SURVEY 1

The use of chaperones by general practitioners

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SUMMARY. A postal questionnaire was sent to 200 male general practitioners to assess attitudes towards chaperones and the extent of their use when female patients are being examined. The response rate was 85.5 per cent. Of the 171 respondents, 23 (13 per cent) claimed they always use a chaperone and 42 (25 per cent) said they never do. Reported use and non-use were related to the doctor's age and to the size of the practice in which he works. The patient's youth and single marital status are apparently important determinants of the decision to use a chaperone, although many of the general practitioners rely on 'instinct'. Reasons given for non-use included inconvenience and habit. Many of the doctors said they felt the presence of a third party to be detrimental to the doctor-patient relationship and just as many said they believed the chaperone's presence to be beneficial.

Introduction

WHEN Henderson (1971) suggested that, with the passing of 'prudishness' and in a trusting doctor–patient relationship, chaperones were no longer needed in general practice, the secretary of the Medical Defence Union (Addison, 1971) replied that allegations of improper or indecent conduct on the part of the examining doctor were as frequent then as in any past decade. Although this last comment begs certain questions about the function of the chaperone, little further discussion has appeared in the literature and there is no information about the attitudes and practices of general practitioners in this respect. In an attempt to fill this gap in our knowledge and also because of the possible light that might be thrown on doctor–patient relationships, this study was undertaken. Its aims were to measure, by means of a questionnaire, the attitudes of general practitioners to chaperones and to assess the extent of their use in general practice.

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Methods

A questionnaire consisting of 12 main questions was sent to 200 male general practitioners whose names and addresses were obtained at random from the list of current general practitioners held by the Hampshire Area Health Authority Family Practitioner Committee. The questionnaire was accompanied by a letter explaining the object of the enquiry, emphasizing anonymity and stating that no reminder would be sent. A stamped addressed envelope for returning completed questionnaires was enclosed and respondents were invited to indicate any interest in seeing the results of the study.

The questionnaire asked the doctor's age, whether he was in single-handed or group practice, worked in a health centre, had a personal list of patients and whether the practice was in a town with a population greater then 50,000. Availability of nursing staff was enquired after and the general practitioner was asked to say whether he used a chaperone never, rarely, sometimes or always when examining female patients and to specify for which examinations he used one. Factors about the patient which influenced the doctor's decision were sought and he was asked whether the patient was consulted about the presence of a chaperone and who was used for this purpose. Finally he was asked to summarize his reasons for using or not using a chaperone.

The questionnaires were analysed manually; nine of the 12 questions could be scored directly from the questionnaire, while a scoring system containing categories of response to encompass virtually all the comments made in the open-ended questions was devised. It was then possible to determine whether certain features about the doctor, his practice or his patient influenced his use of a chaperone and to classify the main reasons for and against her use.

Spearman's rank correlation method was used to test the relationship between variables, and the chi-square test and Fisher's exact test were used to test the differences between groups.

Results

Of the 200 questionnaires posted, 171 were returned, a response rate of 85.5 per cent. All the questionnaires could be analysed.

The results are summarized in Tables 1 and 2. Overall, 75 per cent of doctors use a chaperone always or sometimes, and 25 per cent at no time. Most of the general practitioners who use chaperones do so for pelvic examination, with smaller numbers of doctors also using them during breast, abdominal and antenatal examinations; five doctors use a chaperone only in the

Table 1. Factors influencing the use of chaperones at pelvic examination: effect of general practitioner's age and size of practice.

	Number	Frequency of use (per cent)				Spearman rank correlation
		Always	Sometimes	Rarely	Never	
Age of general practitioner						
25–34	39	21	18	38	23	
35–44	40	12	43	25	20	ϱ =
45–54	57	9	25	40	26	0.13
55–64	32	12	16	38	34	$0.05<\varrho$
64+	2	—	—	100	—	<0.10
Size of practice						
Single-handed	8	38	—	50	12	
2	24	17	33	33	17	
3	23	4	30	39	26	ϱ =
4	44	9	30	34	27	0.4
5	39	18	18	33	31	$\varrho<0.001$
6	27	8	26	44	22	
6+	6	17	33	17	33	
Total	171	13	26	36	25	

Table 2. Factors influencing the use of chaperones at pelvic examinations: effect of practice characteristics and availability of staff.

	Number	Frequency of use (per cent)				Chi-square test
		Always	Sometimes	Rarely	Never	
Site of practice						
Urban	78	13	29	37	20	$\chi^2_3 = 1.82$
Non-urban	93	14	23	35	28	$P>0.5$
Health centre						
Yes	51	12	25	33	29	$\chi^2_3 = 1.02$
No	120	14	26	38	23	$P>0.5$
Personal lists						
Yes	99	15	22	35	27	$\chi^2_3 = 2.43$
No	63	10	30	38	22	$P>0.25$
Not known	9					
Staff available						
Yes	76	17	28	37	18	$\chi^2_3 = 3.17$
No	52	13	19	37	31	$P>0.25$
Not known	43					

antenatal clinic. Age had some bearing on the use of a chaperone, with older doctors using chaperones less often, and practice size was significantly correlated with non-use, with doctors in larger practices using chaperones less frequently. The single-handed group was too small for many types of analysis, but Fisher's exact test showed no significance ($P = 0.14$) in the apparent high incidence of single-handed general practitioners who always use a chaperone.

The site of the practice (whether or not in a town of over 50,000 inhabitants) had no effect on the use of chaperones. Similarly, health centre practice and the use of personal lists did not appear to be determinants. Only the availability of staff, defined as the presence of a nurse at morning and evening surgery, seemed to exert some influence on the use of chaperones.

When a chaperone is used she is almost invariably a nurse, although several respondents pointed out that the patient often brings her own 'chaperone' if a physical examination seems likely.

Reasons for use

Of the 129 general practitioners answering always, sometimes or rarely to the question about frequency of use, 87 (67 per cent) of them said they used a chaperone as medico-legal protection. Forty-seven (36 per cent) believed that having a chaperone in the room was of

benefit to the patient and 14 (11 per cent) said that she could be of practical help.

The main factors influencing the practice of the 106 (62 per cent) doctors answering sometimes or rarely to the question about frequency of use were the age (that is, youth) of patient, her single status and the doctor's knowledge of her. The distribution of age of the respondents among the group who felt that the youth of the patient was a reason for using a chaperone was no different from that in the sample as a whole. Other factors mentioned included old age of the patient, 'neuroticism' (a word used frequently), reference to psychiatric disorder) and, finally, 'instinct'.

Three respondents who always use a chaperone said that they did so because of a 'bad experience' (unspecified) in the past.

Although five respondents volunteered the information that they would not refuse a request from a patient for a chaperone, 99 (58 per cent) of the 171 respondents never asked the patient; several said that they felt that doing so introduced mistrust or an unwanted 'sexual' element into the consultation.

Reasons against use

Forty-two general practitioners (25 per cent of the sample) said they never use a chaperone. The reasons against doing so were varied: there was not enough time or it was impractical; the reassuring presence nearby of partners or female staff; the belief that patients did not want a chaperone; and a conviction that the presence of a third party interfered with the consultation, confidentiality and/or the doctor–patient relationship.

Discussion

The response rate of 85.5 per cent in this survey was high; postal questionnaires sent to general practitioners can normally be expected to yield a return of only 40–60 per cent (Bennett and Ritchie, 1975). This questionnaire was short, and dealt with a topic which is clearly of interest to general practitioners; 30 respondents indicated their interest in seeing the results of the survey.

The main findings of the survey were the wide range in frequency of use of chaperones among general practitioners and the lack of correlation of individual use with many factors such as urban practice, health centre practice and personal lists, although the doctor's age and the size of group practices did appear to exert some influence.

No less striking is the split in opinion evidenced by comments from the doctors who never use a chaperone and those who use one sometimes or rarely. Nearly half of the first group are convinced that the presence of a chaperone is disruptive to the consultation and the relationship, yet the same proportion in the second group believe that it is in the patient's interests to have a chaperone present. In one of the few studies on this topic, an American survey of female college students and staff (Weiss and Meadow, 1979) reported that the majority of women would prefer a nurse to be unobtrusive or absent during pelvic examinations.

True to the meaning of the word, most doctors use chaperones as medico-legal protection. This appears a prudent practice: every year some 30 doctors in receipt of unfounded allegations seek help from the Medical Defence Union. It does, however, presuppose a one-sided view of the possibility of improper behaviour, although this is a difficult area to investigate. For instance, a Californian survey of hospital staff and general practitioners (Kardener *et al.*, 1973) suggested that at least 5 per cent of respondents had engaged in sexual intercourse with patients. Some feminist groups have reported cases of women who "suffered embarrassment and harassment from male doctors they have consulted" (National Women's Aid Federation, personal communication).

In conclusion, although most general practitioners who use chaperones do so to prevent litigation, their sporadic use is unlikely to provide this protection. The factors determining an individual doctor's habits in respect of chaperones are unclear. Opinion about patients' wishes is divided, and there is also disagreement about the effect of a third party on the consultation and the doctor–patient relationship. The attitudes and expectations of female patients toward the use of chaperones is the subject of a further study.

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