Chaperone use amongst UK urological surgeons – an evaluation of current practice and opinion

V Modgil¹, R Barratt², DJ Summerton³, A Muneer²

¹Heart of England NHS Foundation Trust, UK

²University College London Hospitals, UK

³Leicester General Hospital, UK

ABSTRACT

INTRODUCTION Intimate examinations are routinely performed by urologists as part of clinical practice. To protect patients and doctors, the General Medical Council offers guidance on the use of chaperones for intimate examinations. We assessed the opinions and use of chaperones amongst members of the British Association of Urological Surgeons (BAUS).

METHODS An online questionnaire comprising 12 questions on the use of chaperones in clinical practice was sent to all full, trainee and speciality doctor members of BAUS.

RESULTS The questionnaire had a response rate of 26% (n=331). The majority of respondents were consultant urologists, comprising 78.8% (n=261), with a wide range of years of experience. Of the respondents, 38.9% were not aware of the GMC guidance on chaperones. While 72.5% always used a chaperone, 22.9% never use a chaperone when the patient was of the same sex. Chaperones were most commonly used for intimate examinations (64.6%), and for examinations involving members of the opposite sex (77.3%). A majority of respondents felt that chaperones protect both the patient (77.3%), and the doctor (96.6%). However, 42.5% did not feel that using a chaperone assists the doctor's examination, and some (17.2%) participants felt that chaperones were unnecessary.

CONCLUSIONS This study shows considerable variability amongst urologists in their use of chaperones. A significant proportion of respondents were not aware of the GMC guidelines and did not regularly use a chaperone during an intimate examination. In addition, practice appears to be gender biased. Further study and education is suggested.

KEYWORDS

Patient chaperone – Physical examination – Attitude of health personnel – Informed consent – Surgeons

Accepted 28 October 2015

CORRESPONDENCE TO

Vaibhav Modgil, E: vmodgil@nhs.net

Healthcare professionals and, in particular, urologists routinely ask patients personal questions and perform intimate physical examinations. The assessment of a urological patient often includes the examination of external genitalia and a digital rectal examination. The General Medical Council (GMC) recently updated their guidance on the use of chaperones for intimate examinations to protect both the patient and the healthcare professional. It is therefore important that clinicians appreciate the importance of using chaperones in clinical practice.

The physical examination of patients, especially those of an intimate nature, can be both embarrassing and distressing for patients.¹ A survey of consultants in York and West Yorkshire hospitals specialising in colorectal, urology and genitourinary medicine and obstetrics and gynaecology found that 93% of respondents considered the use of chaperones to be important for the protection of doctors, whereas only 84%

viewed this as necessary for the protection of patients. Interestingly 72% of consultants felt that the use of a chaperone was important for medicolegal purposes.²

There are two important and basic principles to consider when examining a patient. First, that the examination is proven to aid the assessment of a patient and is clinically necessary. This can be tested using the 'Bolam principle'. Second, the patient must give his or her informed consent to being examined. In the event that the patient lacks capacity, the examination must be carried out only in the patient's best interest.^{3,4} In the absence of these two requirements, a clinical examination may be considered an assault.^{5,6}

In response to the findings of the 2004 Ayling enquiry, it is now mandatory for every NHS trust to have a formalised chaperone policy, breaches of which should be investigated promptly and thoroughly.⁷ However, a 2010 survey of emergency departments in the UK found that only 3.65%

of all departments had a formal chaperone policy and 25.61% reported receiving complaints involving intimate examinations.⁸ This finding is not unique to emergency departments. A survey of genitourinary medicine consultants found that, of the 175 responders, only 11.4% worked in a hospital which had a chaperone policy, and a further 8% reported knowledge of complaints concerning intimate examinations.⁹

Information related to the use of chaperones in UK medical practice is currently limited. Moores *et al* found that all specialties reported offering chaperones to female patients. However, only 28% of urologists offered a chaperone for male patients, compared with 38% of colorectal surgeons and 90% of genitourinary physicians. These findings were echoed by a national survey of emergency departments and a review of studies on the use of chaperones by general practitioners.^{8,10}

Importantly, from a patient's perspective, the literature suggests that patients do not always want a chaperone during an intimate examination. Furthermore, if patients do request a chaperone, they are likely to prefer chaperones to be of the same gender.^{10–15} One study conducted in a UK urology outpatients setting found that many patients prefer the chaperone to be a friend or family member, although the GMC does current consultant workforce deem them to be acceptable as chaperones.^{13,14}

There is a paucity of literature related to the use of chaperones amongst urological surgeons. Clearly this is a pertinent topic in a specialty such as urology, where it is important to establish best-practice guidelines. To achieve this, it is necessary to establish current views and practice amongst urological surgeons. We endeavoured to achieve this via circulation of a short questionnaire to urological surgeons in the UK.

Methods

A survey was sent to all full, trainee and specialist members of the British Association of Urological Surgeons (BAUS) using the online tool SurveyMonkey. The survey was available online for one calendar month, and consisted of 12 questions. These were designed to capture the demographics of the responder, and their views and current practice with regards to the use of chaperones in the clinical setting (Table 1). Responders were given a choice of answers for each question and, where appropriate, this followed a formalised graded scale. Responders were only able to answer questions in a set sequence, and had to answer all the questions in the survey.

Results

All 1269 BAUS members were invited to participate, with 331 members answering the online questionnaire, which equated to a response rate of 26%. Interestingly, the majority of the respondents were consultant urological surgeons (78.8%, n=261; Figure 1), with 68.28% having had over 10 years of experience within urology. Overall, 90% of

Table 1 Questionnaire sent to full, trainee and specialist members of the British Association of Urological Surgeons.

Number	Question
1	Please state your grade
2	What is your gender?
3	Please choose the option which most appropriately describes the number of years you have spent in the practice of Urology
4	Are you aware of the GMC guidance on the use of chaperones?
5	How would you describe your use of chaperones with patients of the opposite sex?
6	How would you describe your use of chaperones with patients of the same sex?
7	Please describe the availability of chaperones during your clinical practice? (includes all clinical settings)
8	Do you ask the patients if he/she would like a chaperone?
9	What do you do if a patient declines a chaperone?
10	When do you use a chaperone
11	Do you document the use of a chaperone in the notes?
12	Do you feel the chaperone/use of a chaperone: Assists the doctors examination? Assists the patient? Protects the patient? Protects the doctor? Is a legal obligation? Is necessary?

respondents were male, and the remaining 10% female, which reflects the current consultant workforce.

While 38.9% of those surveyed were not aware of the GMC guidance on chaperones, 72.5% stated that they always use a chaperone when performing an intimate examination on a member of the opposite sex. Conversely, 62.8% rarely used a chaperone and 22.9% never used one when performing intimate examinations on a patient of the same gender. The most common reason for using a chaperone was performing any examination on a member of the opposite sex (77.3%), followed by performing an intimate examination on any patient (64.6%).

Only 28.1% of the cohort routinely asked a patient if they would prefer the presence of a chaperone. In the event that a patient declined a chaperone, 37.4% would refuse to perform the examination and 19.3% would continue with the examination; 43.2% would advise the patient that it is more appropriate for a chaperone to be present (Figure 2). Only 41% of urologists would document the use of a chaperone in the clinical notes.

Chaperones were felt to be of no assistance to the doctors' examination by 42.5% of respondents, but 72.2% felt they assisted the patient. The majority felt that using a chaperone protects the patient or the doctor (80.2% and

97.2%, respectively), and 82.3% felt that the use of a chaperone was necessary when performing intimate examinations. Despite this, 68.7% stated they did not think the use of a chaperone was a legal obligation and 17.8% felt that using a chaperone was unnecessary.

In terms of availability, 53.1% of respondents stated a chaperone was always available, with only 9.6% stating that they were rarely or never available (Figure 3).

Discussion

The 2004 Ayling enquiry recommended that each trust have a chaperone policy, and that every patient should have the choice to have a qualified chaperone present at intimate examinations, regardless of the clinical setting.⁷ These recommendations have been reiterated in the GMC guidelines on intimate examinations and the use of chaperones.¹⁴ These state that a chaperone should be offered regardless of the patients' gender, and that the chaperone should be a qualified healthcare professional unrelated to the patient. If a patient refuses a chaperone or one is unavailable, the reasoning behind the need for a chaperone must be clearly explained to the patient. A patient with capacity, who understands the rationale for using a chaperone, may decline the offer for one to be present during examination. In such cases, it is the clinician's decision on

whether or not to proceed. A clinician can refuse to examine a patient in the absence of a chaperone; however, they should refer the patient to a colleague for a second opinion with minimum delay.

The offer, and use, of a chaperone, including their full name and designation, should be clearly documented in patients' notes.¹⁴ Offering a patient a chaperone must not be underrated. A recent survey showed that the act of offering a chaperone is viewed by patients as a sign of respect, regardless of whether they actually desire a chaperone or not, and this is beneficial to the patient-doctor relationship.^{12,15}

Our survey provides an insight into the use of chaperones among UK urological surgeons. Given that a high proportion of respondents were consultant urological surgeons, it also demonstrates a large variability in clinical practice within the UK, with a less-than-satisfactory adherence to the GMC guidelines.

Despite the majority of participants using chaperones for patients of the opposite gender, many do not offer or use chaperones for patients of the same gender. This may be because urologists make assumptions about patients' wishes, which may be inaccurate.

If, however, a patient is asked about using a chaperone, many urologists do follow the GMC guidance on how to proceed, although data on the delay for patients who were

not examined due to examiner refusal was not collected. Even though best practice is often followed, this was not regularly documented in the clinical notes by half of our cohort.

Encouragingly, we found that the majority of urologists feel that chaperones are useful to protect both the patient and doctor, and should be used where possible.

Our findings are in keeping with previous surveys. Commonly, examiners from a variety of specialities will not use a chaperone for a patient of the same gender as themselves, but will almost always use a chaperone if the patient is of the opposite sex.^{2,8,10} Evidently there is work to be done to promote the guidelines set in place by the GMC and change practice.

Conclusions

Our findings reveal considerable variability amongst urologists in their use of chaperones. Moreover, a significant proportion of respondents were not aware of the GMC guidelines and did not regularly use a chaperone during an intimate examination. Practice also appears to be gender biased. We recommend that this highly sensitive and topical issue be further explored, with emphasis on establishing clear guidelines and education for doctors in all specialities, including urology.

Conflicts of interest

The authors confirm that neither they nor their institutions have at any time received payment or services from a third party for any aspect of the submitted work. Equally, the authors are not part of any relationships (financial or otherwise) with any parties that could be perceived or give the appearance of potentially influencing the content of the submitted work.

Acknowledgments

The authors would like to thank the BAUS members who kindly gave their time to complete the survey and SurveyMonkey, which facilitated the questionnaire.

References

1. Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations-teaching tomorrow's doctors. *BMJ* 2003; **326**: 97–101.
2. Moores KL, Metcalfe NH, Pring DW. Chaperones and intimate physical examinations: consultant practice and views on chaperonesnull. *Clinical Governance: An Intl J* 2010; **15**: 210–219.
3. Bolam v Friern Hospital Management Committee, 1 WLR 583 (1957).
4. R (N) v Dr M, EWCA Civ 1789 (2002).
5. Griffith R. Intimate examinations and trained chaperones. *British Journal of Healthcare Management* 2009; **15**: 337–342.
6. Airedale NHS Trust v Bland, AC 789 (1993).
7. Department of Health. *Committee of Inquiry. Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling*. Cm 6298. Norwich: HMSO; 2004.
8. Loizides S, Kallis A, Oswal A *et al*. Chaperone policy in accident and emergency departments: a national survey. *J Eval Clin Pract* 2010; **16**: 107–110.
9. Torrance CJ, Das R, Allison MC. Use of chaperones in clinics for genitourinary medicine: survey of consultants. *BMJ* 1999; **319**: 159–160.
10. Baker R, Mulka O, Camosso-Stefinovic J *et al*. Patients' views on and professionals' use of chaperones during intimate examinations in primary health care: a review. *Quality in Primary Care* 2007; **15**: 337–344.
11. Sharma A, Beveridge HA, Fallowfield LJ *et al*. Postmenopausal women undergoing transvaginal ultrasound screening prefer not to have chaperones. *BJOG* 2006; **113**: 954–957.
12. Feldman KW, Jenkins C, Laney T *et al*. Toward instituting a chaperone policy in outpatient pediatric clinics. *Child Abuse Negl* 2009; **33**: 709–716.
13. Sinclair AM, Gunendran T, Pearce I. Use of chaperones in the urology outpatient setting: a patient's choice in a "patient-centred" service. *Postgrad Med J* 2007; **83**: 64–65.
14. *Intimate examinations and chaperones*. London: General Medical Council; 2013.
15. Whitford DL, Karim M, Thompson G. Attitudes of patients towards the use of chaperones in primary care. *Br J Gen Pract* 2001; **51**: 381–383.