REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC

www.rbmfc.org.br
ISSN 2179-7994

Quality Improvement

Potentialities of feminist gynecological care: an experience report of a medical student at a Family Practice institution in São Paulo

Potencialidades do atendimento ginecológico pela perspectiva feminista: um relato de experiência de uma estudante de Medicina em uma instituição de médicas de família e comunidade em São Paulo

Potencialidades de la atención ginecológica desde una perspectiva feminista: relato de experiencia de una estudiante de Medicina en una institución de médicos familiares y comunitarios de São Paulo

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Abstract

Problem: Feminist movements of the 20th century advocated for changes in medical care provided to women, aiming at promoting self-knowledge and autonomy while going against oppression or body pathologization. They fought for a more tolerant and inclusive healthcare system, which could provide women ownership over their own bodies. Feminist-oriented Medicine sees women as subjects of right, whose wants and needs directly stand face-to-face with medical knowledge. It is, therefore, important to rethink and readjust current gynecological care models in light of autonomy, shared decision-making, self-knowledge, and female protagonism, placing the patient at the center of her own health care. **Methods:** This is a descriptive and qualitative study, in the form of an experience report, which aims to describe the experience of an 8th-term Medical student in a feminist-oriented family practice institution in São Paulo, Brazil. **Results:** The results consist of unusual medical space characterization, mostly in the form of living rooms, judgment-free anamnesis, gynecological physical examination performed in the super flexion position with the aid of a hand mirror, self-insertion of vaginal speculum, detailed narration and explaining of all procedures and conclusions and, lastly, shared decision-making through evidence-based medicine. **Conclusions:** It was possible to conclude that the feminist-oriented female health care provided by the aforementioned family practice institution fulfills the role of empowering, teaching, including, and bringing patients to the forefront through a safe and trusting environment, judgment-free and attentive hearing, promotion of control over their own bodies, and possibility to collectively make choices related to their health care. As a result, it is possible to perceive self-aware patients, immersed and interested in their own care, feeling respected, welcomed and comfortable, and who are capable of noticing and naming changes in their own bodies, becoming an integral part of their own care.

Keywords: Family practice; Decision-making shared; Evidence-based medicine; Gynecological examination; Women's health.

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E-mail: ana.apolaro@gmail.com
Funding:
no external funding.
Ethical approval:
yes.
Informed Consent Form:
not applicable.
Provenance:
Not commissioned.
Peer review:
External.
Received: 02/25/2024.
Approved: 02/01/2025.
Associate Editor:
Francisco Eduardo da Fonseca Delgado

How to cite: Apolaro AVMM. Potentialities of feminist gynecological care: an experience report of a medical student at a Family Practice institution in São Paulo. Rev Bras Med Fam Comunidade. 2025;20(47):4128. https://doi.org/10.5712/rbmfc20(47)4128

Resumo

Problema: Movimentos feministas do século XX advogaram por mudanças no atendimento médico à mulher, prezando por autoconhecimento, autonomia, não opressão ou patologização de corpos, por um sistema mais tolerante, inclusivo e que desse à mulher propriedade sobre o próprio corpo. A Medicina regida pela perspectiva feminista veria as mulheres como pessoas de direito, cujos interesses colocam-se frente a frente com o saber médico. Frente a isso, torna-se importante repensar e readequar os modelos de atendimento ginecológico vigentes à luz dos conceitos de autonomia, decisão compartilhada, autoconhecimento e protagonismo femininos, colocando a paciente no centro de seu próprio cuidado. **Método:** Este trabalho se trata de um estudo descritivo e qualitativo, do tipo relato de experiência, que busca descrever as vivências de uma estudante do 8º período de Medicina em uma instituição de médicas de família e comunidade que oferece atendimento à mulher pela perspectiva feminista em São Paulo. **Resultados:** Entre os resultados encontrados, tem-se a ambientação não usual do consultório em forma de sala de estar, anamnese livre de julgamentos e assunções, exame físico ginecológico em posição de superflexão, oferecimento de autoinserção de espéculo vaginal, auxílio de espelhinho de mão e narração e detalhamento de todos os procedimentos e conclusões obtidas; e, por fim, tomada de decisão compartilhada com base em evidências científicas. **Conclusão:** Diante da experiência vivenciada, é possível concluir que o atendimento à mulher pela perspectiva adotada pelas médicas de família e comunidade em questão cumpre o papel de empoderar, ensinar, incluir e trazer à frente suas pacientes, oferecendo-lhes ambiente seguro e de confiança, escuta atenta e livre de assunções ou preconceitos, controle sobre seus próprios corpos e possibilidade de decidir conjuntamente condutas em saúde. Como resultado, observam-se mulheres atentas a si, imersas e interessadas em seu cuidado, sentindo-se respeitadas, acolhidas e capazes de identificar e nomear alterações em seus corpos, se tornando parte integral de seu próprio cuidado.

Palavras-chave: Medicina de família e comunidade; Tomada de decisão compartilhada; Medicina baseada em evidências; Exame ginecológico; Saúde da mulher.

Resumen

Problema: Los movimientos feministas del siglo XX abogaron por cambios en la atención médica de las mujeres, valorando el autoconocimiento, la autonomía, la no opresión o patologización de los cuerpos, por un sistema más tolerante y inclusivo que otorgara a las mujeres la propiedad de sus propios cuerpos. La medicina regida por la perspectiva feminista vería a las mujeres como personas con derechos, cuyos intereses se enfrentan con el conocimiento médico. Ante eso, es importante repensar y reajustar los modelos actuales de atención ginecológica a la luz de los conceptos de autonomía, toma de decisiones compartida, autoconocimiento y protagonismo femenino, colocando a la paciente en el centro de su propio cuidado. **Método:** Este trabajo es un estudio descriptivo y cualitativo, del tipo relato de experiencia, que busca describir las vivencias de una estudiante de Medicina del 8º período en una institución de médicos familiares y comunitarios que ofrece atención a mujeres desde una perspectiva feminista en São Paulo. **Resultados:** Entre los resultados se encuentran la inusual ambientación del consultorio en forma de sala de estar, anamnesis libre de juicios y suposiciones, examen físico ginecológico en posición de superflexión, ofrecimiento de autoinserción de espéculo vaginal, asistencia con espejo de mano, narración y detalle de todos los procedimientos y conclusiones obtenidas; y, finalmente, la toma de decisiones compartida basada en evidencia científica. **Conclusión:** Dada la experiencia, se puede concluir que la atención a las mujeres desde la perspectiva adoptada por los médicos de familia y comunitarios en cuestión cumple el rol de empoderar, enseñar, incluir y poner en primer plano a sus pacientes, ofreciéndoles un ambiente seguro, de confianza, de escucha atenta y libre de suposiciones o prejuicios, dándoles control sobre el propio cuerpo y posibilidad de decidir conjuntamente sobre conductas de salud. Como resultado, se observa que las mujeres están atentas a sí mismas, inmersas y interesadas en su cuidado, sintiéndose respetadas, acogidas y capaces de identificar y nombrar los cambios en su cuerpo, convirtiéndose en parte integral de su propio cuidado.

Palabras clave: Medicina familiar y comunitaria; Toma de decisiones conjunta; Medicina basada en la evidencia; Examen ginecológico; Salud de la mujer.

INTRODUCTION

Michel Foucault (1926-1984) brings in his vast work the concept of biopower, understood as a form of non-coercive political-social control of populations based on biological knowledge, or, in this case, medical knowledge.[1] Biopower in Gynecology, in turn, involves the existence of health concepts that define right and wrong, appropriate and inappropriate within female sexuality and health.[2] Accordingly, the medical-patient encounter becomes an opportunity for the physician — the expert, knowledgeable and dominant — to exercise such power over the patient — the layperson, unaware and receptive. Women's empowerment, in this case, is inadvisable and the patient must undergo examinations, procedures, and conducts (often embarrassing and uncomfortable, without prior consent or explanations

of its importance) in order to obtain good health. When choosing not to do so, the patients are deemed irresponsible and combative.[2]

Feminist movements that began in the 1960s and the 1970s fought for, above all, self-knowledge and autonomy, for a reform of the current medical model, and for the non-oppression or pathologization of bodies. The idea of a more tolerant, inclusive, and accessible healthcare system was defended.[3,4] Women of the time proposed a non-alienating medical knowledge and behavior, which conferred women ownership over her own bodies and that should take as a premise the shared decision-making regarding procedures and conducts.[3,4] Medicine ruled by the feminist perspective, based on the objection to the control of bodies, violence, prejudice, sexisms, and various judgments,[4,5] would see women as subjects of right, whose needs, desires, and interests stand face-to-face with medical knowledge . Doctors must actively listen to the patient, exploring the patient's biopsychosocial, cultural, and economic context.[6,7]

Gynecological consultation in Primary Health Care (PHC) should include longitudinal and comprehensive care for women's health, including diagnosis and treatment of complaints, prevention of sexually transmitted infections (STIs), contraception, screening for gynecological cancers, climacteric, prenatal care, preparation for childbirth, and postpartum period,[8] and should inquire about gynecological, obstetric, sexual, and reproductive history. Overall, medical conducts deemed appropriate in gynecological consultations, according to the literature, involve anamnesis free from judgments, prejudices, or assumptions, using open-ended questions that avoid bias — for instance, related to the sexuality or the reproductive history of the patient.[9] The professional must behave carefully, comprehensively, calmly, and in an interested way.[8]

Conducts related to the gynecological physical examination include paying attention to the physical environment and nonverbal communication.[9] Physicians are expected to pay attention to the patient's comfort, so as to provide a gown for changing clothes and have the material positioned at the examination site. They should position themselves respectfully in a seat, chair, or beside the patient, narrate the sequence of procedures involved in the examination before performing it,[9] wear gloves, insert and remove the vaginal speculum gently, and watch for the patient's reaction to possible discomfort during the examination or other procedures involved in its entirety.[8] It is recommended that doctors avoid standing too close to the intimate region and that they also immediately inform when the examination is done.[9]

Authors of recent studies point to procedures that can be used in an attempt to relieve discomfort and the sensation of lack of control common during the gynecological physical examination. One of them, for example, is to offer the use of a hand mirror so that the patient follows the step-by-step of her examination. Initially, in 1989, in Germany,[10] it was noticed that the use of the mirror for patients who accepted it led to increased satisfaction during the consultation. In turn, in 2021, in the United States,[11] the use of the mirror increased the sense of control and self-knowledge, although it did not effectively reduce pain or vulnerability rates. Furthermore, there are also questions about the traditional gynecological position (lithotomy), in which the patient is placed in the supine position, with lower limbs apart and in foot supports,[12] without the possibility to follow her examination. Conversely, the super flexion position[13] (legs bent over the thighs and thighs bent over the abdomen, in abduction) is an alternative, for example, to facilitate the physical examination of obese women or patients whose traditional speculum examination has been unsatisfactory, for several reasons. This position causes the uterus to posteriorly fall and bring the cervix closer to the vaginal introitus, allowing clearer anatomical uterine and vaginal inspection,[13] in addition to allowing greater control of the patient over the examination itself, considering that, in this position and with the back supported and elevated, she can use the mirror and can see the performed procedures.

Regarding the definition of conduct and decision-making within the physician-patient relationship, it has been observed that the shared decision-making (SDM) process is a collaborative model based on evidence and preferences, in which the doctor and patient jointly make decisions, based on scientific evidence and focusing on the person-centered care.[14,15] The focus is shifted from the disease to the patient and to how they experience their health status, besides the feelings and ideas they have about it. In this model, the doctor has the role of offering conduct options involving physical examination procedures, screening pathologies, and the use of drug therapies, explaining the degree of evidence and risk/benefit of each of them. The patients, then, have the opportunity to learn about their health and become a protagonist in making decisions that affect them.[14-16] In Gynecology, shared decision-making involves mainly the fields of physical examination (speculum examination and vaginal palpation), screening for gynecological pathologies (breast ultrasonography, mammography, and cervical oncotic colpocytology — also known as Pap Smear), drug therapies (e.g., bone loss during climacteric), contraception and protection against STIs, actively placing the patient within the decision process on her health care.[15,17]

From these data, it is important to rethink and readjust the models of gynecological care in force in light of the concepts of female autonomy, shared decision-making, self-appropriation, self-knowledge, and protagonism, placing the patient at the center of her own care.

The objective of this article was to report the experience of a medical student in an observational internship in a family practice institution focused on women's care from the feminist perspective. Secondary objectives included elucidating, in practice, how the space setting, the conduct of anamnesis, the physical examination, and the decision-making regarding conduct are structured; and to highlight the beneficial effects on female health care observed as a result of this care model.

METHODS

This is a descriptive and qualitative study, of the experience report type, seeking to describe the experience of a student of the 8th term of Medical School in a family practice institution that provides care to women from the feminist perspective in São Paulo, Brazil.

RESULTS AND DISCUSSION

Space setting

The space intended for providing care has the structure of a house similar to any other house. It consists of two floors, being the first composed of a reception and a waiting room, a bathroom, a kitchen, and an office; and the second, of three other offices, a bathroom, and a shared meeting/study room, with books and booklets available for consultation. The structure of the rooms does not resemble a traditional medical office, but rather prioritizes comfort and open dialogue between doctor and patient. The floor and furniture are predominantly made of wood, and there is no table or other structure separating the professional from the patient, both of them have fabric or leather armchairs, one in front of the other. The doctor places her laptop on an easel beside her and makes notes during the conversation. Inside each room there is also a bathroom with luggage storage, a stretcher for the physical examination, cabinets with drawers labeled for identification of materials and supports for equipment pertinent to the examination (speculum, lubricant, kit for performing oncotic colpocytology). Within all rooms there are anatomical

models of the breasts, female pelvis, and exemplars of contraceptive methods (IUD, diaphragm, condom, among others), used in the process of health education. Each patient is happily greeted by her doctor still in the waiting room, and then invited to accompany her to the service room for the 60-minute consultation. It is worth mentioning that, at the beginning of each appointment, doctor and patient entered the room and the door was closed. The doctor then explained the presence of the intern and asked the patient if she felt comfortable with my presence during her consultation. If not, her will was respected and the consultation was conducted normally. If she accepted my presence, the doctor then opened the door and invited me to enter for continuing with the appointment.

Conducting the anamnesis

Upon entering the room, the patient is invited to sit in front of the doctor and feel comfortable. When it comes to first consultations, anamnesis begins with open-ended questions and devoid of assumptions — gender, age, profession, habits, and the reason for searching care. Faced with the gynecological demand or complaint (which constitutes most consultations), the doctor then deepens into details related to sexual and reproductive health, asking about sexual orientation, partners, contraception, obstetric history, and intimate hygiene habits. No response is received with astonishment, judgment, or any kind of discomfort by the doctor. All that is said is welcomed with tranquility and attention. I noticed that patients show little or no discomfort in narrating personal characteristics, habits, or events that could be received with astonishment in other services, which I consider quite positive, as such reactions end up inhibiting, constraining, and preventing patients from truly benefiting from the consultation, which is deemed harmful to their treatment.

Subsequently, patients are asked about the human body systems, personal and family history of any pathologies, which will later influence the process of medical conduct and decision-making. From the patient's report, the doctor asks complementary questions to achieve an adequate biopsychosocial picture, with special attention in identifying triggers, conflicts, or trauma. Many patients report a health history marked by prejudices, mainly related to medical homophobia and fat-shaming, reporting that this history is the reason why they are currently seeking care from the feminist perspective. Usually, patients were emotional when reporting such violence suffered previously in the health scenario, verbalizing their negative impact on their mental health, self-image, and self-perception. Conversely, I noticed the ease with which many women — usually longtime patients — identified and named changes in their bodies, often mentioning guidelines received in previous consultations, showing a very positive mastery of their health status.

Performing the gynecological physical examination

After the first part of the consultation, the doctor asked if the patient was comfortable to have the gynecological physical examination, explaining its necessity and benefit in the current context (for instance, for investigating breast or pelvic complaints or doing the Pap Smear when necessary). Most patients calmly agreed to the physical examination and did not show discomfort in having it. A minority stated to understand the importance of the examination at that time, but indicated preferring to have it in the next consultation, for several reasons (menstrual cycle, insecurity, discomfort, or bad memories of previous experiences in other services). Faced with the refusal, the doctor behaved in a caring and comprehensive manner, stating that from the understanding of the risks and benefits of the examination, the patient had the right to choose not to be examined in that consultation, without harming the continuity of her appointment.

If the patient agreed to the examination, the doctor then invited her to undress herself privately inside the bathroom and gave her a gown in case she wanted to use if. Upon leaving the bathroom, the patient was then led to the stretcher and instructed to lie comfortably. Subsequently, the doctor explained that the gynecological examination happened differently from other services, starting with the gynecological position. The patient supported the back on a triangular pillow, with the headboard elevated. The legs were not placed on foot supporters, but rather bent in a flexion and abduction position, with the heels resting on the stretcher. For all patients, the doctor offered a small rectangular mirror and asked if the patient would like to follow her examination through the mirror. Most patients showed curiosity and excitement, accepting the use of the mirror and stating that they had never had this possibility before. A few would prefer not to see anything, which was respected in the same way.

It was then explained what the examination would consist of (investigation of the breasts, insertion of speculum, cervical cytology collection, palpation, among other procedures). After understanding and consenting it, the doctor then approached the patient, bringing the seat, light source, and support with the necessary materials. When applicable, she started with breast examination and then did the pelvic examination. The doctor showed the packaged equipment for the patient and explained what it was for. By the position, the patient could see and follow the step by step comfortably. After putting on gloves, the doctor checked if the patient was able to see the examination through the mirror and then showed her the speculum. After removing the package, it was asked if the patient would feel more comfortable inserting and opening the speculum herself. Most of the patients stated that they prefer to perform the insertion and opening, and then the doctor guided the most comfortable and anatomical way of doing so, helping them. Some patients preferred the doctor to insert the speculum, which was respected in the same way. With the patient's consent, the step by step of the examination was narrated sequentially, and the patient was informed of any sensations or discomforts she could feel. All findings and observations, including the anatomical description of the vulva, were shared with the patient and shown through the mirror, with room for doubts or inquiries about what the patient saw or wanted to know about herself. Some of the patients were not familiar with the structures of the vulva, vagina, or uterus and did not know exactly what the objective of the speculum examination or cervical cytology collection was. It was explained that the objective was to find and collect material from the cervix (to facilitate the explanation, the anatomical models of the pelvis were often used, in which the structures were evidenced in a didactic way) — this could even be visualized through the mirror if the patient wanted. I noticed that the technique not only offered comfort to the patient, but also taught and empowered her about her own body. For the first time, many patients were getting to know their anatomy or understanding the characteristics and objectives of the gynecological examination, which they had undergone several times. The patient shifted from a place of receiving and accepting medical care to a place of knowledge, protagonism, and conducive to self-knowledge. It was quite clear to realize that, when in this position, patients faced the examination much more comfortable, safe, and conscious.

Decision-making and conduct

After having the physical examination, the patient was invited to return to her seat and continue the conversation with the doctor, where the main points of the anamnesis and the physical examination were summarized. The doctor made her main diagnostic hypotheses and considerations regarding the overall and gynecological health of the patient, explaining how each hypothesis was formulated and consolidated

from anamnesis and physical examination findings, mentioning the diagnostic criteria used and its source. At each statement the doctor asked if what was said made sense and was in line with the patient's personal views and impressions, and the patient had the possibility to agree or disagree, bringing her own thoughts to debate. Once again, the doctor paid attention to the triggers and the past bad experiences, specially committed not to repeat speeches or similar actions, and was receptive to everything the patient had to say, bringing clarifications and new arguments when necessary. Regarding decision-making and conduct, the doctor then shared the different possibilities of what could be proposed for that patient — drug therapies, changes in lifestyle, complementary tests, screening of more common pathologies, contraception, and protection against STIs. For each of them, the degree of scientific evidence, risks, and benefits were presented, and the patient could clarify any questions or doubts. Then, the doctor asked the patient about what conducts made more sense to her and she was given the possibility to make conscious and informed decisions about her health. The patient, aware of the risks and benefits, could then choose which conduct she found most appropriate, which was respected by the doctor.

We can conclude that the feminist-oriented health care provided to women by the aforementioned family and community doctors fulfills the role of empowering, teaching, including, and bringing patients to the forefront, providing them with a safe and trusting environment, judgment-free and attentive hearing, control over their own bodies, and the possibility to collectively make decisions related to their health care. As a result, we observed women attentive to themselves, immersed and interested in their care, feeling respected, heard, comfortable, and welcomed during their appointments and able to know, identify, and name characteristics and changes in their bodies, becoming an integral part of their own care.

The limitations placed by the structuring, resources, and scope of PHC and the Brazilian Unified Health System (SUS) nowadays in Brazil are deemed to prevent the model described in this report from becoming a national reference in women's care. However, it is necessary to take the first step and have something to mirror — this is just the beginning of a long process. Therefore, I make my report available as a proposal for review and remodeling of the current models of women's care in other services and territories.

ACKNOWLEDGEMENTS

I would like to thank the team of family and community doctors, who warmly welcomed and provided me with the most diverse theoretical and practical tools for the care of women in all their needs.

CONFLICT OF INTERESTS

Nothing to declare.

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