found in women's interest magazines. The study findings identified a gender bias against male obstetrician–gynaecologists as well as male physicians in general. The bias was manifested in several different forms, including covert acts of gender discrimination. The constant flow of negative and discriminatory articles may effect gender bias on the readership and lead to female physician preference as a norm. The practice of gender bias toward male obstetrician carries larger societal implications, e.g. the decreasing number of (male) gynaecologists, indiscriminate selection of a gynaecologist based on gender criteria only, which may lead to (de)professionalization of medicine as well as nursing and midwifery.

The fear and discomfort before and during pelvic examination can be significantly diminished if women know they will be allowed privacy to disrobe and that their personal data will be protected. It is important that they receive sufficient information and support prior to and during examination and that they are treated with respect. According to the present study, the necessary measures to

reduce patient anxiety are not fully implemented, especially in regard to tolerance, patient privacy and personal data protection. The respondents reported that patient privacy is often violated due to inappropriate separation of the examination and dressing room. (e.g. "In the dressing room you can hear everything about the patient examined and her health condition. For me this is one of the major problems – I do not want to discuss my concerns with a physician knowing that other patients whom I had met in the waiting room are also listening."). Some other patients commented that health providers pay no attention to the problem of privacy (e.g. "Privacy and confidentiality are not ensured. You have to speak about your personal affairs in the presence of other patients and nurses don't seem to bother.") Protection of privacy and confidentiality is essential to the trusting relationship between nurses and patients (Tabak & Ozon, 2004). Marinič (2012, p. 240) argues that it is difficult to secure quality health care in the environment where patients do not trust their health care providers, fearing that their individually identifiable health information will be used, disclosed or misused, that confidentiality of that information will not be maintained, or that other health professionals will access their medical record information out of sheer curiosity. In the atmosphere of mistrust nurses will not be able to obtain the information about the patient's medical history and presenting complaint which is necessary in planning quality nursing care, tailored to the patients' needs and preferences. Many positive changes can, however, be observed in practice, from better healthcare infrastructure to professionalism. Tabak and Ozon (2004) highlight the activities in the field of nursing, especially in education, management and research.

According to the respondents' feedback, nurses usually try to alleviate women's psychological discomfort by listening to their concerns and by counselling. When asked for their opinion on the issue, the respondents offered different views on nurses' response to their fear and discomfort which were evidently affected by their previous experience. The provision of information about how the examination is performed and the explanation of reasons for the exam can significantly reduce tension before and during examination. Most of the women who described their experiences report that fear and discomfort made them seek information they might not have asked for in different circumstances. This may sometimes irritate and provoke negative reactions of health providers. Several studies confirmed that pelvic examination could be a positive experience if doctors and nurses provide information about the examination, listen to women and show that they have time for them (Hilden et al., 2003; Yanikkerem, et al., 2009). Communication, verbal or non-verbal, is a powerful tool. Trojar and Ramšak Pajk (2013, p. 58) emphasise that in the nurse–patient relationship communication involves more than just transmission of information. It involves attentive listening to what another person is trying to communicate, and making sure that one's, message is not only delivered but accepted and understood. Nurses should be mindful of patients' non-verbal communication, which reveals how the message was received and whether their needs were recognised. Communication should be person-focused, individualised while appreciating the context. Communication patterns, both verbal and nonverbal, are important – nurses may patiently engage and empower the patients or just stand silently by their side, touch them slightly, listen attentively and communicate their recognition and understanding of the patients' situation.

In their comments the respondents highlight the importance of non-verbal communication which is often neglected (e.g. "A more personal approach (of nurses) would be well received by patients, a greeting with an eye contact at each encounter and a bit of humour would reduce the patients' stress."). Interesting were also the respondents' remarks about inappropriate verbal communication (e.g. "During my last pelvic exam the physician was not listening to me. She used four specula. She insisted that she saw my cervix, but it is not possible as my cervix had been removed").

No demanding or expensive measures are necessary to diminish the feelings of fear and discomfort before and during pelvic examination. It would be, however, sensible to consider also other factors associated with experiencing discomfort, such as properly equipped premises or warmed up specula (Hilden, et al., 2003). A randomized controlled trial (Hill & Lamvu, 2012) confirmed that applying even a small amount of lubricating gel decreases patients' pain during vaginal speculum insertion.

The American College of Physicians (ACP) (Qaseem, et al., 2014) made even a step further in this respect but not to everybody's agreement. It developed a guideline to present the evidence and provide clinical recommendations on the utility of annual screening pelvic examination for the detection of pathology. Obtaining a Pap smear for cervical cancer screening is not considered in this guideline. The Clinical Guideline from ACP questions the need to perform screening pelvic examination in asymptomatic, non-pregnant, adult women. According to the current evidence, the physical and psychological harms outweigh any demonstrated benefits associated with the screening pelvic examination (Qaseem, et al., 2014). In response to this recommendation, the American College of Obstetricians and Gynecologists suggests that the annual visit has value, and recommends annual examination for asymptomatic adult women (from age 21 on) which should include internal bimanual pelvic and speculum examinations (Committee on Gynecologic Practice, 2012). Several obstetricians and gynaecologists in the U.S. believe that longer intervals between routine examinations would have negative repercussions for patients and medical practice (Henderson, et al., 2014). The guideline advises against pelvic examination (speculum and bimanual and rectal examination, with Pap smear for cervical cancer screening excluded) in asymptomatic, non-pregnant adult women aged 21 years and over (Qaseem, et al., 2014).

Women who experienced pain or discomfort during their examination are less likely to have a return visit than those with positive experiences. Delay and avoidance of the annual check-up has the potential to harm women, especially if they do not attend cervical cancer screening. Ivanuš and Primic Žakelj (2014) observed that non-respondents to organised screening for cervical cancer are at greater risk than women who attend the screening. New ways of early detection of cancerous and pre-cancerous lesions of the cervix are emerging as the primary test for cervical cancer, among which a self-collected test for human papilloma virus (HPV) seems most promising. Obtaining a self-collected sample for HPV testing requires that a woman collects a sample of vaginal secretions with a small swab and sends it to a laboratory for analysis. Only if infection with one of the cancerogenic HPV is detected, a woman is invited to see a doctor. This way the HPV test will enable a more efficient screening and detection of women at risk who avoid attending organised screening for fear of pelvic examination.

The present study offers an insight into the women's attitudes, perception and expectations regarding gynaecological examination. The study provided data according to which it is necessary to improve some organisational processes and procedures, and foster nurses' professional role development. Due to the lack of systematic data, further research on this topic needs to be undertaken, using a combination of different research methods. Additional variables, such as women's sociodemographic and reproductive characteristics, should be included in the study of factors influencing women's experience of gynaecological examination.

Study limitations

The use of non-random, convenience sampling may have a potential impact on generalizability of the results obtained and representativeness of the sample (Burns & Grove, 2009). The choice of convenience sampling and survey method used in this study was dictated primarily by the nature of the issue studied. According to Burns and Grove (2009) some patients decline participation in the study due to the specificity of the study question. This was also the reason for not using the exclusion criteria in sampling. Although most of the respondents attended a pelvic examination within the last six months, Hilden and colleagues (2003) cautioned that after a longer period of time it is difficult to recall the feelings and the level of discomfort associated with the exam.

Conclusion

Most women will have a gynaecological examination several times in their lives. It is an essential part of gynaecological care which is often associated with feelings of fear, embarrassment and discomfort. Gynaecological examination differs from many other medical exams, especially as it involves exposure of intimate parts of the body in a vulnerable situation with loss of control. For some women it presents also an insight into other spheres of their private and social lives, including their sexual practices or sexual abuse. As negative feelings associated with pelvic examination is a barrier to consistent care, nurses should offer reassurance and establish good patient rapport by showing empathy and having time to listen to the patients' needs, expectations and worries, as well as giving them information on the procedures. As the first pelvic examination is a key experience for future pelvic examinations, it is a great challenge for nurses to make the examination situation more positive for women.

Slovenian translation/Prevod v slovenščino

Uvod

Vaginalni spekulum je eden izmed najstarejših instrumentov v porodništvu in ginekologiji, mnenja o njegovi uporabi so glasno odmevala skozi zgodovino. Skozi časovni pregled razvoja in uporabe tega instrumenta Sandelowski (2000, p. 73) ugotavlja, da za žensko vaginalni spekulum ni bil le preiskovalni instrument, pomenil je nekakšno grožnjo za odkritje morebitnih boleznih in zato vzbujal strah. Medicinske sestre so imele v preteklosti ključno vlogo pri izobraževanju žensk o uporabi spekuluma pri ginekološkem pregledu. S pomočjo ogledal, spekulumov in drugih naprav so ženskam poskušale olajšati razumevanje lastnega telesa, in kar je najbolj pomembno, s tem zmanjšati strah in nelagodje, ki je pri ženskah prisotno še danes. Vsekakor ima vaginalni spekulum v očeh žensk tudi drugačen pomen, ki ga povezujejo zlasti z obiskom pri ginekologu, vaginalnim pregledom ter doživljanjem le-tega. Na ta način se odpirajo številna vprašanja, povezana s telesom ženske (Prosen & Tavčar Krajnc, 2013) in družbenim nadzorom nad njim (Foucault, 2009) ter kulturo in etiko (Stewart, 2005).

Ginekološki pregled je najpogosteje izvajana preiskava v ginekološki praksi in preiskava s katero se večina žensk sreča vsaj nekajkrat v življenju. Tako intimen fizični pregled lahko pri pacientkah povzroča občutke zadrege, sramu, anksioznosti ter nelagodja (Yanikkerem, et al., 2009). Še posebej zaznamujoča je izkušnja prvega ginekološkega pregleda v času adolescence in s tem povezan prvi vtis, ki ga pustijo zdravstveni delavci (Ricciardi, 2008). Podobno ugotavljata v raziskavi tudi Starešinič in Mihelič Zajec (2014), ki med drugim navajata, da sta najpogostejša občutka deklet pred prvim ginekološkim pregledom prav sramovanje in strah. Kasneje v odrasli dobi, Swahnberg in sodelavci (2011) opisujejo, da raziskave glede doživljanja ginekološkega pregleda dokazujejo, da ženske pregled doživljajo kot neprijeten, vendar nujen. Poleg fizičnega neugodja je v ospredju tudi psihično počutje, povezano z omenjenim nadzorom nad telesom. Slednje vključuje slačenje, kazanje

intimnih delov ter vpliv številnih občutkov, kot so sram, skrb, povezana s čistočo in neprijetnimi vonji, strah pred razkritjem spolnih praks in odkritjem bolezni ter bolečine (Hilden, et al., 2003 p. 1030) ali celo razkritjem psihične, fizične ali spolne zlorabe (Swahnberg, et al., 2011). Mrzli inštrumenti, nezadostno informiranje o poteku pregleda in neustrezen pristop ginekologa so še zaznani kot pomembni dejavniki, ki prispevajo k nelagodju (Hilden, at al., 2003).

Pomemben dejavnik doživljanja ginekološkega pregleda je tudi spol izvajalca pregleda, pri čemer Racz in sodelavci (2008) poročajo, da njegov vpliv na doživljanje ginekološkega pregleda upada s povečano frekvenco ginekoloških pregledov. Nenazadnje tudi prostor s svojo opremo prispeva k doživljanju ginekološkega pregleda. Drife in Magowan (2004) zato opozarjata, da mora biti ginekološka ambulanta prostor, ki zagotavlja občutek intimnosti in varnosti. Poskrbljeno mora biti za slačilnico oziroma del, kjer se lahko ženska pripravi na pregled. Priporočljivo je, da so preiskovalni instrumenti, zlasti kovinski, ogreti, saj se tako zmanjša občutek nelagodja ob vstavitvi.

Grundström in sodelavci (2011) v kvalitativni raziskavi ugotavljajo, da je doživljanje ginekološkega pregleda povezano z (1) odrekanjem in ponovno pridobitvijo nadzora nad telesom, (2) pristopom preiskovalca in (3) dejstvom, da je ginekološki pregled neprijetna nujnost. Isti avtorji pojasnjujejo, da so v raziskavi ženske doživljale ginekološki pregled kot intimno situacijo in jo povezovale z lastno seksualnostjo. Čutile so se ranljive in izpostavljene, tako telesno kot duševno, vendar so pregled doživljale kot neizogibno stvar. Med ginekološkim pregledom je prevladoval občutek izgube nadzora nad lastnim telesom. K ponovni vzpostavitvi nadzora po mnenju žensk pomembno prispeva podajanje informacij s strani preiskovalca (Grundström, et al., 2011, p. 59).

Wendt in sodelavci (2004) navajajo, da so ženske tudi v današnjem času nezadostno informirane o tem, kako naj bi ginekološki pregled potekal in kaj vključuje. Informiranje o poteku ginekološkega pregleda ima veliko vlogo pri zmanjšanju strahu in nelagodja, ki ga povzroča ginekološki pregled. Isti avtorji tudi zaključujejo, da ženskam najbolj ustreza, če informacije dobijo pred ali še bolje med ginekološkim pregledom, kar občutno zmanjšuje občutek napetosti in strahu. Glede na ugotovitve Oscarsson in sodelavci (2007) največ informacij o poteku ginekološkega pregleda ženske dobijo od babice ali medicinske sestre, ki deluje v skupnosti ali v bolnišnici, le 4,1 % pa od ginekologa. Prav takšna so tudi pričakovanja slovenskih deklet, ki od medicinske sestre pričakujejo informacije o poteku ginekološkega pregleda (Starešinič & Mihelič Zajec, 2014). Slednje dokazuje pomembnost vloge, ki jo imajo medicinske sestre in babice v ozaveščanju žensk o ginekološkem pregledu. Večja pozornost mora biti namenjena zlasti ženskam oz. dekletom, ki pridejo na ginekološki pregled prvič, saj v primerjavi z ženskami, ki imajo redne, periodične ginekološke preglede, doživljajo večjo stopnjo nelagodja (Ricciardi, 2008). Vsem ženskam, še posebej tistim, ki ginekologa obiščejo prvič, je potrebno posredovati natančne informacije v zvezi s potekom pregleda že pred le-tem in pri tem tudi pridobiti informirano soglasje ženske za izvajanje ginekološkega pregleda (Drife & Magowan, 2004). Hilden in sodelavci (2003) ob tem poudarjajo, da je zaradi prisotnega nezaupanja potrebno graditi na pridobivanju zaupanja in dajanju občutka varnosti, pri čemer sta v ospredju empatija in profesionalni odnos. V povezavi z demografskimi značilnostmi Lewin in sodelavci (2005) ugotavljajo, da imajo ženske z višjo stopnjo izobrazbe, in ženske, ki so zaposlene v zdravstvu, običajno potrebo po bolj podrobnih in obširnih informacijah, medtem ko ženske z nižjo stopnjo izobrazbe običajno ne sprašujejo po podrobnostih in se, po njihovih ugotovitvah, zadovoljijo z manjšo količino informacij.

Doživljanje ginekološkega pregleda je še poseben izziv za gibalno ovirane ženske, saj se že ob prihodu na ginekološki pregled velikokrat srečajo s težavami, kot so težko dostopne ali sploh nedostopne ginekološke ambulante, fizično nedostopne preiskovalne mize, neprilagojeni preiskovalni inštrumenti. Ena izmed najpomembnejših ovir pa je nezadostno poznavanje situacije s strani zdravstvenih delavcev, ki se kaže v pomanjkljivi ali neustrezni komunikaciji. V slednjem primeru je ginekološki pregled lahko še bolj neprijeten (Stewart, 2005), saj zdravstveno osebje ne pridobi potrebnih informacij, ki bi omogočile prilagajanje potrebam in željam ženske. Pogosto invalidne ženske ne zaupajo občutkov strahu in zaskrbljenosti medicinski sestri, ker so bile socializirane, da so »ustrežljive«. Zato je pomembno predvsem poslušanje in zaznava strahov ter potreb pred, med in po ginekološkem pregledu, kar zmanjšuje prisotno nelagodje in strah (Sudduth & Linton, 2011, pp. 141–142).

Namen in cilj

Namen raziskave je bil, ob predhodni ugotovitvi slabe proučenosti tega področja v Sloveniji, raziskati doživljanja žensk ob ginekološkem pregledu. Osrednji cilj raziskave je bil raziskati pomen demografskih značilnosti in vlogo medicinske sestre pri doživljanju ginekološkega pregleda. Na podlagi tega sta bili oblikovani naslednji hipotezi:

Hipoteza 1: Demografske značilnosti žensk (starost, bivalno okolje, stopnja izobrazbe) so povezane z njihovim doživljanjem pred in med ginekološkim pregledom.

Hipoteza 2: Medicinske sestre pomembno prispevajo k zmanjšanju nelagodja in strahu žensk pred in med ginekološkim pregledom.

Metode

V raziskavi je bila uporabljena kvantitativna metodologija. Izvedena je bila neeksperimentalna, opazovalna raziskava. Podatki v raziskavi so bili zbrani s tehniko spletnega anketiranja.

Opis instrumenta

Za pridobivanje podatkov je bil v raziskavi uporabljen strukturiran anketni vprašalnik. Zasnova le-tega je temeljila na podlagi pregleda zlasti tuje literature (Hilden, et al., 2003; Wendt, et al., 2004; Grundström, et al., 2011), saj poročil in objav o tovrstnih domačih raziskavah primanjkuje oz. jih ni. Vprašalnik je obsegal 21 vprašanj pretežno zaprtega tipa, ki so bila razporejena v tri sklope. Prvi sklop se je nanašal na demografske podatke anketiranih, drugi na njihovo doživljanje in občutke ob ginekološkem pregledu, v tretjem so anketirane lahko izrazile svoje mnenje, zapisale svojo izkušnjo ali zgodbo. V uvodnem delu vprašalnika so bili anketiranim pojasnjeni namen in cilji raziskave ter opisana podrobna navodila v zvezi z izpolnjevanjem vprašalnika. Slednji je bil pred uporabo testiran na pilotnem vzorcu desetih žensk, ki so bile pozvane, da ocenijo jasnost in razumljivost zastavljenih vprašanj ter delovanje spletne ankete. Rezultati pilotne študije v ustreznosti zastavljenega instrumenta niso odkrili nobenih odstopanj. Potrjena je bila tudi jasnost in razumljivost ankete. Ocenjeni čas izpolnjevanja je bil deset minut. Vprašalnik je bil oblikovan s spletnim orodjem 1KA (www.1ka.si).

Opis vzorca

Priložnostni vzorec v raziskavi so predstavljale ženske, ki so že imele ginekološki pregled. Spletno anketo je izpolnilo 476 žensk med 15. in 55. letom. Povprečna starost je bila 32 let. Najmlajša anketiranka je bila stara 15 let, najstarejša 55 let. Podrobnejši demografski podatki so prikazani v Tabeli 1.

Opis poteka raziskave in obdelave podatkov

Anketiranje je potekalo od 24. junija do 22. julija 2013. Povezava do vprašalnika je bila objavljena na spletnih forumih, kjer je bilo pričakovati večji odziv žensk, in sicer na www.medover.net, www.bibaleze.si in www.ringaraja.net. Poleg tega je bila povezava do vprašalnika objavljena tudi na socialnem omrežju www.Facebook.com, v profilu prve avtorice. Anonimnost je bila sodelujočim zagotovljena. Raziskava je bila opravljena v skladu z načeli Helsinške deklaracije.

Podatki so bili obdelani s statističnim programom SPSS verzija 17.0 (SPSS Inc., Chicago, IL). V okviru deskriptivne statistike so bili izračunani: povprečna vrednost, strukturni deleži, minimum, maksimum in standardni odklon. Za testiranje zastavljene hipoteze so bili uporabljeni Studentov *t*-test, Pearsonov korelacijski koeficient in Spearmanov korelacijski koeficient. V okviru prve hipoteze so bile testirane naslednje neodvisne spremenljivke: starost, bivalno okolje in stopnja izobrazbe, s katerimi smo pojasnili odvisne spremenljivke (stopnja nelagodja in strahu pred in med ginekološkim pregledom), ob testiranju druge hipoteze pa tudi odziv medicinske sestre na zaznano stopnjo nelagodja in strahu pred in med ginekološkim pregledom. Pri statističnem sklepanju smo upoštevali stopnjo značilnosti $p < 0,05$.

Tabela 1: *Demografski podatki udeleženk raziskave*
Table 1: *Demographic data of the study participants*

Demografski podatki/ Demographic data	***n = 476***	***%***
Bivalno okolje		
Urbano okolje	316	66,39
Podeželje	160	33,61
Socialni status		
Zaposlena	326	68,49
Brezposelna	70	14,71
Študentka	58	12,18
Dijakinja	4	0,84
Drugo	18	3,78
Izobrazba		
Osnovnošolska	5	1,05
Srednješolska	161	33,82
Višješolska	21	4,41
Visokošolska	95	19,96
Univerzitetna	155	32,56
Magisterij	25	5,25
Doktorat	9	1,90
Drugo	2	0,42
Ni odgovora	3	0,63
Starost		
≤ 14	/	/
15–20	11	2,31
21–26	93	19,54
27–32	163	34,24
33–37	112	23,53
38–42	60	12,61
43–47	23	4,83
48–53	11	2,31
≥ 54	3	0,63

Legenda/Legend: n – število/number; % – odstotek/percentage

Rezultati

Opisna statistika

Iz podatkov prikazanih v Tabeli 2 lahko sklepamo, da večina anketiranih (n = 318, 66,81 %) opisuje nedavna doživljanja ginekološkega pregleda, ki so ga imele v zadnjih 6-ih mesecih pred pričetkom raziskave. Izmed tistih žensk, ki imajo izbranega osebnega specialista ginekologije in porodništva, se jih je 66,31 % (n = 307) odločilo za ginekologinjo. Razlog za tako izbiro je bil v prvi vrsti predlog oz. nasvet drugih, da izberejo ginekologinjo (n =157, 26,79 %). Poleg tega navajajo tudi, da občutijo sram in nelagodje, če ginekološki pregled izvaja ginekolog (n = 73, 12,46 %); da ženska bolje razume žensko (n = 67,

Tabela 2: *Izbrana vprašanja o ginekološkem pregledu*
Table 2: *Selected questions regarding gynaecological examination*

Vprašanja/Questions	***Odgovori/Answers***	***n = 476***	***%***
Kdaj ste bili nazadnje na ginekološkem pregledu?	V zadnjih 6 mesecih	318	66,81
	V zadnjem letu	97	20,38
	V zadnjih 2 letih	35	7,35
	Pred več kot 2 leti	22	4,62
	Ni odgovora	4	0,84
Ali imate izbranega osebnega ginekologa oz. ginekologinjo?	Da	463	97,27
	Ne	12	2,52
	Ni odgovora	1	0,21
Ali je v ambulanti poskrbljeno za slačilnico?	Da	447	93,91
	Ne	23	4,83
	Ni odgovora	6	1,26
Ali vas motijo hladni preiskovalni instrumenti?	Da	173	36,34
	Ne	296	62,18
	Ni odgovora	7	1,48
Ali vaš ginekolog/ginekologinja ob pojavu bolečine preneha s pregledom?	Da	317	66,60
	Ne	80	16,81
	Drugo	75	15,76
	Ni odgovora	4	0,83
Ali medicinska sestra upošteva zasebnost in varovanje osebnih podatkov?	Da	330	69,33
	Ne	141	29,62
	Ni odgovora	5	1,05

Legenda/Legend: n – število/number; % – odstotek/percentage

11,43 %) oz. da je ginekologinja bolj sočutna in boljša poslušalka (n = 42, 7,17 %). Po drugi strani 4,95 % (n = 29) žensk, ki so se odločile za ginekologa, meni, da je leta bolj sočuten in boljši poslušalec oz. da ima več znanja (n = 21, 3,58 %).

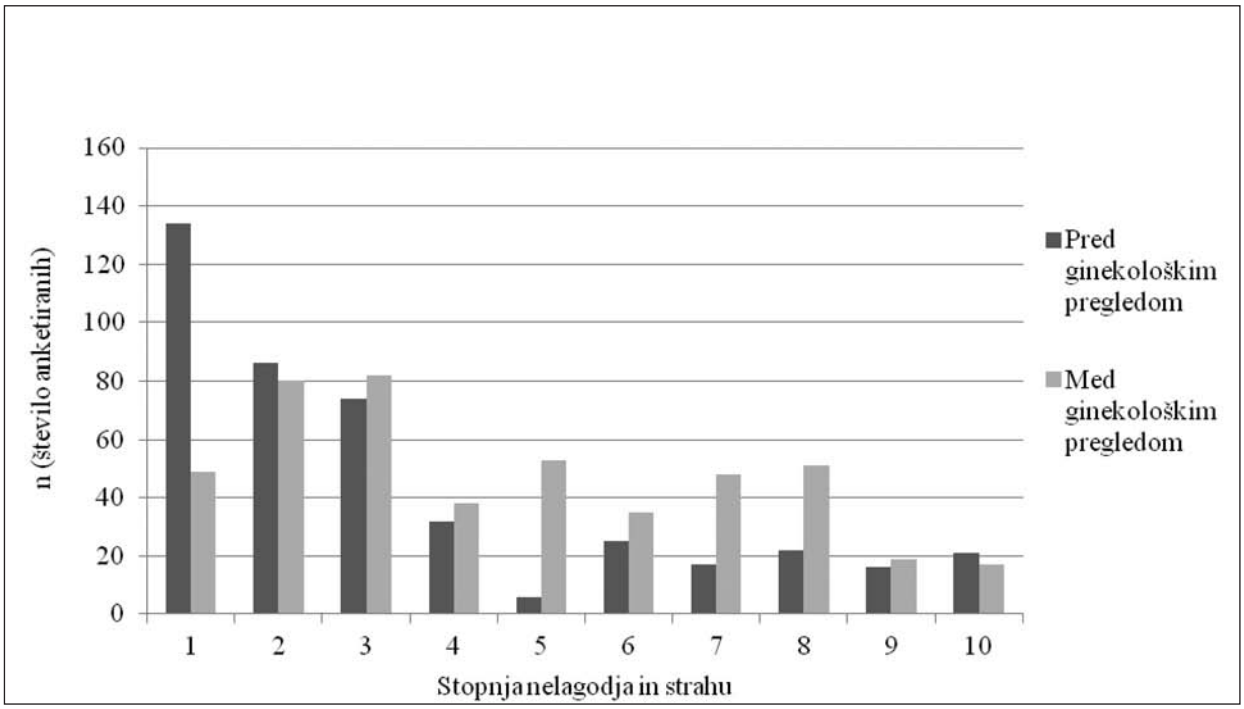
S potekom ginekološkega pregleda je ob vsakokratnem obisku seznanjenih 77,52 % (n = 369) anketiranih, medtem ko jih 21,01 % (n = 100) pravi, da ne dobijo informacij o poteku le-tega. Večina anketiranih (n = 412, 86,55 %) dobi informacije o poteku ginekološkega pregleda s strani ginekologa ali ginekologinje, medtem ko jih 3,36 % (n = 16) pridobi s strani medicinske sestre. Skoraj polovica tistih anketiranih (n = 70, 49,65 %), ki so označili odgovor, da medicinska sestra ne upošteva zasebnosti in varovanja osebnih podatkov, navaja občutke nelagodja, sramu, jeze in nemoči ter občutek, da vsi v čakalnici strmijo v njo, medtem ko se jih 27,66 % (n = 39) s tem ne obremenjuje oz. jih to ne moti. Na kontrolno vprašanje, ali medicinska sestra pred ginekološkim pregledom opazi njihovo zaskrbljenost v čakalnici in jih tudi o tem povpraša, jih 32,98 % (n = 157) odgovarja pritrdilno, 64,92 % (n = 309) pa jih to zanika. Glede nudenja podpore ter zmanjševanja nelagodja in strahu pred ginekološkim pregledom je 25,03 % (n = 183) anketirank izbralo odgovor »Medicinska sestra se odzove s poslušanjem mojega vprašanja ali mnenja in mi svetuje«, 17,92 % (n = 131) odgovor »Medicinska sestra si vzame čas in se mi posveti«, 13,68 % (n = 100) odgovor »Medicinska sestra ima smisel za humor, ki ga uporabi, da me sprosti« in 12,68 % (n = 94) odgovor »Medicinska sestra mi z neverbalno komunikacijo pomaga, da se počutim bolj sproščeno«. Med možnimi odgovori jih je 14,23 % (n = 104) izbralo odgovor, da s strani medicinske sestre ne dobijo nobene podpore oz. 13,95 % (n = 102), da je medicinska sestra v komunikaciji z njimi pasivna.

Slika 1 prikazuje stopnjo nelagodja in strahu pred in med ginekološkim pregledom, pri čemer 1 pomeni odsotnost nelagodja in strahu in 10 močno prisotnost nelagodja in strahu. Povprečna ocena stopnje nelagodja in strahu pred pregledom je bila $\overline{x}$ = 3,56 (s = 2,66), med pregledom pa $\overline{x}$ = 4,59 (s = 2,609).

Preverjanje hipotez

S Pearsonovim korelacijskim koeficientom smo preverjali statistično značilno razliko med starostjo in stopnjo nelagodja in strahu pred in med ginekološkim pregledom. Izkazalo se je, da starost ženske ni statistično pomembno povezana s stopnjo nelagodja in strahu pred pregledom (r = –0,075, p = 0,106) kot tudi ne s stopnjo nelagodja in strahu med pregledom (r = –0,070, p = 0,132).

S t-testom za neodvisne vzorce smo preverjali statistično značilno razliko med bivalnim okoljem ter stopnjo nelagodja in strahu pred in med ginekološkim pregledom. Izkazalo se je, da imajo anketiranke iz ruralnega okolja sicer višjo povprečno vrednost spremenljivke ($\overline{x}$ = 4,82, s = 2,76), ki meri stopnjo nelagodja med pregledom, vendar razlika v primerjavi z anketirankami iz urbanega okolja ($\overline{x}$ = 4,48, s = 2,53) ni statistično značilna (t = –1,345, p = 0,179). Statistično pomembna pa je razlika v stopnji nelagodja in strahu pred prihajajočim ginekološkim pregledom (t = –2,436, p = 0,015), in sicer anketiranke iz ruralnega okolja pred ginekološkim pregledom doživljajo višjo stopnjo nelagodja in strahu kot anketiranke iz urbanega okolja.



Slika 1: *Primerjava stopnje nelagodja in strahu pred in med ginekološkim pregledom*
Figure 1: *Comparison of levels of discomfort and fear before and during gynecological examination*

S Spearmanovim korelacijskim koeficientom smo preverjali statistično značilno razliko med doseženo stopnjo izobrazbe in stopnjo nelagodja in strahu pred in med ginekološkim pregledom. Izkazalo se je, da je stopnja nelagodja in strahu pred pregledom šibko, a statistično pomembno negativno povezana s stopnjo izobrazbe (r_s = –0,153, p = 0,001), kar pomeni, da anketiranke z višjo stopnjo izobrazbe doživljajo manj nelagodja in strahu pred ginekološkim pregledom kot anketiranke z nižjo stopnjo izobrazbe. Za stopnjo nelagodja in strahu med ginekološkim pregledom pa ni mogoče trditi, da je povezana s stopnjo izobrazbe (r_s = –0,068, p = 0,144). Prve hipoteze zato ne moremo v celoti potrditi, saj doživljanje ginekološkega pregleda s starostjo ženske ni povezano, z bivalnim okoljem in stopnjo izobrazbe pa je povezano le deloma.

V primeru testiranja druge hipoteze smo s *t*-testom za neodvisne vzorce ugotavljali, ali se stopnja nelagodja in strahu pred in med ginekološkim pregledom razlikujeta med anketirankami, ki so pritrdile, da medicinska sestra opazi njihovo nelagodje in strah ter se na to odzove, oz. tistimi, ki so to zanikale. Tiste anketiranke, pri katerih je medicinska sestra opazila nelagodje in strah in se je na to odzvala (n = 156, 32,8 %), navajajo nižjo stopnjo nelagodja in strahu pred ($\overline{x}$ = 3,37, s = 2,58) oz. med ginekološkim pregledom ($\overline{x}$ = 4,44, s = 2,68) v primerjavi s tistimi, pri katerih ni bilo odziva s strani medicinske sestre. Slednje navajajo razmeroma večjo stopnjo nelagodja in strahu pred (n = 309, $\overline{x}$ =3,61, s = 2,64) in med (n = 308, $\overline{x}$ = 4,66, s = 2,55) ginekološkim pregledom. Ob preverjanju statistično značilnih razlik se je izkazalo, da glede na navedeni odziv medicinske sestre s strani anketirank razlike med skupinama testiranih spremenljivk niso statistično značilne niti pri stopnji nelagodja in strahu pred ginekološkim pregledom (t = –0,931, p = 0,352) niti pri stopnji nelagodja in strahu med ginekološkim pregledom (t = –0,888, p = 0,375). Tudi druge hipoteze tako ne moremo potrditi.

Diskusija

Rezultati raziskave kažejo, da bivalno okolje in stopnja dosežene izobrazbe vplivata na stopnjo nelagodja in strahu pred ginekološkim pregledom, medtem ko na doživljanje med ginekološkim pregledom nimata vpliva. Ženske iz ruralnega okolja pred samim ginekološkim pregledom doživljajo višjo stopnjo nelagodja in strahu kot tiste iz urbanega okolja. Ženske z višjo stopnjo izobrazbe občutijo manjšo stopnjo nelagodja in strahu pred ginekološkim pregledom v primerjavi z ženskami z nižjo stopnjo izobrazbe. V raziskavi se starost ženske ni ugotovila kot pomemben pokazatelj doživljanja ginekološkega pregleda.

Nasprotno Hilden in sodelavci (2003) ugotavljajo, da starost vpliva na stopnjo nelagodja med ginekološkim pregledom. Najvišjo zaznano stopnjo nelagodja so identificirali pri ženskah med 18. in 25. letom starosti. Fiddes in sodelavci (2003) v raziskavi, opravljeni na Škotskem, ugotavljajo, da ženske nad 25. letom in ženske, ki so že bile noseče, ginekološki pregled doživljajo mnogo bolj pozitivno kot mlajše ženske in ženske, ki še niso bile noseče. Podobno zaključujejo tudi Yanikkerem in sodelavci (2009), ko ugotavljajo, da ženske do 25. leta,

z dokončano osnovnošolsko izobrazbo, nezaposlene in z nižjimi dohodki med ginekološkim pregledom občutijo nelagodje in sram. Običajno si prav slednje največkrat želijo, da pregled opravi ženska, kar v raziskavi odkrivajo tudi Starešinič in Mihelič Zajec (2014).

Zdi se, da je spol izvajalca ginekološkega pregleda za ženske ključen predvsem z vidika empatije, medsebojnega odnosa oz. prepričanja, da ženske tovrstne probleme lažje zaupajo ženski. Rezultati pričujoče raziskave kažejo, da sta se iz tovrstnih razlogov dve tretjini anketirank odločili za ginekologinjo in tretjina za ginekologa. Poleg že omenjenih nekatere druge študije navajajo še religiozne in kulturne vzroke (Racz, et al., 2008; Yanikkerem, et al., 2009). Rizk in sodelavci (2005) v študiji, opravljeni v Združenih arabskih emiratih, ugotavljajo, da večina žensk izbere ginekologinjo zaradi občutka sramu, če jo pregleduje moški, in iz verskih razlogov. Yanikkerem in sodelavci (2009) še ugotavljajo, da obstaja velika verjetnost, da bodo ženske, ki se redno udeležujejo ginekoloških pregledov, raje izbrale ginekologa kot ginekologinjo.

Izbor izvajalca ginekološkega pregleda je vse prej kot zavestna odločitev ženske, ampak največkrat produkt popkulture. Kincheloe (2004) izpostavlja zlasti vpliv tiskanih medijev, ki so namenjeni ženski ciljni publiki. Avtor je skozi analizo izbranih bolje prodajanih revij v Združenih državah Amerike, med katerimi imajo nekatere tudi slovensko izdajo, potrdil spolno pristranskost do ginekologov in splošnih zdravnikov, ki jo skozi prispevke in oglaševanje, posredno ali neposredno sporočajo bralkam. Ti predsodki prevzemajo različne forme, tudi v obliki, ki promovira izbor ginekologinje oz. ženske izvajalke. Tovrstna dejanja imajo seveda širše družbene posledice, ki so predvsem povezane s procesom (de)profesionalizacije medicine ali pa tudi zdravstvene oz. babiške nege.

Na zmanjševanje nelagodja in strahu pred in med ginekološkim pregledom pomembno prispevata védenje žensk, da bo poskrbljeno za njihovo zasebnost in varovanje osebnih podatkov, ter ustrezna podpora zdravstvenega osebja, ki se bo udejanjila skozi komunikacijo. Rezultati kažejo, da v manjšem deležu, a vendar prevelikem z vidika tolerance, spoštovanje zasebnosti in varovanje osebnih podatkov ni v celoti upoštevano. Iz pisnih zgodb anketirank je razvidno, da je zasebnost pogosto kršena zaradi neustrezno opremljenih prostorov (npr.: »Iz slačilnice se sliši čisto vse o prejšnji pacientki in njenem zdravstvenem stanju, ker slačilnica meji na ambulanto. To se mi zdi najbolj pereč problem in potem je tudi meni malo čudno o sebi razlagati, ker vem, da me poslušajo osebe v slačilnici, s katerimi sem prej delila čakalnico.«) ali ravnanja zdravstvenega osebja (npr.: »Težava je v obravnavi – problem zasebnosti. Stvari moraš razlagati še pred kakšno drugo pacientko, sestra pa se prav nič ne sekira.«).

Varovanje zasebnosti in poklicna molčečnost sta ključna koncepta v odnosu med pacientom in medicinsko sestro (Tabak & Ozon, 2004). Marinič (2012, p. 240) razpravlja, da je okolje, kjer pacient ne more zaupati zdravstvenemu osebju, ker se boji, da bi bili njegovi zdravstveni podatki zlorabljeni in da jih ne bi varovali kot skrivnost ali da bi jih drugi zdravstveni delavci izkoristili iz same radovednosti, za zagotavljanje kakovostne zdravstvene oskrbe slabo. V tem primeru medicinska sestra ne bo mogla pridobiti vseh pacientkinih podatkov o njenem zdravstvenem stanju in posledično ne bo mogla načrtovati kakovostne zdravstvene nege po meri pacientke. Spremembe praks se kažejo, poleg urejene infrastrukture, tudi na profesionalnem področju. V zdravstveni negi Tabak in Ozon (2004) izpostavljata zlasti aktivnosti na področjih izobraževanja medicinskih sester, menedžmenta zdravstvene nege in raziskovanja.

Glede na odgovore se medicinska sestra največkrat odzove na nelagodje in strah ženske s poslušanjem in svetovanjem, vendar so si bili vsebinski odgovori tistih anketirank, ki so jih podale, različni in predvsem očitno zaznamovani s predhodnimi izkušnjami. Informiranje in podajanje informacij v zvezi s potekom ginekološkega pregleda lahko bistveno prispevata k zmanjšanju nelagodja in strahu pred in med pregledom. Večina tistih, ki so zapisale svoja doživetja, iz strahu in nelagodja spraševanje po informacijah, ki jih v drugačnih okoliščinah morda ne bi. To lahko včasih sproži negativen odziv pri zdravstvenem osebju.

Številne študije dokazujejo, da je ginekološki pregled lahko pozitivna izkušnja, če je pacientka ustrezno informirana (Hilden, et al., 2003; Yanikkerem, et al., 2009). Komunikacija, bodisi verbalna ali neverbalna, je močno orodje. Toda Trojar in Ramšak Pajk (2013, p. 58) poudarjata, da dobra komunikacija s pacientko ni zgolj vešče sporočanje informacij, ampak pomeni tudi občutljivo opazovanje pacientkinih neverbalnih sporočil, ki kažejo, kako je sporočilo sprejela, in odražajo njene potrebe. Pristop je individualen in v vsaki situaciji drugačen: ni namreč vseeno, ali dodatno strpno dopolnjuje povedano ali pa molče stoji ob pacientki, se je rahlo dotakne in ji pozorno prisluhne. Anketiranke v pisnih odgovorih izpostavljajo prav slednje, prezrto neverbalno (npr.: »Morda bi bil smiseln kontakt na bolj osebni ravni. Da te pogleda v oči vsakič, ko človek pride na pregled in potem malo šale in bi imele ženske manj težav.«) in verbalno komunikacijo pri zdravstvenem osebju (npr.: »Na zadnjem pregledu, kjer je bila ginekologinja, me ni poslušala. Uporabila je štiri spekulume. Trdila je, da vidi maternični vrat, pa ga nimam več (op. histerektomija).«).

Za zmanjševanje neugodja in strahu pred in med ginekološkim pregledom niso potrebni zahtevni in še zdaleč ne dragi ukrepi. Kljub temu pa bi veljalo razmisliti tudi o drugih ukrepih, kot so ustrezno opremljeni prostori, ustrezno ogreti vaginalni spekulumi (Hilden, et al., 2003) ali celo raba lubrikanta pri vstavitvi vaginalnega spekuluma, ki se je v randomizirani klinični študiji izkazala kot pomemben element zmanjševanja bolečine med ginekološkim pregledom (Hill & Lamvu, 2012). Ameriško zdravniško združenje (angl. *American College of Physicians*) (Qaseem, et al., 2014) je v tem pogledu poskušalo narediti korak dlje, ki pa stroko prej deli kot

združuje. V objavljenih smernicah in priporočilih o izvajanju (enkratletne) notranje ginekološke preiskave (tudi bimanualne in rektalne preiskave; PAP-bris ni vključen), med asimptomatičnimi in nenosečimi odraslimi ženskami odsvetujejo njeno rutinsko izvajanje. Na podlagi trenutnih dokazov zaključujejo, da rutinsko (enkratletno) izvajanje notranje ginekološke preiskave ženske izpostavlja nepotrebnim zapletom (Qaseem, et al., 2014), s čimer pa se ne strinjajo ameriški ginekologi in porodničarji, ki pravijo, da bodo daljši intervali med pregledi imeli negativne posledice za pacientke in zdravniško prakso (Henderson, et al., 2014). (V pojasnilo: Ameriško združenje ginekologov in porodničarjev (Committee on Gynecologic Practice, 2012) priporoča enkratletni ginekološki pregled, ki vključuje pregled s spekulumi in bimanualno preiskavo pri vseh ženskah, starejših od 21 let.)

Nelagodje in strah pred ginekološkim pregledom sta lahko pogosto tudi vzrok za odpoved ali odlašanje obiska v ginekološki ambulanti. Zaradi številnih že omenjenih vzrokov lahko tovrstna dejanja resno ogrozijo zdravje ali življenje ženske, saj se lahko na ta način izogne npr. presejanju za odkrivanje raka materničnega vratu. Ivanuš in Primic Žakelj (2014) ugotavljata, da so neodzivnice organiziranih populacijskih presejalnih programov za raka materničnega vratu bolj ogrožene kot redne udeleženke presejalnih pregledov. V svetu zato iščejo načine, kako neodzivnice pritegniti k sodelovanju. Ena izmed takšnih obetavnih metod je tudi presejanje s testom HPV (Humani Papiloma Virus) doma, pri katerem ženska po pošti prejme tester za samoodvzem vaginalnega vzorca in ga tudi po pošti vrne v laboratorij. Šele v primeru okužbe z enim izmed onkogenih HPV je ženska povabljena na ginekološki pregled. Na ta način bi ženskam, ki se morda zaradi strahu pred ginekološkim pregledom izognejo presejanju, ponudili drugačno možnost odziva na presejalne programe.

Opravljena raziskava ponuja vpogled v zakulisje doživljajskega sveta žensk ob ginekološkem pregledu in kaže potrebe po izboljšanju nekaterih organizacijskih procesov, postopkov in krepitvi profesionalne vloge medicinske sestre. Potrebe po dodatnem raziskovanju so, zlasti zaradi neraziskanosti tega področja, nujne. Ob tem se tudi zaradi njegove specifičnosti kot izredno primerna kaže kombinacija različnih raziskovalnih metod. Z vidika proučevanja povezanosti demografskih spremenljivk in doživljanja ginekološkega pregleda bi bilo potrebno vključiti dodatne spremenljivke, poleg dodatnih demografskih spremenljivk tudi tiste, povezane s socialno-ekonomskim statusom ter značilnostmi ginekološke anamneze.

Omejitve raziskave

V raziskavi je bil uporabljen nenaključni, priložnostni vzorec, kar z metodološkega vidika predstavlja omejitev v posploševanju predstavljenih rezultatov. Z rabo priložnostnega vzorca so možne številne, manjše ali večje omejitve v reprezentativnosti vzorca (Burns & Grove, 2009). Priložnostni vzorec in način anketiranja sta bila prvenstveno izbrana zaradi narave preučevane tematike, ali kot pravita Burns in Grove (2009), pri nekaterih tipih pacientov s specifično tematiko je težko drugače proučevati problem, saj se z njihove strani pogosto pojavi odklonilni odnos. Tudi zaradi te predpostavke niso bili postavljeni izključitveni kriteriji vzorčenja. Čeprav je večina anketiranih imela ginekološki pregled v zadnjih šestih mesecih, Hilden in sodelavci (2003) navajajo, da lahko skozi daljše časovno obdobje ženske težje prikličejo v spomin občutke in stopnjo nelagodja, povezano z ginekološkim pregledom.

Zaključek

Ginekološki pregled je za ženske nekaj, kar jih spremlja skoraj celo življenje in jim, kot kaže raziskava, vsaj na neki stopnji povzroča občutke strahu, sramu in nelagodja. Ginekološkega pregleda ne moremo enačiti s čisto vsakim pregledom v zdravstveni instituciji. Čeprav ima vsak pregled svoje specifike, ginekološki pregled predstavlja vstop v intimo ženske. Za nekatere pa tudi vstop v druge sfere zasebnega ali družbenega življenja, saj se na ta način lahko razkrijejo spolne prakse ali zlorabe. Pri preprečevanju teh neprijetnih občutkov in strahov je profesionalna vloga medicinske sestre, ki se osredinja v komunikacijo in podporo, nenadomestljiva. Slednje je še prav posebej pomembno ob prvem ginekološkem pregledu, saj prva izkušnja zaznamuje dojemanje in vpliva na doživljanje bodočih ginekoloških pregledov.

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