LETTERS

Teaching vaginal examination

EDITOR,—Having just spent a week examining medical students in the final MB, I am convinced of the need for an improved standard of training in all aspects of clinical examination, especially vaginal examination. As a teacher I could take no sense of pride in watching fumbling medical students desperately trying to impress on an examiner that they knew what they were doing when clearly they had rarely, if ever, inserted a vaginal speculum during their training.

If the operating theatre is not an appropriate place to learn vaginal examination then where is? Surely not the outpatient clinic, where throughput is so rapid that there is no time for the student and patient to develop rapport, or the ward, which is always bustling with people in these enlightened days of open visiting.

By taking such a negative attitude towards vaginal examination of anaesthetised patients and differentiating between the vaginal and other organs Susan Bewley is instilling into us the views of an articulate and vociferous minority who will, if allowed to continue, undermine the education of future generations of doctors.[1] It is hard enough to encourage medical students to come to the operating theatre without making them feel that if they examine patients they may be committing a criminal offence.

Some years ago, in response to demands from the local community health council, we introduced signed consent to clinical examination by medical students as part of the form giving consent to operation. Only a handful of women have ever refused to sign this part of the form. But surely by introducing different "rules" for medical students we are making the learning process more difficult and differentiating the medical student-patient relationship from the doctor-patient relationship.

Personally, I would prefer to see a new generation of well trained doctors who are able to relate appropriately to women who require gynaecological examination rather than a nation of women whose vaginas are protected from battery by medical students.

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1 Bewley S. The law, medical students, and assault. *BMJ* 1992;**304**:1551-3. (13 June.)

EDITOR,—After reading Susan Bewley's article I was left with one question: do medical students really need to learn how to perform a vaginal examination?[1] I think not. In 11 years of practising general internal medicine, both in hospital and in the community, I have yet to do a vaginal examination. I passed my postgraduate examinations without having to know about it. Even if I found or suspected something abnormal on vaginal examination a more experienced finger than mine would be needed to confirm and interpret the finding. I can thus spare my female patients (and myself) the additional embarrassing examination by referring them to the appropriate expert.

Vaginal examination could easily be taught to first time senior house officers in obstetrics and gynaecology (either general practice trainees or prospective gynaecologists) without anybody suffering. The trainee would then be a qualified doctor, a member of the team with a direct interest in the patient's welfare. Under such circumstances consent would not be an ethical or legal problem. All other doctors apart from those practising obstetrics and gynaecology need know only that vaginal examination, like psychoanalysis, is best left to those trained in it.

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1 Bewley S. The law, medical students, and assault. *BMJ* 1992;**304**:1551-3. (13 June.)

EDITOR,—Susan Bewley's article opens a new debate on an old subject—namely, the need for respect for patients and how their consent is obtained by doctors and others who care for them.[1] The charge of battery for examination without consent has not been tested in court, and the risk of such a charge being raised is minimal. Bewley emotively uses vaginal examinations by medical students to illustrate the question of respect and consent. After 30 years of teaching medical students to perform vaginal examinations I believe that such teaching could and should be completely abandoned.

All trainee general practitioners and gynaecologists are taught the value and limitations of vaginal examination as postgraduates. Doctors working in other specialties do not perform vaginal examinations, so only those who need the skill should acquire it, and they should do so as doctors, not as medical students. Gynaecologists could then concentrate on teaching medical students about women's needs for medical care related to their reproductive organs, and the sensitivities and human values be illustrated by giving such care.

The present approach whereby all students are taught vaginal examination is unjustified as well as educationally harmful to the students. I am sure that if the teaching of vaginal examination to medical students was stopped for 12 months as an experiment it would never be considered necessary to restart it.

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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

Management of breast cancer

EDITOR,—In responding to J Michael Dixon's review of the management of elderly patients with breast cancer[1] I H Kunkler argues for a palliative approach aimed at improving quality rather than duration of life, particularly for the large proportion of women with locally advanced disease.[2] In Edinburgh Roberts *et al* showed that even during a screening trial more than a third of symptomatic women present with advanced disease.[3] The proportion is highest in women living alone—and elderly people commonly live alone. It would, however, be too easy to assume that palliation alone is required. Of 100 elderly or frail patients (median age 76·3 years) treated in this centre with tamoxifen as primary treatment for non-metastatic breast cancer, 47 had T4 tumours and 14 had T3 tumours.[4] Initially 68 patients responded, but 53 of these required subsequent treatment. Despite failure of local control overall in 42% of patients the five year survival was almost 60%.

In two reviews of radiotherapy in this department over the past 16 years we have found that the technique and dose are important. Langlands *et al* showed that low dose palliative techniques given in a few fractions for convenience were more commonly used in elderly people but produced poorer control of disease (table).[5] More recently, Price *et al* showed that even high dose but palliative techniques produce poorer locoregional control of disease.[6]

Relation between radiation dose, mean age, and control of local disease at death

Radiation dose (Gy)	No of patients	Mean age (years)	Control of local disease at death (%)
30	23	72·3	19
40	10	65·4	
45	132	59·2	41

Clearly, elderly patients can survive many years after breast cancer is diagnosed. Treatment should be as radical as the stage requires and the patient can tolerate. Admittedly, radiation therapy can take several weeks to deliver. Arrangements for travel and so on should be such as to ensure minimal stress. The alternative of short palliative techniques will be poor control of disease, resulting in the increased stress precipitated by advancing local disease.

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1 Dixon JM. Treatment of elderly patients with breast cancer. *BMJ* 1992;**304**:996-7. (18 April.)
2 Kunkler IH. Treating elderly patients with breast cancer. *BMJ* 1992;**304**:1377. (23 May.)
3 Roberts MM, Alexander FE, Elton RA, Rodger A. Breast cancer stage, social class and impact of screening. *Eur J Surg Oncol* 1990;**16**:18-21.
4 Akhtar SS, Allan SG, Rodger A, Chetty U, Smyth JF, Leonard RCFL. A ten year experience of tamoxifen as primary treatment of breast cancer in 100 elderly and frail patients. *Eur J Surg Oncol* 1991;**17**:30-5.
5 Langlands AO, Kerr GR, Shaw S. The management of locally advanced breast cancer by x ray therapy. *Clin Oncol* 1976;**2**: 365-71.
6 Price A, Kerr GR, Rodger A. Primary radiotherapy for T4 breast cancer. *Clin Oncol* (in press).

EDITOR,—Neither R D Rubens nor J Michael Dixon considered an important element of the management of breast cancer.[1,2] A King's Fund consensus conference recognised the high rates of psychiatric morbidity in patients with primary breast cancer and recommended that a psychiatrist should be attached to each district team.[3] A recent