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Research paper

Patients' views on and professionals' use of chaperones during intimate examinations in primary health care: a review

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ABSTRACT

Background In the UK, the conviction of several general practitioners for sex offences against patients has led to recommendations on use of chaperones in general practice.

Aim To determine (i) the preferences of patients for the presence of a chaperone and (ii) the use of chaperones in primary care.

Design Qualitative review of published articles.

Method A bibliographic search for articles published up to March 2007 reporting quantitative or qualitative studies of patients' views on and professionals' use of chaperones in primary health care.

Results Five studies of patients' views were identified, none being undertaken in more than three general practices. In two studies, 75–90% of respondents wanted a chaperone offered, but in a third only 35% of females and 10% of males wanted a chaperone offered. In all studies, patients' preferences for the presence of a chaperone varied depending on a variety of factors, including age and sex of the patient and doctor. Ten studies of the use of chaperones were identified and indicated that male general practitioners increasingly report routine offer and use of a chaperone for intimate examinations of female patients, but female general practitioners commonly do not.

Conclusion The studies included in this review indicate that male general practitioners should adopt a policy of routinely offering a chaperone by a practice nurse for intimate examinations of female patients. Research into the role of chaperones is limited, and more evidence is needed about how and when offers should be made by male and female primary healthcare professionals, the views of certain patient groups including ethnic minorities, and the costs of ensuring the ready availability of chaperones in primary care.

Keywords: chaperones, patient safety, primary healthcare

How this fits in with quality in primary care

What do we know?
Current guidance advises that a chaperone should be present if an intimate clinical examination is carried out in most situations in general practice.

What does this paper add?
This paper reviews the published literature on the preferences of patients for the presence of a chaperone and the use of chaperones in primary care. Patient preference for a chaperone varied depending on age and sex of the patient and doctor. Male general practitioners increasingly report routine offer and use of a chaperone for intimate examinations of female patients, but female general practitioners commonly do not. The studies included in this review indicate that male general practitioners should adopt a policy of routinely offering a chaperone for intimate examinations of female patients.

Introduction

The recent cases of two UK general practitioners (GPs) who were convicted of committing sexual offences against patients have raised concern about the need for chaperones during intimate examinations. In 2000, Peter Green was convicted of nine counts of indecent assault on five patients, and a subsequent review indicated that Green had not complied with his practice's chaperone policy, and that the implementation of the policy had not been monitored.[1] The review recommended auditing of chaperoning policies, training to raise awareness of staff to the issue, and local determination of the most appropriate staff to take on the role of chaperone. Clifford Ayling was convicted in 2000 on 12 counts of indecent assault relating to 10 patients. The subsequent independent statutory inquiry made several recommendations, including that: (i) patients should be able to choose whether to have a chaperone present; (ii) chaperoning should not be undertaken other than by trained staff; (iii) NHS trusts should develop a chaperoning policy; and (iv) breaches of the policy should be formally investigated through each trust's risk-management or clinical governance arrangements.[2] However, in addition to offering some protection to patients from sexual offences by doctors, chaperones can protect the doctor from unfounded complaints and help patients feel less embarrassed when undergoing intimate examinations.

The joint advice of the Royal College of General Practitioners and the British Medical Association's General Practitioner Committee is contained in *Good Medical Practice for General Practitioners*,[3] which recommends that 'You should always arrange for a chaperone to be present if intimate clinical examinations are carried out in situations that are open to misinterpretation'. The Royal College of Obstetricians and Gynaecologists has recommended that 'A chaperone should be available to assist with gynaecological examinations irrespective of the gender of the gynaecologist'.[4] The General Medical Council (GMC) issued guidance in 2001, defining an intimate examination as involving examination of the breasts, genitalia or rectum.[5] It advised that the reason for the examination should be explained, consent obtained, discussion kept relevant, a chaperone be offered or the patient invited to have a relative or friend present, the identity of the chaperone should be recorded in the records, and if the offer of a chaperone is declined this should be recorded in the notes.

Despite the advice of the professional bodies, however, some issues remain unclear. It may be difficult to always ensure that a chaperone is available in primary care,[6] for example when attending patients in the home, and the costs of always providing a chaperone in all practices, including the small practice or branch surgery, is uncertain. Furthermore, patients' preferences for a chaperone may vary according to gender, age, ethnic group, the established relationship between the patient and the doctor or nurse, and other factors. Different doctors may also have different preferences for the presence of a chaperone. Therefore, we undertook a review of current evidence with the specific aims to determine (i) the preferences of patients for the presence of a chaperone and (ii) the use of chaperones in primary health care.

Method

Searches for potentially relevant literature were conducted in the following 10 electronic databases: MEDLINE (1966 to March 2007), EMBASE (1980 to March 2007), the Cochrane Library (Issue 1, 2007), CINAHL (1982 to March 2007), AMED (1985 to March 2007), BNI (1994 to March 2007), PsycINFO (1987 to March 2007), DH-DATA (1983 to March 2007), ASSIA (1987 to March 2007), and Sociological

Abstracts (1963 to March 2007). Search terms employed included 'chaperone' (and the alternative spellings: 'chaparone' and 'chaparon'), 'third party', 'primary care', 'primary health care' 'general practice', 'family practice', 'family physician' 'physician–patient relations', and 'physical examination'. Relevant MeSH terms were used where available, and these were combined with free text terms. MEDLINE In-Process was also searched (May 2007) for any relevant literature not yet indexed in MEDLINE. An internet search on the Google search engine was conducted using the term 'chaperone'. No systematic effort was made to search the grey literature for unpublished reports. Details of all searches are available on request. The GMC's definition of intimate examination was followed. The titles and abstracts of all identified articles were reviewed independently by two reviewers for relevance, and the full text of articles identified as relevant by at least one reviewer was obtained.

The articles were assessed for relevance, and the data extracted into tables by two researchers. A standard assessment tool was used to appraise the quality of the studies.[7] Studies were included if they were reported in English and had been undertaken in primary care and had investigated the views of patients and/or primary care doctors or nurses on the role of chaperones. We included either qualitative or quantitative observational studies and also experimental studies, for example comparisons of the impact of chaperones versus no chaperones. Studies were excluded if they had been undertaken in secondary care because patients in these settings tend to be selected and may have more serious problems with associated greater anxiety and therefore potentially different views on the need for intimate examinations. In addition, clinics in secondary care and also family planning clinics may have more staff and examination rooms available, and hence fewer barriers to undertaking intimate examinations. The reference lists of included articles were also scanned to check for relevant articles not already identified by the searches.

Results

A total of 85 articles were identified as potentially relevant. Of these, 71 were excluded because they were letters in response to articles or expressing the personal opinion of the author, general discussion articles, had been undertaken in specialist outpatient settings or were otherwise not relevant. No experimental studies were identified. Study quality was generally satisfactory, although most studies were limited in size and involved only small numbers of practices.

Five studies of patients' views were identified, two from the UK, two from the US and one from Canada (see Table 1).[8–12] All five involved the administration of questionnaires, although one also involved focus groups.[12] Three studies were undertaken in single primary care practices, one in two practices and one in three practices. Three were restricted to women patients, but two included both men and women. Two studies were concerned with pelvic examinations only.[8,9] In the three studies that specifically asked whether patients thought they should be offered a chaperone, the majority (75–90%) of respondents in two studies wanted a chaperone offered, but in the third study undertaken in a single US practice, only 35% of females and 10% of males wanted a chaperone offered. In all studies, patients' preferences for the presence of a chaperone varied depending on a variety of factors. Women were more likely to prefer a chaperone if the examining doctor was male,[9,11] particularly those women who would prefer a female professional if possible, and if the examination was pelvic rather than breast.[11] When being examined by the usual doctor, fewer patients expressed a preference for the presence of a chaperone.[9,12] Men were less likely than women to want a chaperone present – 7% of males in one study,[10] and up to 13% in another[12] preferring a chaperone for intimate examinations. Patient age also influenced preferences. In one study, younger female patients tended to prefer consulting female doctors for intimate examinations.[11] In a US study older women were more likely to prefer a chaperone when being examined by either a male or female doctor,[10] but in a UK study younger women and those who had not had a pelvic examination before were more likely to express a preference for a chaperone.[9] Female teenagers were more likely than adults to prefer a chaperone with a male doctor, but the evidence about the preferences of male teenagers is very limited.[11] In two UK studies, the majority of respondents thought the chaperone should be a nurse,[9,12] and in the most recent UK study 74% of respondents said that receptionists were not acceptable as chaperones.[12]

Ten studies of the use of chaperones were identified, six from the UK, two from the US, one from Canada and one from Nigeria (see Table 2).[13–22] Nine involved questionnaire surveys of samples of GPs (in two cases national samples)[19,20] to investigate reported use of chaperones, and one was a qualitative study involving lesbian, gay or bisexual health professionals.[18] One of the surveys was restricted to male doctors examining female patients,[15] one to rectal examination,[14] and one to cervical cytology,[19] all the others involving male and female GPs and examination of male and female patients.

Table 1 Studies of the views of patients

Paper	Design	Subjects	Country	Findings
Jones, 1985[8]	Questionnaire survey of women consecutively attending a single general practice	190 women	UK	Six percent of women wanted, 61% did not mind, and 33% would prefer not to have another female present when having a pelvic examination by the patient's own doctor. If it was another doctor, 17% would prefer a chaperone, and 57% did not mind; 75% thought the doctor should ask if a chaperone was preferred. Women who wanted a chaperone were younger.
Patton *et al*, 1990[9]	Postal questionnaire survey of a systematic sample of women patients of a family practice	440 women patients	US	Overall, 56.4% of women had no preference for the sex of the doctor, but in those aged 18–24 years this was 39.0%, and in those 65 years or older, it was 66.7%. Preference for a chaperone was related to preference of sex of doctor, 75.8% of patients preferring a female doctor wanted a chaperone if the doctor was male, but only 20.8% if the doctor was female. Of those preferring a male doctor, 61.2% wanted a chaperone if the doctor was male, and 47.5% if female; of those with no preference for sex of doctor, 57.8% wanted a chaperone if the doctor was male and 36.0% if female.
Penn and Bourguet, 1992[10]	Questionnaire survey of patients attending a family practice	251 female and 201 male patients aged 14 years and over	US	Thirty-five percent of females and 10% of males preferred the offer of a chaperone; 30% of females and 12% of males said they would feel uncomfortable requesting a chaperone. If the doctor was of the same sex, 9% of females and 3% of males preferred a chaperone; 31% preferred the chaperone to be a nurse, and 24% a spouse (66% of teenagers preferred a parent).
Webb and Opdahl, 1996[11]	Cross-sectional questionnaire study of women aged 18 years or older attending two family physicians	336 women	Canada	Ninety-nine percent and 93% of respondents had previously had a pelvic and breast examination, respectively. A chaperone was more likely if the doctor was male rather than female for both pelvic (68% versus 18%) and breast examinations (42% versus 14%). Fifty-two percent and 51% had no preference for sex of doctor for breast and pelvic examinations, 42% and 43% preferred a female doctor respectively; 50% preferred a chaperone for breast examination and 62% for pelvic examination if the doctor was male, but only 24% and 30% if the doctor was female. Eight percent reported having experienced physicians who behaved in less than a professional manner (three female doctors, 22 male doctors).

Table 1 Continued

Whitford *et al*, 2001[12]	Cross-sectional questionnaire survey	190 men and 261 women randomly sampled from three practices	UK	Three percent of men and 11% of women would prefer a chaperone when the usual doctor is of the same sex; 11% of men and 51% of women when the usual doctor was of the opposite sex; 13% of men and 55% of women when other than the usual doctor. Ninety percent of women and 78% of men thought they should be offered a chaperone; 74% of all respondents stated that receptionists were not acceptable as chaperones.

Table 2 Studies of the use of chaperones in general practice

Paper	Design	Subjects	Country	Findings
Conway and Harvey, 2005[13]	Questionnaire survey of samples of GPs in Norfolk	178 male and 106 female GPs	UK	Forty-five percent of male and 92% of female GPs reported never or rarely using a chaperone for intimate examinations on women; 96% of male and 87% female GPs never or rarely used a chaperone for intimate examinations of men. When used, the chaperone was reported as usually a nurse (75% of respondents), 18% reporting a receptionist as the usual chaperone.
Hennigan *et al*, 1990[14]	Questionnaire survey of GPs' decisions to do a rectal examination	609 GPs	UK	GPs were deterred from doing a rectal examination by the reluctance of the patient (278, 45.6%), the expectation that the examination would be repeated (141, 23.2%), lack of time (123, 20.2%) or lack of a chaperone (39, 6.4%).
Jones, 1983[15]	Questionnaire survey of male GPs	171 GPs	UK	Seventy-five percent of doctors always or sometimes used a chaperone, and 25% at no time.
Obionu, 1998[16]	Interview study of GPs	15 female and 85 male GPs	Nigeria	Seventy-two percent of doctors rarely or never used chaperones, and only 3% always used chaperones during examination of the opposite sex.
Price *et al*, 2005[17]	Questionnaire survey of primary care physicians	500 physicians	Canada	Chaperones were more commonly used with female than with male patients and highest for female pelvic examinations. Sixty-nine percent of respondents reported using nurses as chaperones; 15% cited using other office staff; 10% relied on the presence of a patient's family member. The availability of a nurse in the clinic was associated with more frequent chaperone use.

Table 2 Continued

Paper	Design	Subjects	Country	Findings
Renfroe and Replogle, 1991[18]	Questionnaire survey of primary care physicians	994 physicians	US	92.6% of male doctors always used a chaperone when undertaking a pelvic examination of female adults, and 94.0% in female adolescents; 26.7% of female doctors usually did not use a chaperone for adult females, and 24.7% for adolescent females; 8.4% of male doctors and 50% of female doctors usually used a chaperone when examining the genitalia of male adolescents, but in adults the proportions were 2.3% and 31.6%, respectively.
Riordan, 2004[19]	Qualitative study of lesbian, gay or bisexual healthcare professionals	16 subjects, including four GPs	UK	Desexualisation strategies such as use of a chaperone assume heterosexual orientation and present difficulties for lesbian, gay and bisexual health professionals.
Rockwell *et al*, 2003[20]	Questionnaire survey of random sample of active members of the American Academy of Family Physicians	3551 respondents	US	Eighty-four percent of male and 31% of female physicians reported using a chaperone. In addition to gender, younger physician age and doing fewer smears per month were also associated with greater use of chaperones.
Rosenthal *et al*, 2004[21]	A questionnaire study of doctors in 18 primary care trusts	1246 respondents	UK	Thirty-seven percent of respondents had a policy on use of chaperones; 68% of male and 5% of female GPs usually or always offered a chaperone; 54% of male and 2% of female GPs usually or always used a chaperone; 8% of males and 70% of females never used one. Use of chaperones was correlated with increasing age of GP, belonging to a non-white ethnic group, and working in a smaller practice. Practice nurses were reported as likely to be the chaperone by 78% of GPs, a family member by 47%, non-clinical member of staff 43%, a student or GP registrar 22%, another doctor 10%. Issues affecting use of a chaperone included costs, the doctor–patient relationship, time and availability. Patient factors influencing doctors included 'instinct', a psychiatric history, the patient's ethnic group and age.
Speelman *et al*, 1993[22]	Cross-sectional questionnaire survey	51 female and 181 male doctors in Norfolk	UK	Thirty-one male doctors felt uncomfortable and 129 felt comfortable without a chaperone. Sixty-five percent of male doctors (90% of female doctors) never or rarely used a chaperone or intended to offer a chaperone. Sixteen percent (0% of female doctors) always and 19% (6% female doctors) sometimes used a chaperone. Male doctors mostly used practice nurses (135), but 40 also used receptionists.

The surveys indicate that an increasing proportion of male GPs report routine offer and use of a chaperone for intimate examination of female patients, but female GPs commonly do not use chaperones for the same examinations.[13,15,19–22] In addition to sex of the doctor, factors associated with the greater use of chaperones included the examination of the genitals, undertaking a high number of cervical smears,[19] the availability of a nurse in the clinic (to act as chaperone),[22] and the doctor being older, of a non-white ethnic group or working from a smaller practice.[20] Reasons given for not using a chaperone included intrusion on the doctor–patient relationship,[21] confidentiality and availability of a chaperone.[20] Lack of a chaperone was also reported as one reason for failure to perform a rectal examination.[14] Practice nurses were the most common chaperones, although a family member or another member of the practice staff was sometimes used.[13,20–22] The doctor's sexual orientation and the patient's awareness of that orientation may also be a factor in deciding whether or not to offer a chaperone.[18]

Discussion

There are relatively few studies about patients' views on and professionals' use of chaperones in general practice. Our review brings together the available evidence in order to provide guidance to practitioners and policymakers. The review has some limitations. Since we excluded studies not reported in English, relevant studies from some other countries may have been overlooked. The search was broad and we believe it included all relevant published articles, although we did not contact study authors to ask if they knew of other relevant articles. The studies themselves were limited in terms of numbers of practices involved and the predominance of questionnaires over more in-depth qualitative methods. We excluded studies of the use of chaperones in settings other than primary health care since, while these studies might have thrown light on the views of specific patient groups, it would have been difficult to extrapolate this information to primary care. For example, we excluded studies of women attending family planning services; these services are almost entirely provided by female health professionals and the patient group involved – women of reproductive age – is only a subgroup of the mix of people attending primary health care.

A small number of researchers have recognised the importance of the issue and have conducted sufficient studies to support a policy of routine offer by male doctors to female patients of a chaperone when conducting pelvic examinations and taking cervical smears. The evidence also indicates that the chaperone should be a nurse rather than a non-clinical member of the practice staff, although more information is needed about patients' views on family members as chaperones. It is also clear that some women do not want a chaperone to be present, and some do, irrespective of the sex of the doctor. This presents considerable opportunity for misunderstandings unless the preferences of individual patients are established before examinations are undertaken. Moreover, it is not clear whether a patient's preference not to have a chaperone should be over-ruled to reduce the risk of unfounded complaints against the doctor. The available evidence does not provide detail about how the offer of a chaperone should be made, for example whether it should be in writing during a consultation, at the time the appointment is made, announced in practice leaflets or on posters, or made verbally, nor what form of words should be used. The impact of the offer of a chaperone on the patient–doctor relationship also requires investigation.

There were relatively few studies of patients' views, and they had been undertaken in a limited range of practices, a fact that may explain some of the differences in findings between studies. Research is required involving a wider range of patients, including those from ethnic minorities, particularly vulnerable patients and different age groups including teenagers. Most studies of the use of chaperones by GPs relied on respondents' reports of their usual approach. Studies of what actually happens in practice are therefore required. Furthermore, qualitative studies are required to better understand the reasons for patients' preferences, the use of chaperones in the context of the doctor–patient relationship, and potential barriers and facilitators to their use. The development of practice policies on use of chaperones also requires evidence about the costs of ensuring the ready availability of a chaperone.

Until more evidence is available, practices should be advised to implement a policy of routinely offering a chaperone for intimate examinations. Research funders concerned about patient safety or patients' experiences of care should commission additional studies to enable better understanding of: which patients may prefer a chaperone and when; in what manner to offer a chaperone; how concordant the views of patients and providers are; and how primary care services can be organised to ensure a chaperone is available when needed.

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CONFLICTS OF INTEREST

None.

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