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Ethical Decision Making in Gynaecological Ultrasound Practice

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Consent, autonomy and professional accountability in TVUS

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Learning Objectives

This session focuses on ethical decision-making in autonomous gynaecological ultrasound practice, with emphasis on:

- Transvaginal ultrasound (TVUS) as an intimate examination
- Real-time consent and patient-centred decision-making
- Managing complexity: capacity, safeguarding, and distress
- Professional accountability and documentation

Why Ethics Matters in Gynaecological Ultrasound

Where ethical risk arises in practice

- TVUS as an intimate and potentially distressing procedure
- Power imbalance between practitioner and patient
- Real-time decision-making without immediate clinical oversight
- Increasing diversity in patient populations
- Complaints and litigation often relate to communication, consent, and dignity—not diagnosis

Fundamental Principles of Ethics

Applying ethical principles in real-time scanning

- Autonomy: valid, ongoing, withdrawable consent
- Beneficence / non-maleficence: clinical value vs patient distress
- Dignity: privacy, language, positioning, control
- Justice: equitable access without assumption or bias

Professional and legal framework

- BMUS (2025): Transvaginal Ultrasound Guidance
- SoR (2023): Intimate Examinations & Chaperone Policy
- SoR/BMUS: Guidelines for Professional Ultrasound Practice
- GMC (2024): Intimate examinations and chaperones
- RCR guidance
- Local trust policies

Practice must be defensible, documented, and patient-centred

Infection prevention

Infection prevention and governance

- Use sterile ultrasound gel where indicated
- Follow probe decontamination protocols
- Use probe covers appropriately
- Align with local IPC and national guidance

Ethical practice includes safe systems, not just communication

Consent in TVUS

Must be informed, voluntary, and ongoing

Requires explanation of:

- Nature of examination
- Alternatives (e.g. transabdominal)
- Potential discomfort

- Explicit verbal consent required before probe insertion
- Patients may pause or withdraw consent at any time

Operationalising consent

- Consent is a process, not a one-off event
- Check understanding, not just agreement
- Monitor verbal and non-verbal cues
- Reconfirm consent if:
  - Technique changes
  - Discomfort increases
  - Findings require extended examination

Students / trainees

Learners in intimate examinations

- Must be clearly identified and consented to
- Patients must not be disadvantaged if they decline
- Trainees should not perform TVUS unsupervised
- Supervisor retains responsibility

Minors and capacity

TVUS in patients under 18:

- Only in specific clinical circumstances
- Requires senior decision-making

- Assess:
  - Capacity (Gillick competence)
  - Best interests
- Follow local policy and escalate if unsure

Scenario

- A 32-year-old patient attends for TVUS with pelvic pain.
- She gives clear verbal consent and the scan begins.
- During the examination she becomes quiet, avoids eye contact, and grips the couch.
- When asked if she's okay, she says "yeah, it's fine."

Chaperones

Chaperones in TVUS (BMUS / SoR)

- A chaperone should be present for TVUS
- Must be:
  - A trained member of staff
  - Positioned to observe the examination
- If declined:
  - Decision to proceed is at practitioner discretion
  - Must be clearly documented
- Documentation must include:
  - Offer, acceptance/decline, and identity of chaperone

Scenario

- A patient attends alone and declines a chaperone.
- You are the only sonographer available.
- The scan is clinically important (e.g. query ectopic pregnancy).

Privacy and Dignity

- Ensure appropriate exposure only
- Maintain verbal communication throughout
- Use clear, respectful, non-assumptive language
- Avoid unnecessary observers
- Give patient control (e.g. probe insertion if appropriate)

Cultural sensitivity and Individualised care

Individualised approach to patient context

- Trauma history
- Cultural/religious views on intimate examinations
- Gender preference for practitioner
- Need for clear explanation and choice
- Communication barriers
- Anxiety or previous negative experiences

Never assume tolerance or acceptability — always individualise

Patients with no previous penetrative vaginal intercourse

Requires careful, individualised consent discussion

TVUS should not be assumed appropriate or inappropriate solely on this basis

Consider:

- Clinical indication
- Patient preference
- Likely tolerance of examination

Alternatives should be discussed

Decision and rationale must be clearly documented

Scenario

- A 24-year-old patient is referred for TVUS.
- She states she has never had penetrative vaginal intercourse and appears anxious.
- The indication is clinically relevant but not urgent.

Transgender patients

Inclusive and person-centred practice

- Use correct name and pronouns
- Focus on relevant anatomy, not identity labels
- Avoid assumptions about anatomy or history
- Ensure privacy, dignity, and clear explanation
- Adapt approach based on individual needs

Later-life TVUS considerations

Vaginal atrophy → potential discomfort

- May require:
  - Smaller probe movements
  - Increased lubrication
  - Slower technique
- Consider:
  - Capacity
  - Cognitive impairment
- Balance diagnostic benefit vs distress

Safeguarding

Safeguarding considerations

- Offer opportunity to speak without accompanying person present
- Be alert to:
  - Coercion
  - Controlling behaviour
  - Trafficking indicators
- Follow local safeguarding pathways
- Document concerns and actions taken

Scenario

- A patient attends with a partner who insists on staying.
- She avoids eye contact and lets the partner answer questions.
- She appears reluctant to proceed but does not refuse.

FGM

- May be identified incidentally during gynaecological scanning
- Do not assume prior disclosure
- Consider:
  - Pain or difficulty with examination
  - Psychological impact
- Maintain:
  - Privacy
  - Neutral, non-judgemental language
- Legal duty: mandatory reporting in under 18s
- Escalate via safeguarding pathways

When stopping is the safest decision

- Withdrawal of consent
- Distress or pain
- Unclear clinical benefit
- Safeguarding concerns

Stopping is a defensible clinical decision

Scenario

- During TVUS, the patient develops increasing discomfort.
- You have partial views but not a complete assessment.
- The indication is important but not immediately life-threatening.

Documentation

Record:

- Verbal consent obtained
- Chaperone (offer + outcome)
- Patient preferences (e.g. accompaniment)
- Any distress or adaptations
- Withdrawal or refusal
- Rationale for proceeding or not proceeding

Documentation examples

- “Verbal consent obtained. Chaperone offered, patient declined. Examination tolerated well.”

- “TVUS declined following discussion of options. Transabdominal scan performed.”

Complaints and learning from practice

Complaints in gynaecological ultrasound

- Most complaints relate to:
  - **Communication**
  - **Consent**
  - **Patient experience**
- Rarely about diagnostic accuracy

Common themes:

  - Feeling rushed or not listened to
  - Insufficient explanation of the procedure
  - Discomfort not acknowledged
  - Concerns about dignity or privacy

Complaints and learning from practice

Good practice reduces risk:

- Clear, ongoing consent
- Active communication during the scan
- Appropriate use of chaperones
- Accurate, concise documentation

Complaints as learning:

- Opportunity for reflection and improvement
- Reinforces importance of patient-centred care

Key messages

Ethical TVUS practice requires:

- Ongoing consent
- Skilled communication
- Situational judgement
- Clear documentation

- Technical competence alone is not sufficient

References

- BMUS (2025) Transvaginal Ultrasound Guidance
- SoR (2023) Intimate Examinations & Chaperone Policy
- SoR/BMUS Ultrasound Practice Guidelines
- GMC (2024) Intimate examinations and chaperones
- RCR guidance
- RCOG consent resources