Review Articles

The Use of Chaperones in Clinics: Ethical Needs for Protection of the Patients and Health Care Providers

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Abstract

Introduction: Chaperone is a third person in a clinical office who serves as a witness for both the patient who is being examined and the physician, acting as a safeguard for both parties during a medical examination or procedure. This ensures that the relationship with the patient is well managed and remains purely professional. Their presence also protects the physician against accusation of misconduct especially sexual assault by the patient, as well as guarding the physicians against being physically assaulted by patients. Despite these significant benefits of the use of chaperones some physicians do not practice the act and some patients also object to the presence of a third party when being seen by a physician, as this serves as impedance to their free communication with the attending physician, and that their confidentiality is compromised. In this article, a review is therefore made to assess the usefulness and ethical challenges of the practice or non-practice of the use of chaperones in our clinics.

Materials and methods: This review involved an extensive search of databases that included Medline, Elsevier, Medscape, Medicine and PubMed. Literature on the subject was also researched using manual library searches of cited textbooks and articles in journals. The search covered a period of 1990 to 2013, but the literature included was from 1999 till 2013.

Results: Despite established guidelines and recommendations, the use of chaperones by clinicians is not consistent or universal, as both practice and consumer opinion regarding their use varies widely within and across continents.

Conclusion: The role of the chaperone in several clinical contexts is important and critical. Therefore, there should be a deliberate policy for the use of chaperones in every health facility, and efforts must be made to counsel and educate patients and clients as well as attending physicians as to the ethical implications and imperatives of the use of chaperones.

Keywords: *Chaperone, Clinical Examination, Patient's views, Ethics*

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Introduction

A chaperone is expected to support a patient emotionally, with a reassurance during an examination or procedure that may be embarrassing or uncomfortable to that patient. The chaperone should be trained to be able to provide some quality assistance to the physician during such examination or procedure[1]. The

presence of a chaperone provides the assurance that the physician recognizes the potential vulnerability of doctor-patient interactions, and demonstrates the professional character of the procedure being done. The presence of this "extra pair of eyes" also provides a source of legal protection for the physician in case of being accused falsely of improper conduct by a patient. In cases of false accusations, a chaperone, if present, will be a witness to testify regarding the conduct during the examination[2].

The chaperones therefore serve a two-fold function. The primary purpose is to protect, comfort and assist the patients being examined by a physician[1]. The second function is to protect the physician against claims of inappropriate sexual behaviour[1-3]. It is therefore expected as enshrined in the working documents of several regulatory councils that physicians deploy the services of chaperones when seeing patients. The General Medical Council of the United Kingdom, in December 2001, produced a guideline for physicians performing intimate examinations. They recommended that a chaperone should be present during the examination of the breast, genitals and rectum[3]. Similarly, the Royal College of Obstetricians and Gynecologists recommended that a chaperone should be offered to all patients having intimate examination in gynecology and obstetrics, irrespective of the gender of the gynecologist, and that if they decline, such should be fully documented[4]. This is absolutely important as it is medico-legally expedient that a chaperone should always be present during genital examinations[5]. But in cases where the patient declines the use of a chaperone, it is at the discretion of the attending physician to carry on with the procedure if he feels comfortable enough with it in that situation provided he has clearly documented in the patients notes as stipulated above.

Cases of sexual misconduct are on the increase even though most go unreported[3]. Several physicians have been accused of unprofessional conducts and sexual assault after clinical examination on patients without the services of a chaperone. In a survey of the use of chaperones in clinics, several allegations of improprieties were identified[4]. Half of such reports could have been prevented if there were chaperones in attendance. The authors therefore recommended that chaperones should be more widely offered to patients and be used during genito-urinary examination[4]. Another study reported that eight percent of the women sampled gave instances where physicians had conducted gynecological examination in a "*less than professional manners*"[5]. There is also a particular incidence where a general practitioner had practice restrictions and sanctions placed on him after he was found to have engaged in professional misconducts[6]. He was reported to have said to a female patient that he was conducting intimate examination on, "that he could do this all day". The woman reported that she went to have her breast checked and had to pull down her shorts and underwear down to her knees. She reported that the doctor was feeling her groin for lump and then said "I could do this all day". Just for those comments that he made, he was sanctioned. He had since brought in the services of a chaperone into his practice and his sanctions have been lifted by the board[6].

Genital area examination is one area where the gender of the patient and the physician do have a strong influence on patients' preferences. Assistance is rarely needed in the examination of male patients irrespective of the gender of the physician, but female nurses are routinely present during the examination of female patients so as to provide support to the patient and assistance to the physician[5].

However, the use of chaperones in our clinical setting seems to be poorly emphasized and there

is paucity of reports in the literature on the place of the practice of its use or non-use. Yet there also seem to be rising litigations against physicians in this environment. We conjecture that there may be urgent need to recommend policy guidelines that may make the use of chaperones necessary in our practice. But first there is the need to review available evidence from different settings to guide such recommendations. It is against this backdrop that this review was conceptualized.

Methodology

This was a review of published articles on the use of chaperones by clinicians over a 15-year period from 1999 to 2015. Overall 89 articles were searched out, however only 24 full articles reporting on quantitative or qualitative studies of patients' views on the use of chaperones by physicians in all practice settings were used for this review. Those that did not fit into the scope of this review, or their full articles not retrievable were excluded. This review involved an extensive search of databases that included Medline, Elsevier, Medscape, Medicine and PubMed. Literature on the subject was also researched using manual library searches of cited textbooks and articles in journals. The search covered a period of 1990 to 2015, but the literature included was from 1999 till date. This literature search was done using the following keyword as a guide: Chaperone, Clinical Examination, Patient's views, Ethics.

Discussion

The need for a chaperone (Who does the chaperone protect?)

The reality is that there always has been, and always will be, healthcare providers or professionals who will abuse their position of trust. There are also cases of false accusations of physicians by patients of sexual abuses and assaults especially when a chaperone was not in attendance [8]. The absence of a chaperone makes it difficult to say who the victim is or who the assailant is in such circumstances.

The policy of the General Medical Council (GMC) UK, on chaperone was developed following legal cases of healthcare providers who got involved in inappropriate behavior and sexual assault of their patients[8]. The council stated that a chaperone is essentially there to protect the patients. But then, the physician also needs to be protected from the patients. The end-result of a false accusation if no chaperone was present can be damaging, can destroy the physicians reputation that was built over the years, can lead to suspension and removal of name from the Medical Register of the nation, loss of livelihood and possible criminal proceeding and conviction [8].

Therefore, the role of a chaperone should be for the protection of both the patients and physicians alike.

Patients' preferences (Do patients want chaperones?)

A study done in Ireland found that most women (65%) did not feel a chaperone was necessary during pelvic examination by a male doctor[9]. However, up to 20% of patients would want a chaperone irrespective of the examiners gender which highlights the fact that gynaecological examination by a female clinician does not necessarily exclude the need for a chaperone[9].

Similarly, in a postal survey of 451 patients in primary case setting in the UK, involving both men and women, 59% of responders stated that they will fill uncomfortable if a chaperone were present when they have not asked for it.[10] On further analysis, there were as many patients who resent the presence of a chaperone as there were those who would always want a chaperone to be

present. Women were more likely than men to prefer a chaperone to be present. It was also shown that patients are less likely to prefer a chaperone to be present with their usual doctor (17%) than with a new doctor (41%)[10]. This suggests that trust is an important factor for the patient in an intimate examination.

Similar findings of low request or desire for chaperones among genito-urinary patients have re-echoed in several other studies across the globe,[11-14] just as most women (75.5%) attending a urology clinic in Manchester, UK did not wish to have a chaperone present[15]. Of those who wished to have a chaperone present more than half want a family member or friend to fill this role.[15]

On the contrary, a study of women's opinions, attitude and preferences regarding the presence of chaperones during pelvic examinations in south- eastern Nigeria showed that 53.9% would like to have chaperones present during such examinations if the examining physician is a male,[16] while 51.7% of the women studied preferred female physicians for pelvic examinations. Family members and friends were the least preferred persons to serve as chaperones.[16] However, further studies in African populations are needed to fully establish our orientation towards the issue of chaperones.

Criteria for recruiting individuals as chaperones

A chaperone should be a real professional, most probably a female or male nurse. The American Medical Association (AMA) recommends that an authorized health professional should serve as a chaperone whenever possible[2,8].

The General Medical Council (GMC), (UK) advices that a chaperon must be a third eye of the same gender as the patient and with nothing to gain for interpreting the facts [3]. The GMC recommends that a family member or a friend is appropriate but this is satisfactory only if the role is to protect the patient only. This role will not protect the physician as he will be less able to defend himself in the face of an accusation[8].

Due to this, the Royal College of Obstetricians and Gynecologists do not recommend family members or friends alone[8].

Due to the poor economic resources available, and the fact that the use of a trained nurse as a chaperone is viewed as an expensive use of resources, the use of health care assistants, even medical students can be allowed. A properly trained receptionist can even be allowed[8].

Ultimately, whoever the chaperone maybe, the 2004 committee of inquiry that looked into the role and use of chaperones recommended that all chaperones need to receive proper training[17].

But the keyword that should be maintained is confidentiality and respect for patient's privacy, to which the "chaperone must adhere"[8].

Physicians' practice and perspectives

A survey of Australian sexual health practitioners' attitude and practice showed that only a minority (19%) routinely provide chaperones for female genital examinations while 9% only did for male genital examinations[18]. Others randomly offered chaperones for female examinations only 19% of the time. However, majority of the practitioners feel chaperones are important for medico-legal reasons and as support for the patient[18]. But ironically, only 39% of male practitioners and 36% of female practitioners in that survey believed that resources spent on chaperones were justified by the benefits they provided.

Similarly, a postal survey of 20 genitourinary medicine clinics in the North Thames Region in the UK showed that only two (10%) had a written policy on the provision of chaperones and only one has surveyed patients views about chaperone

use. None had carried out a survey of staff views about chaperoning.[19] Interestingly, there was a significant difference in the provision of chaperones for female patients being examined by female doctors (60%) compared to female patients being examined by a female nurse (5%) as well as male patients being examined by male doctors (10%). Several clinics reported that they were more likely to offer chaperones to those patients with past history of aggressive behavior towards staff or those with psychiatric problems[19].

In another study, chaperones were especially used when the patient was anxious and uncomfortable, young, or mentally retarded as well as when the patient behaved seductively or is one who had a history of sexual abuse or rape[20]. While in this survey of 59 attending obstetrician-gynaecologists, patient preference was cited the most common reason for chaperone use, physician's age and era of training impacted on their use of chaperones as physicians older than 40 years were more likely to have been taught to use chaperones, and they indeed used them more often than younger physicians[20].

On the other hand, majority of consultant breast surgeons in the UK use chaperones although documentation of the offer and identity of the chaperone was very poor[21]. Similarly, a study in Nigeria showed that most Nigerian gynecologists use chaperones at least some of the time and also support a policy of routinely offering chaperones during intimate gynecologic examination while respecting patients' right to decline this offer[22]. The main obstacles to the use of chaperones were scarcity of personnel to serve in the capacity (87.6%) and patients' refusal to be examined in the presence of a third party (12.4%).[22]

Arguments against the use of Chaperone

Against the seemingly good intentions of the proponents of chaperoning principle and policy, there are several arguments against their presence.

One factor standing against this concept is the concern for confidentiality and patients' privacy which may be compromised by the presence of a chaperone[2]. This third person may not have sworn the Hippocratic Oath of Secrecy administered on newly qualified doctors. This core principle of medical ethics is very essential and the attending physician must find ways of ensuring that the chaperones do not abuse the privileges of their position dictated by duty. Second, the presence of the extra person watching intimate examination increases the embarrassment factor for many patients. It is more difficult to discuss intimate problems in the presence of a third party[11,23].

The use of chaperone seems to erode the trust that patients may have on physicians because of the rapport previously established between them. The introduction of chaperone makes the patient think that the physician do not trust them anymore[2], and vice versa.

Furthermore, the introduction of chaperone means extra funding, extra staffing, coordination and office space allocation. This will put more burden on already over-stretched funds available for healthcare, and of course, this will have greater implications for resource poor countries.

Are there alternatives to having chaperones present during clinical examinations?

It has been suggested that the door of the examination room be kept open [2]. But this exposes the probably undressed patients to public view. Also an intercom can be connected to the reception and kept open[2]. Again, this may inadvertently transmit private discussion to the public domain. Also, the use of video cameras

could be employed to record all discussions and activities in the examination room[3]. However the use of cameras has obvious demerits. Not only will such practice erode patients' confidentiality, it is also a relatively expensive technology to deploy to this purpose.

Summary

Intimate examination can be embarrassing and even distressing for patients. But this should not stop the clinician from conducting an examination when it becomes necessary. Examinations should be conducted in an atmosphere that demonstrates sensitivity to patients' feeling, care, support, and respect for privacy, dignity and patients' choice. Most female patients welcome and expect the presence of a female nurse. Health care providers must therefore treat patients as individuals and respect their dignity and privacy[5].

Therefore, before conducting an intimate examination, they must explain to the patient the need for the examination and obtain her consent for it. Then, they should offer the patient the option of having a chaperone as an impartial observer to be present. This applies whether or not the clinician is of the same gender as the patient[7].

A relative or a friend of the patient is not an impartial observer and therefore cannot play the role of a chaperone during an examination. Both the physician and the patient must agree on the choice of a chaperone. The patient may decline the use of a chaperone. If this happens, the clinician should document the patient's decision, explaining in clear terms his/her preference for a chaperone to be present. If a chaperone is used his/her identity should be noted for future reference if situation warrants.

Conclusion:

Despite popular guidelines and recommendations, evidence abound, as shown in this review, that the use of chaperones by clinicians is not consistent or universal, as both practice and consumer opinion regarding their use varies widely within and across continents.

While it is in the very nature of health care provision that it is often necessary to touch patients, often intimately, in order to examine them and provide care for them[24], the legal requirements that must be followed in performing such intimate examinations must be well defined to guide all care givers and safeguard against sexual boundary violations. Therefore, a clear chaperone policy should be in place in all health facilities. In addition, documentation of physician's offer of a chaperone, identity of the chaperone used and patient's preference are currently best practices.

The role of the chaperone in several clinical contexts is not only important but critical and physicians everywhere should appreciate that. It may look expensive to fund but the cost maybe lower than the cost of facing litigation in court or being made to face disciplinary committees of medical councils.

Recommendation

The need for a chaperon policy cannot be over emphasized. Regardless of the difficulties that may be encountered, a policy for the use of chaperon should be in place in every health facility, making it clear that chaperons are available. A policy that patients are free to make a request for a chaperon should be established in every health care facility[17]. This policy should be communicated to patients either by a prominent notice or by conversation initiated by the intake nurse or the physician[2,17].

The presence of a chaperon acknowledges a patient's vulnerability and provides emotional

comfort and reassurance. From the standpoint of ethics and prudence, the general protocol of having a chaperon available on a consistent basis is advised [2].

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