



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

POSITION PAPER

THE USE OF CHAPERONES IN GENERAL PRACTICE

Introduction

Recently, there has been some discussion around the issue of the use of chaperones during intimate examinations. This has been prompted by concerns expressed by some GPs, recent negative media reports concerning alleged sexual misconduct by GPs and the publishing of articles referring to the use of chaperones in the British Medical Journal.

During the review of the RACGP *Standards for General Practice* some GPs, Health Complaints Commissioners and Medical Defence Organisations raised the issue of the importance of offering chaperones in a limited range of consultations. Many State Medical Boards have provided guidelines on ethical conduct, including the use of chaperones. Some stakeholders expressed the view that the next edition of the *Standards* needed to include the requirement to offer chaperones in a limited range of consultations. The feasibility of this was questioned by other discussants.

The issue of chaperones needs to be considered in the context of protection of the doctor-patient relationship. The doctor-patient relationship is based on mutual trust and understanding, communication and decision making.

Communication between doctor and patient which ensures a clear understanding in the patient's mind of the necessity of a procedure and what it entails is an essential component of the consent process. This communication extends beyond the initial briefing to include ongoing explanation to the patient during the procedure, watching and listening for signs of withdrawal of consent. The Medical Practitioners' Board of Victoria, in a policy statement on Physical examinations encourages GPs to provide an explanation and to ensure the patient's willingness to proceed with the procedure. If the patient should seem resistant to the procedure the doctor needs to explain the necessity to the patient. If the patient declines the procedure the fact needs to be documented¹.

Chaperoning can be considered a risk management strategy when performing intimate examinations. The use of a chaperone may protect the doctor from allegations of inappropriate behaviour and misconduct², or from misconduct by the patient. Allegations against doctors occur infrequently, and are reported on by Medical Boards and in the press. The RACGP also receives anecdotes regarding the inappropriate behaviour of patients towards doctors. Both male and female doctors report inappropriate behaviour by patients, e.g. spurious requests for intimate examinations, sexual harassment of doctors.

¹ <http://medicalboardvic.org.au/content.php?sec=54> Accessed 30 January 2007

² Howarth, G. Chaperone use in medical practice. Available at: www.medpharm.co.za/safp/2003/mar/chaperone.html. [accessed 21 June 2005]

Defining an 'intimate examination'

In the context of this discussion paper, an intimate examination refers to an examination involving the genital, groin or anal region in any patient, and includes breasts in female patients.

There are other situations that may cause embarrassment or stress to patients. Examples include when a patient may need to undress for a skin check; patients who may be uncomfortable to be alone with a member of the opposite sex, or the physical examination of a patient with a psychiatric history or the inmate of a prison. These kinds of situations, whilst not considered to be intimate examinations, may still require the GP to consider how to provide care in a way that is safe and acceptable to the patient and doctor.

Use of chaperones highlighted in literature review

Most literature revolves around the appropriate use of chaperones during intimate examinations, though some refers to issues such as physical examinations of inmates and patients with mental illnesses.

Nearly all of the relevant research has been conducted in Britain, which raises the question as to what is appropriate and feasible in the Australian general practice context.

An opinion offered by Richardson³ encourages GPs to use their instincts and professional judgment in determining when to consider a chaperone. Clear communication with patients about what the procedure entails is crucial. Documentation of the patient's response to offer of chaperone and the name and position of the chaperone is also important. Richardson cites an example of a doctor against whom an allegation of inappropriate comments was made, who used a chaperone for an intimate examination, but had not recorded the name of the chaperone. The complaint was upheld.

The Royal College of Obstetricians and Gynaecologists have released guidelines⁴ based on a General Medical Council (GMC) inquiry into the conduct of a GP accused of sexual misconduct⁵. In these guidelines, intimate examinations are defined as examinations of the breasts, genitalia and rectum.

Specific consideration of the need for a chaperone was thought to be important for:

- the unconscious or anaesthetised patient
- adolescents
- mentally ill patients
- patients with learning disabilities
- women from ethnic minorities
- women who have previously had a traumatic intimate examination or who have been sexually assaulted.

Rosenthal et al⁶ conducted a self completed postal survey of more than 1200 GPs in Britain to determine usage of chaperones and issues affecting the use of chaperones.

³ Richardson C Chaperones: who needs them? British Medical Journal 30 April 2005 Vol 330: 175

⁴ Royal College of Obstetricians and Gynaecologists Gynaecological Examinations: Guidelines for Specialist Practice, London 2002

⁵ General Medical Council Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling 2002

⁶ Rosenthal J et al. Chaperones for intimate examinations: cross sectional survey of attitudes and practice of general practitioners. British Medical Journal 29 Jan 2005; Vol 330: 234 – 235

Sixty percent of male GP respondents usually or always offered a chaperone, 54% of male GP respondents usually or always used a chaperone. Of female GP respondents, 5% usually or always offered a chaperone, and 2% usually or always used a chaperone.

The results of the survey demonstrated issues affecting the use of chaperones, identified by GPs included availability of an appropriate person, time constraints in arranging a chaperone, confidentiality concerns, embarrassment of the patient, and cost of providing a chaperone

Patient factors likely to affect doctor's use of chaperones include GP's instinct, psychiatric history, ethnic minority, aged <20 or >65, unacquainted with the patient, marital status, psychosexual issues

Practices nurses were the most commonly used chaperone. Other chaperones included a family member or accompanying person, non-clinical staff member, a medical student or GP registrar or another doctor.

Whitford et al⁷ conducted a questionnaire of 800 patients. Ninety percent of women and 70% of men thought that chaperones ought to be offered for intimate examinations. The study identified that patients undergoing intimate examinations wish to be treated with respect and that most patients regard the offer of a chaperone as a sign of respect. Patients also identified the expectation of a shared decision making process with the doctor over the intimate examination.

Current literature results from research conducted mainly in Britain, one may question whether the same conclusions would be reached in Australian general practice. There is a need for research in the use of chaperones in Australian general practice.

Potential barriers to provision of chaperones in Australian general practice

- **Practice Issues**

- Cost**

- The RACGP also recognises that, in many circumstances, provision of a chaperone may lead to additional practice costs being incurred. In some instances costs may be absorbed by the practice, or the additional costs may be passed on to patients. Additional costs may be perceived as a barrier to the provision of chaperones.

- Feasibility**

- The RACGP recognises that the provision of a chaperone may not be feasible in all circumstances in the general practice setting in Australia. There may be situations where the provision of a chaperone will be limited because of workforce issues, eg solo GPs, unavailability of suitable person, (wrong sex, and staff member unwilling to perform duty as chaperone).

- **Doctor-patient relationship**

- The doctor – patient relationship is based on mutual trust and understanding, communication and decision making.

⁷ Whitford DL, Karim M & Thompson G. Attitudes of patients towards the use of chaperones in primary care. British Journal of General Practice May 2001: 380 – 383.

Some members of the profession believe that if a patient chooses to attend a particular doctor, the consent to perform intimate examinations is implied.

Some members believe that offering of a chaperone may imply that this relationship of trust can be undermined; however research (Whitford et al, 2000) has shown that the vast majority of patients interpret the offering of a chaperone as a sign of respect for the patient.

- **Patients**

Patients may not want a chaperone. The study by Whitford et al (2000) suggested that even if the patient declines the offer of a chaperone, patients undergoing intimate examinations wish to be treated with respect and that most patients regard the offer of a chaperone as a sign of respect.

The RACGP is aware that GPs, their teams and patients may wish to comment about this position. Comments can be sent to standards@racgp.org.au .



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Using a chaperone

Following, is a summary from the literature review regarding the use of chaperones.

Consent

As highlighted in the literature, patients undergoing intimate examinations want to be treated with respect, and expect a shared decision making role in their health care.

Practice policy

It is advisable for practices to have a documented policy covering the following:

- When to offer a chaperone e.g. sedated patients, patients who are very young, mentally ill patients, patients who request a chaperone, patients with a previous history of sexual abuse
- Who can chaperone
- Training of chaperones - untrained administrative staff are unsuitable
- Managing a patient request for a chaperone - how the chaperone will be arranged, by whom and when (For example, when sending out Pap smear reminders, it may be helpful to let women know the practice's policy and ask women to let the practice know when they book an appointment that they will require a chaperone)
- Managing the situation where the patient or doctor feels uneasy before or during the consultation
- What procedure is followed in the event that a chaperone cannot be provided?
- Out of practice requirements – consider how chaperones can be provided for out of practice visits
- Alternatives if a chaperone is not available, e.g. the patient to bring someone with them whom the patient would find acceptable to be a chaperone.

Identity of the chaperone

In general a chaperone may be the same sex as the patient, though a patient's request for a chaperone of a particular sex needs to be considered.

Research (Whitford, Karim and Thompson, 2000) indicates that patients prefer the chaperone to be a nurse. The nurse has professional obligations to the patient, independent of those of the doctor (Howarth, 2003).

Some research indicates that patients find that a receptionist acting as a chaperone is not professionally unacceptable, and that patients find that choice objectionable (Whitford, Karim and Thompson, 2000; Howarth, 2003).

Chaperone duties

In order for the chaperone to be effective in providing a level of support and protection to both the doctor and patient, the chaperone needs to understand the procedure to be undertaken and the normal way in which it is performed.

It is preferable that the chaperone be positioned in such a way as to be able to clearly observe the procedure.

Some members employ the chaperone to assist during the procedure, e.g. passing Pap smear equipment to the doctor, positioning lighting.

If no chaperone is available

If a chaperone cannot be provided when required the situation needs to be discussed with the patient. Mutually acceptable alternatives can be decided upon, for example, booking the procedure when a chaperone can be organised, or referral to another appropriate service.

Patient record

Documentation of the discussion and offer of a chaperone, and the patient's response is important.

It is also important to document the name and designation of the chaperone.

Further guidelines are available from the following organisations:

AMA National Code of Ethics

<http://www.ama.com.au/web.nsf/tag/amacodeofethics>

General Medical Council UK

Good Medical Practice

http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Medical Practitioners Board of Victoria

Professional boundaries <http://medicalboardvic.org.au/content.php?sec=55>

Physical examinations <http://medicalboardvic.org.au/content.php?sec=54>

Medical Board of South Australia

MBSA Code of professional conduct

<http://www.medicalboardsa.asn.au/page2.php?parentid=54&pageid=54>

Medical Board of WA

Duties of a Medical Practitioner registered with the Medical Board of WA

<http://www.wa.medicalboard.com.au/draftPolicies.cfm>

Medical Council of Tasmania

Guide to Good Medical Practice

<http://www.medicalcounciltas.com.au/MedicalCouncilPolicies.htm>

NSW Medical Board

Medico-legal guidelines <http://www.medeserv.com.au/nswmb/publications/Medico-Legal.cfm>

United Medical Protection

United's GP Registrar Toolkit Topic 5: The chaperone – stand by me, available at the following: <http://www.unitedmp.com.au/0/0.13/home.htm>

The RACGP is aware that GPs, their teams and patients may wish to comment about this position. Comments can be sent to standards@racgp.org.au.