The Use of a Chaperone in Obstetrical and Gynaecological Practice

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Abstract
The aim of this study was to assess the use of a chaperone in obstetrical and gynaecological practice in Ireland and to explore patientsâ opinions. Two questionnaires were designed; one for patients and the other one was sent to 145 gynaecologists in Ireland. One hundred and fifty two women took part in this survey of whom 74 were gynaecological and 78 were obstetric patients. Ninety five (65%) patients felt no need for a chaperone during a vaginal examination (VE) by a male doctor. On the other hand 34 (23%) participating women would request a chaperone if being examined by a female doctor. Among clinicians 116 (80%) responded by returning the questionnaire. Overall 60 (52%) always used a chaperone in public practice, in contrast to 24 (27%) in private practice. The study demonstrated that most patients do not wish to have a chaperone during a VE but a small proportion would still request one regardless of the examinerâ s gender. Patients should be offered the choice of having a chaperone and their opinion should be respected and documented.

Introduction
Little has been written about the use of a chaperone in gynaecological practice. Past studies have investigated doctors and health care workersâ opinions on chaperone use with little known about patientâ s opinion regarding the need for a chaperone during gynaecological examinations. The RCOG working party recommended that a chaperone should be available for gynaecological examinations irrespective of the gender of the gynaecologist [1]. The General Medical Council (GMC) standards committee advises the use of chaperones for gynaecological examinations and also suggests documenting the offer and the identity of the chaperone in the medical notes [2]. This is supported by medical insurance groups.

Despite these recommendations, the use of chaperones is not universal. Johnson et al in their survey of obstetricians and gynaecologists in Canada found that chaperones were used more frequently by male physicians compared to female (70% v/s 22%) [3]. These findings were echoed by similar surveys of general practitioners in the United Kingdom [4,5]. Speelman et al found that 75% of female and 21% of male general practitioners never used a chaperone when performing gynaecological examinations on patients of the opposite sex [6]. The aim of our study was to explore patientsâ opinions on the need for a chaperone and to describe the attitudes and current practices regarding chaperone use for gynaecological examinations among obstetricians and gynaecologists in the Republic of Ireland and to explore possible barriers and concerns with their use.

Methods
Our study involved both patients and clinicians and questionnaires were designed for both groups. A questionnaire was available for patients attending general antenatal and gynaecology clinics at the Rotunda hospital. An information leaflet about this survey was given to participating patients and a written consent was obtained. Age, gravidity, parity and history of vaginal examination were obtained from participating patients, and their opinion was sought about the need for a chaperone during gynaecological examination by either a male or a female doctor and about the use of a female or a male chaperone. Womenâ s view regarding the presence of their partners during examination was noted as well.

A questionnaire for doctors was sent to all 108 Consultant Obstetrician /Gynaecologists working in Ireland and to 37 Specialist Registrar (SpR) or Senior Registrars working in obstetrics and gynaecology on the SpR training scheme. Doctors were asked about age, gender, status, and current practice in public and private clinics. They were also questioned about availability, time constraints, practicality and views regarding the importance of chaperone use. Those who had worked with a chaperone were asked for their reasons for doing so, their personal views on issues affecting the use of chaperone and specific questions about documentation and record keeping. This study was approved by the Research Ethics committee at the Rotunda hospital.

Results
Patients
One hundred and fifty two women took part in this survey. Seventy four were gynaecology patients and 78 were obstetric patients. Eighty nine (60%) patients were 35 years old. Fourteen (9.5%) were nulligravida and 39(26.5%) were nullipara. Sixteen (11%) patients never had a vaginal examination. Ninety five (65%) patients felt that there was no need for a chaperone during vaginal examination by a male doctor. On the other hand 34 (23%) participating women would request a chaperone if they were examined by a female doctor and a similar proportion of them 30 (20%) would want a chaperone regardless of the doctorâ s gender (Table 1). Obstetric patients were more likely to ask for a chaperone than gynaecology patients. The majority of patients (95%) had not asked their GP about the gender of the doctor they were being referred to and 114 (75%) women were happy to have a male chaperone whilst the remaining 25% would prefer a female chaperone. Only 43% of patients would prefer to have their partner present during a vaginal examination. Eighty one percent considered that there was no need for a chaperone if their partner was already present.

Clinicians
There was a response rate of 80% (116/145). Seventy four percent of respondents were consultants and 26% were specialist registrars. Sixty two percent were male and 38% female. Fifty two percent of respondents always used a chaperone in public practice compared to 27% in private practice. Analysing by gender we found that 75% of male clinicians always used a chaperone in public practice compared to 33% in private practice. These figures fell to 14% and 10% respectively for female clinicians (Table 2). Thirty percent of those questioned found that it was not practical to use a chaperone and 22% felt it was not that important to have a chaperone. The practice midwife was most commonly employed as chaperone (33%).Trainee midwives or medical students also assisted as chaperones if available. Fifty percent of respondents agreed that requesting a chaperone entailed a waiting time for availability.

Medico-legal implications were the commonest reasons cited for chaperone use and although 42% overall offered a chaperone, documentation was very poor. 4% always made note of the offer with only 1% always recording the identity of the chaperone in the notes (Table 3). Opinions were split as to the usefulness and practicality of a chaperone. Forty three percent found it valuable but difficult in clinical practice and the same number found it valuable and not difficult. A minority of 14% did not find it valuable. An interesting finding was that the male â female ratio at consultant level was 3:1, which was reversed 1:3 among specialist registrars.

Discussion
A chaperone has been traditionally defined as an adult, who accompanied or supervised one or more young unmarried men or women during social occasions to safeguard against inappropriate social or sexual interactions. The chaperone would be accountable to a third party for example to a parent. Historically the term is derived from the French word chap-er-on meaning hood or head gear which subsequently came to mean â to protectâ [7]. In medicine it has been accepted practice for a male physician to have a female nurse/midwife or relative present as chaperone.

Specific guidelines relating to chaperones vary from continent to continent. The American College of Obstetricians & Gynaecologists does not have specific recommendations for routine chaperone use during pelvic examinations, though their ethical committee states that â the request by a patient or a physician to have a chaperone present during physical examination should be accommodated regardless of the physicianâ s genderâ . It would imply that it is an optional practice [8]. In general in the United States each state medical board has its own practice recommendations and similarly in Canada, the guideline varies from province to province [9]. The GMC in the UK advises that all patients irrespective of gender of the patient or the physician should be offered a chaperone. It also advises noting both the offer and the identity of the chaperone in the medical notes. The RCOG working party recommends that a chaperone should be able to assist with gynaecological examinations irrespective of the gender of the gynaecologist [1]. The Medical Council in Ireland in their ethical and behavioural guide for intimate examinations advises that any intimate examination must be preceded by an explanation and that the patient irrespective of age and gender should be offered a chaperone [10].

The literature to date largely reflects the experience of general practitioners. Little is known about patientsâ views on this subject. Therefore we considered it relevant to highlight patientâ s views as some patients may feel more comfortable if a chaperone is present during a vaginal examination, however others may opt not to have a chaperone for privacy reasons. This survey found that most women did not feel a chaperone was necessary during pelvic examination. This might be more convenient for patients and clinicians alike by reducing waiting times in outpatient clinics or private rooms particularly when a chaperone is not available or less accessible. On the other hand up to 20% of patients would want a chaperone regardless of the examinerâ s gender which highlights the fact that a gynaecological examination by a female clinician does not necessarily exclude the need for a chaperone. The chaperone does not necessarily have to be a female person as up to three quarters of surveyed women were happy with a male. This is an interesting finding as doctors tend usually to ask for a female chaperone. Some patients will be accompanied by their partner when attending obstetric and gynaecology services. Our study showed that some women feel more comfortable if their partner stayed during a vaginal examination. This is particularly relevant for obstetric patients who invariably have their partner present for their labour and delivery.

There is disparity apparent between male and female practitioners. This survey found that male gynaecologists used chaperones more than females. Johnson et al noted similar disparity among gynaecologists in Canada 77% versus 28% [3]. In our study the practice midwife was the most common individual to be asked to be a chaperone. A similar observation was made in a survey of general practioners in the UK [5]. There was a difference in behaviour between public and private clinics with 75% of males and 13% of females always utilising a chaperone in public practice versus 36% and 4% respectively in private practice. The RCOG working party points out that chaperones are there to safeguard the patient from abuse, for reassurance, and to aid communication. There is also a role to protect doctors against false allegations of abuse or impropriety. Surprisingly 22% of respondents did not feel that a chaperone is of importance and 30% felt it is impractical. Whether a chaperone is offered or attends examination is rarely recorded. Only 4% always recorded the offer and 9% sometimes noted the identity. This seems at odds with the finding that 84% cited legal reasons for the use of a chaperone [4].

The two main barriers identified by clinicians were time and availability. This may reflect cost as a barrier but also 50% of clinicians found that chaperones were not easily available [11]. Gynaecologists in Ireland are divided in equal numbers as to whether having a chaperone is valuable or not. The use of a chaperone for gynaecological examinations in Ireland is not universal and among female gynaecologists is uncommon. There is disparity between current practice and advice from regulatory bodies. The recommendations of the RCOG working group seem not to be implemented in clinical practice. A vaginal examination is often an essential part of any obstetric or gynaecological physical exam

and constitues an invasive procedure into patientâ s privacy and dignity. Patient-doctor trust is critical and every effort should be made to reduce patientsâ anxieties in this situation by prior explanation, obtaining informed consent and offering a chaperone. In conclusion we would recommend that women should be offered the choice of having a chaperone and their opinion should be respected and documented. Some clinicians may prefer to have a chaperone for their own protection.

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