ORIGINAL ARTICLE

Use of a Chaperone during Breast Examination: the Attitude and Practice of Consultant Breast Surgeons in the United Kingdom

S Sinha, A De, RJ Williams, E Vaughan-Williams

The Breast Unit, Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, CF72 8XR

Correspondence to

Mr Surajit Sinha, MS, FRCS, 6 Ducane Walk, Plymouth, PL6 5WE
Tel: 07748 908192 Email: sinhasurajit@hotmail.com

Abstract

Background

Professional guidelines and clinical practice regarding use of chaperones vary substantially in different health care settings. Although there are several studies in primary care practice, no such studies are available in a breast care setting. We have undertaken a questionnaire survey of practicing consultant breast surgeons in the UK regarding the use of a chaperone during breast examination.

Method

A self-completion questionnaire, with 18 items was developed, piloted, modified and mailed to 400 consultant breast surgeons across the UK.

Result

302/400 questionnaires were returned (76%). Sixty-five per cent had a policy on the use of chaperone. Although 73% always offer a chaperone, the majority never documented the offer (74%) or identity (73%). Overall use of chaperone was significantly higher among male (82%), compared to female surgeons (38%, $p<0.001$). The majority said that patient embarrassment (54%) and the availability of a nurse (57%) strongly influence chaperone use unlike patient's age, marital status, ethnicity, anxiety, instinct. Seventy per cent of respondents believed that the presence of a chaperone was important for medico-legal protection of doctor and patient (55%).

Conclusion

Our study shows that the majority of consultant breast surgeons in the UK use a chaperone. The overall use of a chaperone in secondary breast care setting is higher compared to previous studies in primary care. Documentation of the offer and identity of the chaperone is very poor.

Introduction

Wide variation exists amongst different health-care professionals regarding their use of a chaperone during intimate examinations. For a male clinician it is usually customary to have a chaperone during intimate examination of female patients. But this tradition differs with female clinicians, where chaperones are used less frequently. The reasons for the use of chaperone are numerous; mainly medico-legal protection, the need for an assistant and custom.[1] Professional bodies in the UK such as the General Medical Council (GMC),[2] the Royal College of Obstetricians and Gynaecologists (RCOG)[3] and defence organisations,[4] have all produced guidelines regarding the use of a chaperone during the conduct of intimate examinations. These guidelines stress that whenever possible, patients undergoing an intimate examination should be offered a chaperone irrespective of the sex of the patient or clinician. The offer and the identity of chaperone should be documented.

Several studies assessing the attitude and practice of physicians regarding the use of a chaperone have been performed in primary care.[5,6] No such studies have been performed in the breast care setting. The objective therefore of this study was to determine the attitude and practice of consultant breast surgeons in the UK regarding the use of chaperones during intimate examinations and reflect their views regarding this issue.

Materials and methods

A self-completion questionnaire with 18 items was developed, piloted and then modified. It was then sent to 400 practising consultant breast surgeons across the UK, whose names were obtained from the BASO yearbook. Recipients received a covering letter and were asked to return the questionnaire in the self-addressed envelope. In order to maintain absolute confidentiality of respondents, no identifying marks were to be left on the questionnaire. Returned questionnaires from non-consultant grades were excluded.

The returned information was entered into a spreadsheet for analysis using SPSS for Windows®. Comparisons between different age groups, between male and female consultants, between teaching hospital and District General Hospital (DGH) were evaluated using the chi-square test and the Kruskal-Wallis test.

Results

A total of 302 questionnaires were returned (response rate 76%). The median age of respondents was 49 (35-69) years. The majority were male (81%) and were from a white ethnic background (70%). Sixty-two per cent had their original medical qualification in UK, 17% in Asia, 7% in Africa and 5% in Europe. Two thirds of the respondents were from a DGH, and the other third were from a teaching hospital. A total of 197 (65%) respondents had a policy on the use of a chaperone and 270 (89%) had a specialist nurse practitioner.

Although 73% respondents said that they always offer a chaperone during breast examination, the majority never documented the offer (74%) or identity (73%) of the chaperone used. Overall use of a chaperone during breast examination was significantly higher among male (82%) consultants, compared to their female (38%) counterparts ($p<0.001$). Consultants in DGH's used a chaperone more often than a teaching hospital ($p= 0.18$). Eighty per cent of respondents from DGH's always use a chaperone compared to only 66% in teaching hospitals. There was no significant variation in chaperone use in different age groups ($p = 46$) or with the years of practicing ($p = 24$). The clinic nurse was most favored to act as a chaperone (88%). The majority of respondents said that patient embarrassment (54%) and availability of a nurse (57%) strongly influence chaperone use as opposed to patient's age, marital status, ethnicity, anxiety, psychiatric history or instinct (Table 1).

Table I: Factors that influence chaperone use among male and female consultants

Factors influencing	Overall	Male (%)	Female (%)
Younger patients	23	25	16
Older patients	9	9	9
Ethnicity	15	14	16
Psychiatric history	24	21	36
Unmarried/single	14	15	11
Patient's anxiety	28	27	38
Instinct	30	28	42
Time constrains	36	36	40
Cost	31	27	49
Availability	57	55	67
Protection of doctor	67	68	66
Patient embarrassment	54	57	46
Protection of patient	55	55	56

However nearly half of female consultants also expressed that time constrains (40%) and costs (49%) are important in influencing chaperone use in contrast to their male colleagues. Female consultants also felt patient anxiety (38%), psychiatric history (36%) and own instinct (42%) played a role in using a chaperone (Table1).

Sixty-seven per cent of respondents believed that the presence of a chaperone was important for medico-legal protection of doctor and 55% for the protection of the patient. Most respondents were of the opinion that the presence of a chaperone did not have negative effect on doctor-patient relationship (85%), or patient confidentiality (83%). Only 35% of female consultants felt that a chaperone was important for technical assistance during breast examination, as opposed to 47% male respondents. The majority (69%) support the idea of not examining a difficult patient when he/she refuses to have a chaperone.

Discussion

This survey reflects the current practice and attitude of consultant breast surgeons in the UK towards the use of chaperones during intimate examination. The result indicates that the majority of consultant breast surgeons would prefer to use a chaperone during breast examination (73%). The use of a chaperone is significantly higher among the male consultants compared to their female counterparts, a result previously demonstrated in primary care.[5] In the UK, the GMC has a clear set of guidelines and it recommends using a chaperone during intimate examination irrespective of the sex of the patient or clinician.[2] It is important to point out that the complaints of indecent assault are not limited to a doctor of the opposite sex. This survey also indicates that the overall use of a chaperone during intimate examination is higher in a secondary care setting compared to that reported in primary care practice. Eighty-two per cent of male and 38% of female consultants always offered a chaperone compared to only 68% of male and 5% female GPs in primary care.[5] This indicates that there are significant improvements in chaperone use in secondary health care practice, although there is still scope for further improvement especially in female consultants. The Medical Defence Union (MDU) in their guidance, advises every general practitioner to ensure their practice has a clear policy on when to offer a chaperone and to consult the defence organisation if in doubt.[4] This is equally applicable to secondary healthcare services. The Ayling report published in September 2004 put the complex issue of chaperones under the spotlight. The report followed an independent inquiry into the way that the NHS dealt with the allegations about the conduct of Clifford Ayling, a GP from Folkestone, Kent. Clifford Ayling was convicted on 13 counts of indecent assault on female patients between 1991 and 1998 and was sent to prison for four years in December 2000. In June 2001 the GMC removed him from the Medical Register. The Ayling report made a number of recommendations to try to prevent a similar situation occurring again, including how and when chaperones should be used. It states that all NHS Trusts need to set out a clear chaperone policy and should ensure that patients are aware of it and that it is adequately funded.[7] Sixty-five per cent of respondents in this study reported having a fixed policy for the use of a chaperone compared to only 37% in a survey in general practice.[5] According to the UK's leading defence organisations the key to defending an allegation once made is an adequate clinical record, which should include a note regarding the offer and identity of a chaperone on each and every occasion of an intimate examination.[8] But how is this best done and is it really a cost effective use of time? The majority of consultants admitted rarely recording the offer and identity of the chaperone. In a busy outpatient setting when time is precious, a sticker in the patient's notes indicating the use of a chaperone and their identity or putting a stamp with the chaperone's signature may be a more practical approach.

In this survey although the age of respondents and years of practice do not have any influence, consultants from DGH's are more likely to use a chaperone compared to their teaching hospital colleagues. Clinic nurses were most commonly used as a chaperone, a finding that is consistent with previous reports.[5,6] Although GMC guidelines stress the need to use a chaperone, they do not specify who should act as a chaperone. The guidelines state that a clinician should either offer a chaperone or invite the patient to have a relative or friend present, making note of the chaperone's identity.[2] In contrast, the Alying report highlighted that a trained chaperone should be available to all patients having intimate examinations.[7] Untrained administrative

staff or family or friends of the patient should not be expected to act as chaperones. Similar views have been expressed by the Medical Protection Society, a leading defence organisation in the UK. It states potential embarrassment and inadvertent breaches of confidentiality makes friends and relatives poor choices as chaperones.[8] The presence of a chaperone does not provide an absolute guarantee of protection against legal action and there are cases reported by the MDU where allegations have been made despite the presence of a chaperone. Keys to avoid such allegations are good communication and a full explanation to the patient about the nature and purpose of the examination. Rosenthal and colleagues in their survey of general practitioners found that own instinct, a psychiatric history, ethnicity, age<20, unacquainted, single or divorced status strongly influences chaperone use.[5] A study by Conway and Harvey in primary care suggested that the most common factor influencing chaperone use is a patient's reputation followed by youth or minor, patient's choice and anxiety.[6] In our study patient's age, marital status, ethnicity and patient's anxiety have no influence on chaperone use. However, patient embarrassment and availability of a clinic nurse strongly predispose the use of a chaperone. Time constraints and cost are other factors influencing chaperone use, a view expressed by female consultants. This indicates cost and availability of nurses continues to be a problem. It appears while the GMC has issued guidelines, hospital trusts do not provide chaperones on a regular basis and it is clear that this continues to be an issue within the UK. The majority of consultants expressed the view that they will not examine a difficult patient if the patient refuses a chaperone. Similar guidance has been recommended by the MDU and the Ayling report. The guidance states that if the offer of a chaperone is declined, this should be documented in the patient's notes. If the clinician does not want to proceed with the examination in the absence of a chaperone, he/she should inform the patient of this and ask them either to re-consider or to accept a referral to another doctor.[4,7] The majority felt that the presence of a chaperone did not negatively influence patient confidentiality or the doctor-patient relationship and is important for medico-legal protection of both patient and doctor.

Conclusion

Our study shows that, although the overall use of a chaperone is high, it is significantly less among female consultants. It clearly indicates that same sex preference plays a role in the clinician's decision to use a chaperone. This may provide a false sense of security and expose clinicians to potential litigation. Further research about patient's preference and reservation regarding chaperone use in breast care would be helpful to understand this complex issue. Poor record keeping of chaperone use and identity is worrying as the clinician would be unable to defend against potential litigation in the absence of adequate clinical documentation. Finally, a qualitative study of breast surgeons may help to identify the key issues regarding chaperone use among male and female surgeons. There is still a long way to go to close the gap between medico-legal recommendations and current practice patterns.

References

1. Price DH, Tracy CS, Upshur RE. Chaperone use during intimate examinations in primary care: postal survey of family physicians. BMC Fam Pract 2005; 6: 52.
2. General Medical Council. Intimate examinations. In: Duties of a doctor 2002. London: GMC, 2002. www.gmc-uk.org/standards/intimate.htm.
3. Royal College of Obstetricians & Gynaecologists. Gynaecological examinations: guidelines for specialist practice. London: RCOG, 2002. www.rcog.org.uk/resources/ public/WP_GynaeExam4.pdf.
4. GP registrars advised always to offer a chaperone for intimate examinations. Media releases, 10th February 2006. www.the-mdu.com/section_GPs_and primary care_professionals.
5. Rosenthal J, Rhymer J, Jones R et al. Chaperone for intimate examinations: cross-sectional survey of attitudes and practices of general practitioners. BMJ 2005; 330: 234-5.
6. Conway S, Harvey I. Use and offering of chaperones by general practitioners: postal survey in Norfolk. BMJ 2005; 330: 235-6.
7. Department of Health, Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling (Ayling Report) 2004. http://www.dh.gov.uk/assetRoot/04/08/90/65/04089065.pdf
8. Medical Protection Society, Close encounter of risky type. http://www.medicalprotection.org/uk/keywords/chaperones