What should GPs be doing about chaperones?

Trust remains the cornerstone of the relationship between a GP and patient. If a GP should use words or actions of a sexual nature with a patient in the context of the consultation, a professional boundary may have been crossed and the inherent trust between doctor and patient may have been compromised.¹ In this unique clinical environment, both patient and GP are vulnerable. Failure to address this issue can have life-changing repercussions for one or both parties.

INTRODUCTION

The use of medical chaperones (or the presence of a third party as observer) during clinical examinations is important whether one practises as a GP, specialist, medical student, nurse, or other member of the practice staff (for example, physiotherapist) who examines patients. This is regularly highlighted in tabloids and medical magazines where health practitioners have acted inappropriately, and minimising this risk to patients is an important component of good medical practice. The offer of a chaperone, as advocated by the General Medical Council and various medical defence organisations in the UK and elsewhere, goes some way to reduce this risk. As secondary functions, the role of a chaperone may include providing comfort to patients and protection for doctors from false allegations.² The accompanying commentary by Rob Hendry on the paper by Wai *et al* is probably a more pragmatic and succinct approach for GPs.³

WHAT IS THE ONGOING 'ISSUE' WITH MEDICAL CHAPERONES?

The concerns surrounding medical chaperones have been debated elsewhere over nearly three decades now and are not the purpose of this commentary.^{2,4,5} Rather, what should GPs be doing about chaperones (now, in the 21st century)? The latter phrase has specifically been added in parentheses to reflect our ever-changing social norms and attitudes. We need to acknowledge that general practice is very different from the hospital setting: GPs generally work alone as independent practitioners in their consulting rooms, when conducting home visits, and in doing out-of-hours work.

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"Perhaps the key issue with medical chaperones is that the offer (and uptake or not) of a chaperone and its subsequent documentation is erratic ..."

or not) of a chaperone and its subsequent documentation is erratic, not only between GPs but also where an individual GP is inconsistent in his or her approach.^{4,5} It is perhaps this practice variance that leaves GPs and other health professionals open to criticism, inference, potential allegation, and litigation.

IS THE TERM 'MEDICAL CHAPERONE' JUST A WESTERN CONCEPT?

There are certain limitations when comparing studies on chaperoning conducted in different countries, for example, with differences in healthcare systems, consultation style, and patient expectations. This is emphasised by the small number of studies, which were conducted in various secondary settings rather than in general practice. In addition, there is limited information about whether chaperones are used in some countries of the world.⁶ The research literature about medical chaperones in general practice is limited to a handful of predominately English-speaking countries.⁴⁻⁸ However, one would be naïve to think that sexual misconduct only occurs in these Anglosphere countries. This is evidenced by the number of medical negligence claims and episodes of sexual misconduct by doctors that have been reported beyond these predominately English-speaking countries.^{9,10} Whether the offer (and use) of a medical chaperone is merely specific to general practice in a few predominately English-speaking countries requires

further research. One can argue that perhaps chaperoning is not necessarily a concept relevant to a particular region, and/or culture that is, not just a Western concept, but an intervention based on need across all health professions.

To explore this further, we conducted a small pilot survey¹¹ among international GPs attending a world primary care conference in 2013. The results make for interesting reading and warrant further exploration. It showed that those participants who were not familiar with the term 'chaperone' or similar were more likely to have qualified in Europe (excluding the UK) and less likely to offer a chaperone. Although almost two-thirds of participants overall would consider offering a chaperone to a patient, only one in five reported that they would always use a chaperone. Chaperone availability, the time constraints of the consultation itself, and issues related to confidentiality and privacy were the three most frequently identified barriers among chaperone 'users'. The least three problematic factors were: cost; personal choice of the doctor; and lost opportunities to discuss intimate issues between the practitioner and patient. In comparison, non-users reported the 'personal choice of the doctor', 'confidentiality', and 'impact of the doctor-patient relationship' as the three main areas influencing their decision not to use a chaperone.

WHAT DO PATIENTS THINK?

Most research has been conducted in sexual

"... practice variance ... leaves GPs and other health professionals open to criticism, inference, potential allegation, and litigation."

“... there is a need to look again at this ‘well established’ topic.”

health clinics where patients are likely to anticipate an intimate examination.¹² Whether these results can be extrapolated into the general practice setting remains untested.

The literature contains very little on the views and opinions of patients in UK general practice,^{13–15} sometimes limited to only one GP practice, only female patients, or pioneering research completed nearly 30 years ago. Taking these limitations into account, there is some commonality. Patients do want to be offered a chaperone. Whether they choose to take up the offer varies depending on the doctor they consult with: patients are less likely to prefer a chaperone to be present with their usual doctor than with another doctor. How common actual chaperone uptake is in general practice (and its electronic documentation) is something that remains unanswered.

A recent study highlights that patients attending a GP practice may be unaware of the term ‘chaperone’¹³ and emphasises the need for an appropriate (and contemporary) communication style (printed and verbal). One of our main learning points from designing a questionnaire aimed at an international audience is to refrain from using (English) medical jargon such as the term ‘medical chaperone’ (and likewise for patients). Instead, participants were more likely to understand the concept when applied to a clinical scenario in their daily practice (or a patient visiting his or her GP or nurse).

IMPLICATIONS FOR FUTURE RESEARCH

There is a need to gain an updated, contemporary view from patients in general practice on the offer (and uptake) of medical chaperones. The most recent large survey among GPs conducted in England only, was almost 10 years ago.⁵ This in turn will inform how best to address and implement the practice of medical chaperoning in general practice and complement patients’ views. Similarly, there is a need to extend and compare this research beyond the UK, perhaps with the help of international organisations such as the World Organization of National Colleges, Academies and Academic Associations of

General Practitioners/Family Physicians (WONCA). The aim would be to tease out why some practitioners offer and/or use medical chaperones while others do not.

CONCLUSION

Doctors who do and do not use chaperones hold different views about their effect on the consultation and their impact on the doctor–patient relationship. Likewise, the views of contemporary patients may also differ and are dependent on their understanding of what ‘chaperoning’ entails. We cannot assume that social norms are unchanged in 21st-century Britain and there is a need to look again at this ‘well established’ topic. This is not only because of our changing society, but also because of uncertainty about custom and practice internationally. There are new opportunities for research in areas such as electronic documentation of chaperone offer and uptake.

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Provenance

Freely submitted; externally peer reviewed.

Acknowledgements

The authors wish to thank all of the GPs who participated in this pilot work during the WONCA World Conference, Prague 2013. The RCGP International Scholarship (Katharina von Kuenssberg Award) supported OVH to attend the WONCA World Conference 2013. Professor Leon Piterman AM (Office of the Pro Vice-Chancellor, Berwick and Peninsula Campus, Monash University, Australia) supported Kay Jones to attend the WONCA World Conference.

Competing interests

The authors declare that they have no conflict of interests.

DOI: 10.3399/bjgp14X682489

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