Chaperones:

are we protecting patients?

A GP was suspended for 4 months in 2005 from the medical register after a Fitness to Practise panel found him guilty of serious professional misconduct. A female patient had consulted him with bowel problems. He proceeded to examine her back and in bending her right knee, placed his hand directly into her vulval area.[1]

Cases of sexual misconduct are on the increase. The General Medical Council (GMC) in December 2001 issued guidance on intimate examinations, recommending a chaperone is present during examination of the breasts, genitalia, and rectum.[2] This case highlights the requisite for these guidelines to be challenged and the situations in which chaperones are required to be redefined. It is likely and possible, either advertently or inadvertently, that patients are sexually harassed by their doctor even during an examination of the torso.

How do you define a chaperone?

In medical practice there is no exact definition of a chaperone. The English word was first recorded in the 15th century and originally meant 'hood for a hawk.' It later came to mean 'a woman who protects a young single woman.' The French verb 'chaperonner' means 'to cover with a hood' and therefore the word came to have the sense 'protector.'

GMC guidelines

Physicians have long been advised to have a chaperone present during specific parts of the physical examination. The GMC in 2001 produced guidelines for doctors performing intimate examinations. Intimate examinations include examination of breasts, genitalia or rectum. It is recommended that doctors offer a chaperone or invite the patient (in advance if possible), to have a friend or relative present.[2] The GMC pointed out that in the case of Clifford Ayling, a GP alleged to have assaulted former patients, a chaperone must be a third party of the same sex as the patient and with nothing to gain by interpreting the facts.[3]

The role of chaperones

Trust is an integral part of the doctor–patient relationship. Nowhere else in society will a person allow a stranger to have access to his or her body. The doctor–patient relationship will often involve an inequality between the doctor and patient. However, in an increasing litigious society, the role of chaperones is gaining increasing importance. The role of a chaperone is predominantly to comfort and protect the patient but they also serve a secondary role to protect doctors from false allegations.

There has been a documented case of a GP who was the target of a hate-campaign from an ex-patient. Dr W received 3 anonymous letters, one of which claimed he would be accused in the future of inappropriate examination.

He now uses a chaperone when examining patients.[4] In another case, a GP who asked an older female patient to undress without a chaperone was found guilty of serious professional misconduct by the GMC. Dr S was reprimanded for acting 'inappropriately and insensitively' in the way he carried out intimate examinations on a number of female patients.[5] However, it could also be argued that as patients can choose the GP they see, they have already decided they trust that doctor. Suggesting a chaperone could actually undermine this trust.[6]

Should we extend the use of a chaperone to examination of the torso?

There have been many documented cases of doctors behaving inappropriately during intimate examinations. However, there have also been alleged cases of sexual misconduct or alleged inappropriate behaviour during examination of the patient's torso. In some religions, examination by a member of the opposite sex is prohibited and the removal of clothes may also be embarrassing or distressing. It could be argued that a chaperone should be recommended for examination of all parts of the body. New supplementary guidance from the GMC on 'Maintaining Boundaries' states that when examining, 'doctors should be sensitive to what patients may perceive as intimate. This will include examination of the breasts, genitalia and rectum. But, could also include any examination where it is necessary to touch, or even be close to the patient.'[7]

In August 2005, Dr G was found guilty of serious professional misconduct when patient B consulted thinking she might be pregnant. He proceeded to perform an abdominal examination during which he put his hand beneath her knickers, pressed on her pubic bone and pressed at the point where her outer labia start. The examination was found to be unnecessary, inappropriate, and indecent.[8] In another case, Dr R, a GP registrar was found guilty of an inappropriate examination in May 2005 when Ms S consulted complaining of a possible chest infection. No chaperone was offered. During the examination, Dr R unfastened Ms S's bra and squeezed each of Ms S breasts.[9] The Medical Defence Union has recognised circumstances where examination of the torso of female patients poses problems if occurring without proper explanation.[10]

Should a doctor examining a patient of the same sex use a chaperone?

A study of chaperone use in primary care involving over 250 patients reported that the use of chaperones during intimate examinations continues to be disconcordant with the recommendations of medical associations and medico–legal societies. It was seen that chaperones were only used by a minority of the female patients than of male patients ($P<0.001$).[11]

Also, use was higher for female pelvic examinations (53%).

A study of chaperone use by residents in the US found when examining female patients, male residents overall were very likely to use a chaperone during a pelvic examination, but less likely for the breast exam and rectal exam. For the female doctor, there was a significantly lower likelihood of using a chaperone during pelvic, breast, or rectal examinations. Interestingly, there was a much lower rate of chaperone use during the sensitive portions of the male physical examination compared with the female examination, with higher use by female residents.[12] A key issue is whether a male doctor examining a male patient should always be chaperoned.

Recent studies suggest that from 3–10% of the population are almost exclusively homosexual.[13] A National survey of sexual attitudes and lifestyles (1999–2001) involving 11 000 people reported 6.3% of males and 5.7% of females have had sex with a same sex partner, and 8.4% of males and 9.7% of females have had a sexual experience, not necessarily genital contact, with a partner of the same sex.[14] With the increasing recognition of homosexuality, it could be argued that a male doctor examining a male patient should be chaperoned, and likewise for a female doctor examining a female patient. In other words, a chaperone should be present regardless of the sex of the doctor.

This idea is supported by the guidelines produced by the Royal College of Obstetricians and Gynaecologists in 1997, which stated that a chaperone should be offered to all patients undergoing intimate examinations in gynaecology and obstetrics irrespective of the sex of the gynaecologist.[15] Male rape was only recognised in 1995, so there have been only a few documented cases of sexual misconduct of a male doctor on a male patient. However, there have been cases when doctors have been accused of inappropriate behaviour by patients of the same sex. The guidance given by the *GMC today* was that if you feel it is necessary, you should ensure a chaperone is present.[16]

In 2003, Dr Leahy, a doctor staying in a backpacker's dormitory in Queensland, Australia was proven guilty of touching a male patient's penis through his boxer shorts and squeezing the end of his penis whilst he was asleep.[17] Clearly homosexual doctors can sexually harass a patient just as heterosexual doctors can. The Medical Protection Society recommended in 2004 that doctors should not assume they do not need a chaperone if they are the same sex as the patient.[18]

The issue of chaperones has implications for the nursing profession. A male nurse won a case of sex discrimination against two NHS trusts after he was not allowed to carry out procedures including electrocardiograms because one or both of the patient's breasts might be exposed. Female staff were not chaperoned when providing similar care to male patients. He complained that the trust had a different policy on chaperoning for male nurses.[19]

Do chaperones protect patients?

Furthermore, the presence of a chaperone does not always prevent inappropriate behaviour as illustrated in the case of Clifford Ayling.[3] The Inquiry was told the presence of a chaperone did not prevent Ayling from acting unprofessionally. In fact, the chaperone was sent out of the room from time to time. It could be argued that there is no role for a chaperone and the installation of video cameras could provide a more effective way of preventing inappropriate behaviour, also serving to protect doctors from false allegations.

What are the legal implications of harassment?

When the term harassment is used in a legal sense, it refers to the behaviours of persons which are found to be disturbing or even threatening to others and beyond those that are sanctioned by society. Sexual harassment refers to persistent and unwanted sexual advances, typically in the workplace, where the consequences of refusing are potentially very disadvantageous to the victim.

In the UK, the main legislation which protects people from harassment is the Criminal Justice and Public Order Act 1994. This Act only applies in England and Wales and provides means whereby intentional harm, alarm, or distress is a criminal offence. This makes all forms of harassment illegal, and punishable on conviction by a 6-month jail term or a £5000 fine. To prove harassment under this Act, it is necessary to prove that the harasser's actions were intentional, and that someone was actually harmed by their actions.

Another legislation protecting people from harassment is the Protection Against Harassment Act 1997. This Act was primarily created to provide protection against stalkers, but with time it has been used in other ways. Under this Act, it is an offence for a person to pursue a course of action which amounts to harassment of another individual, and that they know, or ought to know, what amounts to harassment. Under this act the definition of harassment is behaviour which causes alarm or distress. The Act provides for a jail sentence of up to 6 months or a fine. Under this Act, there are also a variety of civil remedies that can be used including awarding of damages and restraining orders backed by the power of arrest.

Both these legislations do not suggest that harassment is limited or restricted to a particular sex. Therefore, actions of males or females considered to be harassment would come under their purview.

There exist reported cases which suggest that a medical doctor's name is struck off from the register by the GMC on account of conducting an intimate examination on a patient of the opposite sex without the presence of a chaperone.[20,21] Although these cases have

set a precedent for the requirement of a chaperone while examining patients of a different sex, it is time that this aspect is looked at again under the relevant legislations and specific arguments put across in this paper.

Conclusion

There is no doubt of the importance of the role of the chaperone in protecting patients. However, the current GMC guidelines are limited to recommending the use of chaperones only during intimate examinations. Cases of inappropriate behaviour during examination of the torso have generated huge concern. Surely it is legitimate to question whether these guidelines are sufficient in protecting patients in all situations. In addition, with increasing acceptance and recognition of homosexuality, it is necessary to establish widespread awareness of doctors to use chaperones regardless of the sex of the patient, both for the protection of patients and themselves. In order to prevent actions being misinterpreted, it is imperative that the practitioner communicates exactly what he/she proposes to do and the reason for it.

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COMMENTARY

Most GPs reading this well-researched article will concentrate on the practicality of the measures it recommends. They will consider the implications of deploying extra staffing, of additional employment costs and the diversion of scarce resource away from productive clinical activity. I, however, challenge it on the fundamentally different parameter of whether it is an appropriate expression of risk-management — what is the problem to which this article is the answer?

The authors raise issues on the basis of a few reported cases over many years which, in the context of the annual number of consultations, are vanishingly small in comparison. They prescribe a chaperone within all 'sensitive' consultations, but forget that intimate examinations are often unpredictable, that a third party intrinsically compromises confidentiality and are often unwelcome to patients. How will this encourage the often reluctant attendance of anxious and suspicious teenagers?

The authors go further than the traditional area of anxiety and by reminding us that between 3 and 10% of the population are exclusively homosexual and they suggest the need for a chaperone in those consultations where doctor and patient are of the same sex. They propose an enormous administrative and human resource burden upon general practice to address a perceived problem that is either negligible or, in a more unlikely scenario in these days of accountability and scrutiny, significantly under-reported. If the authors are reasonably seeking to reduce risk, what additional risks would they perversely introduce in this endeavour?

First, and most significant, is that of adding petrol to the fire of suspicion engendered by the very rare cases they cite as evidence. This is the '*Daily Mail* approach' to risk that produced the banning of handguns and the destruction of an Olympic sport in the wake of Dunblane, anxieties over the appropriate use of opiates leading to sub-optimal terminal care post-Shipman ,and a discredited Dangerous Dogs Act.

Where there is an unscrupulous GP like Clifford Ayling and others, what is to prevent collusion with a perverted chaperone?

The doctor–patient relationship, as the authors themselves report, is built upon centuries of trust predicated upon professional medical regulation that is in place to protect patients and enhance confidence in their doctors. These proposals do nothing but pander to a society that demands certainty in all things, within a world outside our self-regarding British perception, that fundamentally needs access to clean water more than doctors, let alone chaperones.

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COMMENTARY

There are few things that a doctor fears more than being wrongly accused of sexual misconduct by a patient. Wai *et al* question whether the current GMC guidelines on the role of chaperones are sufficient to protect patients and doctors. They suggest that consideration of the use of chaperones during a wider range of examinations of patients, including their torso as well as intimate examinations should be considered.

The only way to completely avoid allegations of inappropriate conduct arising from the examination of patients is to cease seeing patients altogether. Since this is an unrealistic position to adopt the risk to both doctors and patients needs to be managed. Leaving aside the question of the extent of protection the chaperones actually provide, there are a number of broad areas which should be considered by practitioners when considering how to minimise the medico–legal risks involved in the examination of patients.

Communication. The need for good communication between patients and doctors has become somewhat clichéd over recent years. However, before proceeding to undertake any examination it is important to explain to the patient why an examination is necessary and give the patient an opportunity to ask questions. Following discussion of what the examination will involve and obtaining the patient's permission to proceed, the issue of whether the patient would wish a chaperone in attendance should be discussed.

Practices should have a clear chaperone policy which is published in practice literature.

Situational awareness. Before undertaking any examination of a patient it behoves doctors to ask themselves whether there is anything about the situation they find themselves in which increases the risk of misunderstanding between doctor and patient. Examples here might include examinations of parts of the body close to the genitals such as the hip, vulnerable patients, or situations where patients may be under duress such as in police custody. Examining patients whom one doesn't know particularly in circumstances where there is potential for antipathy between doctor and patient ,such as in Benefit Agency or Occupational Health situations, might also be considered at higher risk.

Feedback. Many of the high profile cases concerning alleged sexual misconduct are characterised by the fact that the accused doctor's colleagues had low grade concerns about the doctor's behaviour often for a considerable length of time before the problem came to light. It is important that practices have effective ways of letting practitioners know when their behaviour, whether simply naïve or as a result of more reprehensible reasons, may be placing them and their patients at risk.

The risk of doctors being the subject of false allegations of sexual misconduct remains low. A thoughtful approach to clinical risk management may be more appropriate than the blanket use of chaperones in clinical settings.

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