The danger of chaperones

The growing pressure on GPs to use chaperones when conducting intimate examinations (vaginal, rectal, breast, testicular) reveals an alarming deterioration in doctor–patient relationships.

The peculiar intimacy of the relationship between doctor and patient renders the patient vulnerable to the doctor’s abuse of power. Hence, making a sharp distinction between doctor and lover has been one of the first principles of medical ethics since the emergence of the medical profession. Medical authorities have always — quite rightly — taken severe disciplinary measures against doctors who have violated this basic code.

This is another subject that is sensitively discussed in John Berger’s ‘story of a country doctor’:

‘The emphasis in medical ethics on sexual correctness is not so much to restrict the doctor as to offer a promise to the patient: a promise which is far more than a reassurance that he or she will not be taken advantage of.’

The promise that the doctor makes to a patient is that if the patient submits to medical authority, even to the extent of permitting intimate examinations, he or she will be treated as an ‘honorary member of the family’. In flagrant defiance of contemporary critiques of ‘paternalism’, Berger describes the patient as being in ‘a state of childhood’, in which they are treated as ‘an ideal brother’ — for, as he emphasises, ‘the function of fraternity is recognition’, the essence of the therapeutic relationship.

The increasing insistence on chaperones reflects the replacement of relations of trust between doctors and patients with those of contract, and the shift from professional self-regulation to policing by external agencies. The transformation in medical practice that has been accelerated over the past year by the new GP contract has provoked more tension and conflict in relations between doctors and patients. From the doctors’ side, a glance at the popular weekly GP news magazines reveals a preoccupation with violence from patients, with regular accounts of assaults, details of training in self-defence and security procedures and accounts of special arrangements between surgeries and the police. Another recurrent theme in the GP press is that of the unprecedented levels of stress in the job, resulting, at least in part, from the excessive demands of patients, with warnings of the dangers of ‘burn-out’ or breakdown, unless doctors seek appropriate counselling and support.

From the patients’ side, the decline of deference is proclaimed by numerous self-help groups and by the growing scale of complaints (encouraged by the proliferation of complaints procedures) and by the increase in litigation. Once distinguished by their confidence and composure, some doctors now seem to regard their patients with fear and rage; some of their once acquiescent patients now view their doctors with undisguised suspicion and hostility. In the prevailing misanthropic cultural climate, which regards all intimate relationships as potentially abusive, and in which sexual abuse is a particular preoccupation, doctor–patient relationships have come under a cloud of suspicion.

One of the most striking themes in the current discussion is the notion that ‘ultimately the chaperone is there for the protection of the doctor rather than the patient’. This reverses the historic concern of medical ethics with the vulnerability of the patient and presents the doctor as potential victim of the patient, now regarded as either sexual predator or vexatious litigant. The bad faith implicit in the offer of a chaperone is revealed: a gesture which appears to be protective towards the patient is in fact motivated by the doctor’s self-interest.

Commentators make a distinction between ‘offering’ and ‘using’ chaperones (while warning that ‘merely offering a chaperone does not protect either the patient or the doctor’). But it seems to me that the very act of asking a patient whether they want a third party in the consulting room to ensure that you do not sexually assault them (or vice versa) in the process of a physical examination implies such a profound breakdown in the doctor–patient relationship that the prospects for Berger’s therapeutic ‘recognition’ are gravely diminished.

REFERENCES