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Editorial
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Chaperones: protecting the patient or protecting the doctor?

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Abstract. The routine use of chaperones during medical examinations, including intimate examinations, is variable. Practice varies between countries and also within them. Use of a chaperone may protect patients from sexual abuse by medical or nursing practitioners. An appropriate chaperone may also protect healthcare practitioners from false accusations. This article considers issues surrounding the use of chaperones and suggests a chaperoning policy for sexual health clinics, while acknowledging that it may not be appropriate or acceptable to all patients or medical staff, or for different parts of the world.

Additional keywords: intimate examinations, sexual health.

Introduction

Although chaperones have been used for many years by doctors conducting intimate examinations, there is no uniformity as to how and when they should be used across different countries, nor within some countries. Lack of guidance and different policies can lead to confusion, particularly if doctors and other medical professionals move from one area to another, with different requirements. Guidance from professional bodies can be at odds with practicalities of running a medical practice. A chaperone may seem unnecessary until a case arises in which a patient has been abused by a doctor or a medical professional is suddenly falsely accused.

There are several considerations and questions when deciding on chaperoning policies. These are:

(1) is it to protect the patient?
(2) is it to protect the doctor (either from false accusations or violence)?
(3) who should be the chaperone?
(4) do patients want chaperones?
(5) will it destroy the doctor–patient relationship?
(6) which doctors should be chaperoned?
(7) which patients should be chaperoned?
(8) which medical settings require chaperones – e.g. sexual health, general practice, private practice?
(9) do other health-care workers need to be chaperoned?
(10) for what type of examination is a chaperone necessary?
(11) who is going to pay for the chaperone?
(12) what if the patient declines a chaperone?
(13) is documentation necessary?
(14) what are the chaperone's responsibilities and is training necessary?

Who is a chaperone intended to protect?

Many of these questions are inter-related and the first decision must be what is the purpose of a chaperone, and who is the chaperone intended to protect. A chaperone's role covers several areas ranging from someone to help the patient undress or provider of emotional support, to a protector of patient or doctor.[1]

Traditionally, in hospital settings, a chaperone, usually a female nurse, has been used when a male doctor performs a gynaecological examination on a female patient. Medical practice has changed over recent years. The use of qualified nurses as doctors' 'handmaidens' has long disappeared. Approximately 50% of medical graduates in the UK are now female, and many nurses are male. Doctors in hospitals may not routinely have a nurse with them and, as their role extends, nurses also see patients alone. The tabloid newspapers thrive on a diet of doctors accused of assaulting patients.[2] The reality is that there always has been, and always will be, healthcare professionals who abuse their position of trust. There have also been cases where patients have falsely accused their doctors of sexual abuse, including rape.[3] Without a chaperone in the room, there is no way of discerning who is telling the truth when accusations arise. Also, patients may perceive an examination as abusive through lack of understanding, inadequate explanation or because of mental health problems. The UK General Medical Council (GMC) states the function of a chaperone is primarily to protect the patient,[4] but the protection of doctors is also essential. The consequences of a false accusation, if no chaperone was present, can destroy a doctor's reputation and lead to suspension and removal from the specialist register, with loss of livelihood and possible criminal proceedings and conviction. A recent consultation in the UK is advocating that the burden of proof for professional misconduct enquiries be changed from the criminal to the civil, making conviction against a doctor more likely. For all these reasons, the role of a chaperone should therefore be not only for the protection of the patient but also for the protection of both doctors and nurses.

When should a chaperone be present?

There are strongly opposing views on when a chaperone should be present and Baber *et al*. discusses these in a paper in this issue of the journal.[5] Much of recent UK chaperoning policy appears to be influenced by a few medico-legal cases, where doctors or nurses have behaved inappropriately and sexually assaulted their patients. In the UK, the GMC recommends a

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chaperone is *offered* for all intimate examinations. This includes breast, rectal and genital. These examinations are, obviously, when patients could be most vulnerable. Any examination where the patient has to remove clothing off the chest or abdomen could potentially cause problems, but consideration has to be given to what is realistically feasible. In UK genitourinary medicine (GUM) sexual health clinics, it is usual for female doctors to see patients of either sex on their own, if no assistance is needed. Male doctors, however, in most services have had a chaperone with them when they examine female, but not male, patients. There have been cases where male doctors have been accused by male patients of inappropriate behaviour. This suggests a chaperone should be considered irrespective of the doctor's or the patient's sex. Nurses increasingly perform intimate examinations and there is no reason to suppose that they also should not be chaperoned.

As opposed to UK guidelines, the American Medical Association (AMA) advises doctors in the USA to have a policy that patients are free to make a request for a chaperone in each healthcare setting, and that this policy should be communicated to patients, either by means of a well displayed notice or preferably through a conversation initiated by the intake nurse or the physician.[6] The AMA also states that the request by a patient to have a chaperone should be honoured.

In Australia, guidelines from the Victoria Medical Board are less proscriptive and suggest that the practitioner should offer the presence of a chaperone during intimate physical examinations, if this would make the patient feel more comfortable – this leaves the decision to the judgement of the doctor.[7]

In general practice, there may already be a trusting relationship between doctor and patient, and a chaperone may be more difficult to obtain, but the same issues are relevant. Some practitioners may object to chaperone use, some on the basis of resource and funding issues. Many, as discussed by Baber *et al*., are also rightly concerned that it could impact negatively on the patient–doctor relationship.[5]

Who should a chaperone be?

In the past a chaperone was likely to be a female nurse. Is it appropriate for a male nurse to chaperone a male doctor? There is no reason to think a male nurse cannot be an appropriate chaperone, unless the patient is uncomfortable with a male. The patient should therefore be asked. The AMA recommends that an authorised health professional should serve as a chaperone whenever possible. The GMC recommends that a family member or friend is appropriate but this is satisfactory if the only role is to protect the patient. It would not, however, protect the doctor and could actually make them more at risk, and less able to defend against false accusations. The British Association for Sexual Health and HIV (BASHH) GUM guidelines,[8] and Royal College of Obstetrics and Gynaecology (RCOG) guidelines[9] do not, therefore, recommend family or friends alone.

Use of a qualified nurse as a chaperone, unless also assisting, is an expensive use of resources. Health care assistants are cheaper and medical students or, in some services, an appropriately trained receptionist, could be used. These members of staff must be made aware of their role as a chaperone and feel comfortable to report to their line manager if they feel a doctor or nurse is behaving inappropriately with a patient. Confidentiality when acting as a chaperone is essential, as highlighted by the AMA – 'in their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere'.[6]

What if the patient refuses a chaperone?

Patients may refuse a chaperone for different reasons. There is an increased likelihood of an accusation against a man by a woman, so many consider a chaperone should always be present in these circumstances, and the BASHH guidance recommends this, stating that if the woman will not accept a chaperone, she should be examined by a female doctor, or offered an alternative appointment when a female doctor is available.

There may be some cases where the doctor, irrespective of their or the patient's sex, does not feel comfortable about a chaperone not being present. This may particularly be the case with a patient who is especially vulnerable either because of mental health problems, confusion, violent behaviour, learning difficulties, or for an adolescent or child. If the practitioner believes a chaperone should be present, but the patient declines, then they should consider whether the examination should be performed at that particular time. Ascertaining why the patient is declining may help resolve the situation, e.g. they may accept one if they are behind a curtain, or turned away from them.

Documentation on chaperone use is recommended, usually by the chaperone countersigning the notes. This means they can be approached if an accusation arises. The use of a stamp in notes can be a useful aide-memoire.

Do patients want chaperones?

Baber's research on attendees at a sexual health clinic in Australia shows that when being examined by a male, one-third of women want a chaperone, but almost as many did not.[5] If being examined by a female, only 4% wanted a chaperone. Of men being examined, only 1% wanted a chaperone, irrespective of the examiner's sex. Many patients stated they had a problem asking for a chaperone, therefore a verbal offer to all patients would be good practice. The desire for a chaperone may be related to cultural issues, societal norms, or dependent on previous experience. Patient's rights must be considered.[1] The RCOG and BASHH guidelines would be against the wishes of one-third of Baber's women who do not wish a chaperone when being examined by a male. A male doctor performing an intimate examination on a woman without a chaperone could have his career ruined by a false accusation. The BASHH and RCOG guidance would, theoretically, prevent both of these situations.

Chaperoning policy in sexual health clinics

It is a sad reality that there are some doctors who may abuse their patients and in an increasingly litigious society, there are some patients who may falsely accuse their doctor. Newton *et al*.[10] in an article in this issue has found that doctors themselves, particularly male (72%), believe a chaperone is important for medico-legal purposes when examining females. Any policy needs to consider both patients' and doctors' rights and protection, as well as any patient cultural and religious considerations.

A pragmatic approach is the best way forward for sexual health care clinics. If a nurse or healthcare assistant will not be in the examination room assisting:

- female doctors should offer a chaperone to all. In most of cases the patient will indicate this is not necessary;
- male doctors should offer a chaperone to all men. Again, in most of cases the patient will indicate this is not necessary; and
- male doctors should have a chaperone when they examine female patients. If the patient objects they should ascertain the reasons why, and consider whether a female colleague should perform the examination.

These recommendations may come across as rather too prescriptive and be contested by many sexual health care practitioners. Attitudes of patients and individuals, which vary enormously, need to be taken into account, and this model may not be acceptable, appropriate or desired in different parts of the world. However, the author advocates that trained chaperones used in the appropriate circumstances can ensure the protection of patients and their doctors – surely this is a win-win situation?

Conflicts of interest

None declared.

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