



Chaperone use in medical practice

Graham R. Howarth, MBChB, MMed(OetG), MPhil(Bioethics)
 Medico-legal advisor for the Medical Protection Society
 Leeds, UK.

It may be speculated that having a chaperone present during the intimate clinical examination was originally instituted to protect women from inappropriate advances by the doctor. In the current medico legal climate the rationale has probably been reversed, and the presence of a chaperone is felt to minimise the risk of the patient accusing the doctor of taking unnecessary liberties. Medical indemnity organizations consider the presence of a chaperone helpful in the defense of a doctor against an allegation of sexual misconduct during an intimate examination. They do, however, realise that presence of a third party does not necessarily protect either the patient or the doctor and may be counterproductive in some situations. (*SA Fam Pract 2003;45(2):58-59*)

Medical practices are required to provide a physically safe environment for the patient, but little thought is given to psychological or emotional welfare. Utilising a chaperone during intimate examinations may enhance the patient's perception of psychological or emotional well-being¹. None would dispute that there are potential advantages and disadvantages to utilising a chaperone in obstetric and gynaecological practice. Advocates of chaperone use stress the advantages while detractors stress the disadvantages. The Royal College Guidelines show their bias by referring to the advantages as being self evident, while the disadvantages are referred to as potential².

In the absence of definitive guidelines, individual doctors may tend to adopt a standard approach to chaperone use; always, never or occasionally³. Always and never appear to be inappropriately prescriptive and are incompatible with shared decision making between doctor and patient. If one only occasionally utilises a chaperone, unless having inquired about the patient's preference, what criteria does one use and how does one justify those criteria?

Unlike the standard approach usually adopted by doctors, individual patients vary in their desire for a chaperone⁴. Other than asking the patient, there can be no definitive answer to the question "When do I need to use a chaperone?" since the decision is dependent on the doctor-patient relationship, the situation and cultural issues.

While many patients do not express a strong opinion on the presence of a chaperone during intimate clinical examination, a substantial proportion would prefer a chaperone to be present, either during the taking of an intimate history, during an intimate examination or both⁴. Should the patient not wish to have a third party present during the taking of the history, there is no reason not to confine chaperone use to the physical examination, allowing for one-to-one communication during the consultation². Even if the patient declines the offer of a chaperone, patients undergoing intimate examinations wish to be treated with respect and it seems to be clear that most patients regard the offer of a chaperone as a sign of respect⁴. Failure to offer a chaperone removes choice from the patient, reinforces the perceived paternalism in the doctor-patient relationship and fails to give the

deserved respect to the patient.

If the patient wishes to have a chaperone present, it must then be determined whom the patient would prefer, obviously the choice has to be mutually acceptable. It has been suggested that the chaperone should preferably be female in the gynaecological environment². The patient's partner or a relative, as is often the case with a teenager, are both acceptable, should the patient request them. In the case where the partner or relative makes the request, they may only be present following the patient's independent consent. Unless the patient specifically requests one, a peer should preferably not be used. A practice nurse is the ideal candidate as she has professional moral obligations to the patient, independent of those of the doctor and would be an ideal assistant. A practice receptionist is not only professionally unacceptable but empirical research has shown that patient's find that choice objectionable⁴.

Fortunately, complaints of sexual misconduct are rare². If accused of malpractice, it is a challenge to your medical ability, but you have an opportunity to defend your actions on the basis of the medical records. However, if accused of sexual mis-

conduct, it is an attack on your ethical and moral character, to the very core of the person you are. You have to prove a negative, that something did not occur, in a situation where you usually have no documentation. The notoriety and embarrassment, which will inevitably ensue, are injurious and potentially scarring to your reputation⁵. One's practice can be ruined, merely by an allegation of sexual misconduct, even if later found to be unproven. There may well be a trial by the media, which may be headline news, any subsequent findings of not guilty are usually long after the sensationalist news and any newspaper retraction is unlikely to make the headlines. The consequences can be professionally and personally devastating to the accused health care professional. Public opinion is notoriously fickle, unproven may be equated with getting off on a technicality and although possibly found not guilty, many may feel where there is smoke there is fire. Additionally the effects extend beyond the accused, the effect on the doctor's family can be equally, if not more, devastating.

The opposing influences of today's medicolegal climate and cost containment, affecting staff availability, are causing doctors to have to make difficult choices. While accepting that these tensions are very real, the guidelines given in the table are prudent. □

The 2003 Ethics CPD programme is accredited for 2 CPD points. The programme consists of 4 articles. Make sure you receive the March, May July and September issues. Please refer to the CPD questionnaire on page 51.

References

1. Patton DD, Bodtke S, Horner RD. Patient perceptions of the need for chaperones during pelvic exams. *Fam Med* 1990;22:215-218.
2. Working Party Report. Intimate examinations. London: Royal College of Obstetricians and Gynaecologists, September, 1997.
3. Speelman A, Savage J, Verburgh M. Use of chaperones by general practitioners. *BMJ* 1993;307:986-987.
4. Whitford DL, Karim M, Thompson G. Attitudes of patients towards the use of chaperones in primary care. *British Journal of General Practice* 2001;51:381-383.
5. Clyman SG. Why do we chaperone the female pelvic examination? *Del Med Jrl* 1982;54:105-108.

Table I: Prudent advice for those performing intimate examinations.

- a. The health professional must believe that the intimate examination is necessary and will assist in the patient's care.
- b. Explain to the patient that an intimate examination needs to be done and why.
- c. Explain what the examination will involve.
- d. Obtain the patient's permission. Verbal permission and the cooperation of the patient to adopt an appropriate state of undress and position probably provides sufficient authorisation.
- e. Offer all patients that are to undergo an intimate examination a chaperone, irrespective of the gender of the doctor.
- f. Where a chaperone cannot be offered due to an emergent situation or staff shortages, the patient should be informed of the unavailability of a chaperone and asked if they would consent to the examination in the absence of a chaperone or offered an alternative appointment when a chaperone is available.
- g. Once it has been established that the patient would prefer the presence of a chaperone, it must be agreed upon who would be the most appropriate individual. The choice of the chaperone should be mutually acceptable to both the examiner and the patient.
- h. Should the patient wish to have a chaperone then the presence of the chaperone and the chaperone's identity should be noted contemporaneously.
- i. Should the patient decline a chaperone this should be noted contemporaneously.
- j. Should the patient decline the offer of a chaperone and doctor for some reason would prefer to have one present, then this should be communicated to the patient. Should the patient still decline the offer of a chaperone then the examiner should probably not perform the examination.
- k. Give the patient privacy to undress and dress.
- l. Adequate and appropriate draping should be used when the patient is undressed.
- m. Keep the discussion relevant and avoid unnecessary personal comments.
- n. Encourage questions and discussion.

ACCREDITED CPD CHILD ABUSE TRAINING

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