The Case for Medical Chaperones

ALLEN L. PIMIENTA, MD, AND RACHEL E. GIBLON, MSC

It's time for more discussion about how best to incorporate chaperones in primary care.

"Do you have a few minutes to chaperone a Pap smear?"

I [Dr. Pimienta] have been in medical practice for only a few years, but I have already lost count of how many times I've asked that question of my nursing staff. In family medicine, we are taught to be sensitive to patient modesty when providing a thorough physical exam, but best practices for chaperoned exams are unclear at best.

References to medical chaperones began to appear in the literature in the 1970s and 1980s, with varying connotations and differing role descriptions.[1,2] Currently, the American Medical Association (AMA) says any authorized member of the health care team can serve as a medical chaperone as long as there are clear expectations to uphold professional standards of privacy and confidentiality.[3] The addition of medical chaperones to the patient encounter coincided with increasing rates of medical litigation in the United States,[4] although it is unclear that this was the catalyst. In any event, it appears the intended use was to protect the interests of both patients and physicians.

> Although a number of associations and government bodies have attempted to centralize recommendations on this topic, these guidelines are often ambiguous and conflicting.

Family physicians are routinely entrusted by their patients to perform the most sensitive physical exams. Unfortunately, every year there are news stories and litigation alleging cases of physician misconduct during patient encounters. The "Me Too" movement has recently empowered more individuals to speak up about improper sexual behavior within and beyond medicine. In this environment, patients may be increasingly wary of their own health care providers. Physicians, too, understand that they can become targets to unethical or unwell patients who may allege misconduct that never happened but is difficult to disprove without witnesses.[5]

ARE CHAPERONES THE SOLUTION?

How often do inappropriate examinations occur, and does the use of chaperones reduce cases of inappropriate conduct? Unfortunately, current statistics available through the National Practitioner Data Bank (NPDB) do not provide details on these types of cases.[6] One estimate indicated that almost 11 percent of provider misconduct reports were sexual in nature.[7] The most rigorous published studies conclude that we lack sufficient information on malpractice to accurately establish the rates and types of physician misconduct.[6]

There also have been no studies examining whether the presence of medical chaperones decreases the risk of physician misconduct. Some studies have investigated whether medical chaperones affect patient satisfaction, and the results generally indicated that patients

ABOUT THE AUTHORS

Dr. Pimienta is a family medicine resident at the Mayo Clinic in Rochester, Minn. Rachel Giblon is a biostatistician and epidemiologist at the Mayo Clinic. Author disclosures: no relevant financial affiliations disclosed.

found it respectful to be offered a chaperone and, depending on the country, often expected one.[8,9]

Finally, it is important to note that many victims do not report sexual violations by their physician, with one study estimating that fewer than 1 in 10 victims choose to report it.[10]

The lack of hard evidence notwithstanding, if we agree that chaperoned exams have value, difficult implementation questions arise, including these: Must chaperone expectations apply to physicians of both genders? How does the sexual orientation of the patient and physician factor into the chaperone selection? What happens if the patient declines the offer of a chaperone, but the physician feels he or she must bring one in anyway? How does the presence of a third person in the exam room affect the physician-patient relationship? Will we come to a point when physicians can no longer examine any patient alone? Where do the resources come from? Where is the line to be drawn?

Although a number of associations and government bodies have attempted to centralize recommendations on this topic, these guidelines are often ambiguous and conflicting. The AMA Code of Ethics recommends, in part, notifying patients about chaperone guidelines and always honoring a patient's request to have a chaperone.[3] The American College of Obstetricians and Gynecologists recommends, in part, accommodating patient requests for a chaperone, regardless of the physician's gender.[11] The American Academy of Pediatrics (AAP) explicitly recommends having a chaperone attend genital, rectal, and breast exams of adolescent patients but also recommends using shared decision making if the patient is old enough.[12] The exam of an infant, toddler, or child should always be performed in the presence of a parent or guardian, according to the AAP policy. The American College of Physicians Ethics Manual says, in part, that "in general, the more intimate the examination, the more the physician is encouraged to offer the presence of a chaperone."[13] The American Academy of Family Physicians has not published recommendations on the use of chaperones.

Several states have implemented legal mandates that range from requiring that physicians offer a chaperone for intimate examinations (Ohio)[14] to defining an examination of the genitals or breasts by a physician of the opposite gender without a chaperone as professional misconduct (Georgia).[15] In Canada, associations in the individual provinces have made their own recommendations.[16] In the United Kingdom, the General Medical Council requires that a physician offer a chaperone for an intimate examination whenever possible.[17]

STARTING THE DISCUSSION

Ideally, each practice, department, or institution would implement a medical chaperone policy for all providers to follow. However, standard approaches may not be pragmatic or sustainable. Explicitly requiring a chaperone for every visit would place a greater burden on staff and increase already ballooning health care costs. In addition, there will be physicians who feel uneasy with or outright reject the idea that they need to be chaperoned. There will be patients who do not want an extra person present for sensitive examinations. Insurance companies may have their own requirements that would override departmental or local policy. Ultimately, as is the case with much of medicine, decisions about chaperoning will continue to be made on a case-by-case basis.

Ideally, each practice, department, or institution would implement a medical chaperone policy for all providers to follow.

Nevertheless, it is imperative that we start talking about chaperones in our practices. Speak with your patients about their preferences regarding medical chaperones, and have frank conversations with your colleagues about current policies and procedures. Having a local or enterprise-wide consensus on the use of chaperones will improve the quality of care from the perspectives of both the physician and the patient.

To encourage such discussion, and understanding the limitations of staffing and costs, here are several ideas to consider for

how to handle medical chaperones in your practice:

1. Offer a medical chaperone to any patient undergoing genital, rectal, breast, or full-body skin exams.

2. Provide information explaining chaperones and chaperoned exams when a patient first seeks care at your practice.

3. Document in every patient's chart his or her preference regarding chaperones; front-desk staff could ask about this during check-in to make the process more standardized.

4. If your practice consensus is to require a chaperone for certain types of examination, apply this requirement to both male and female physicians.

5. Develop chaperone selection criteria that consider issues such as gender and training.

6. Develop practice guidelines that support both the physician and the patient in cases where a patient declines a chaperone but the physician still feels uncomfortable. These guidelines could allow you to defer the exam to another day or to another physician or chaperone, and should reassure the patient that this is standard practice.

7. Do not allow the process of ensuring that an exam is chaperoned to interfere with appropriate and timely patient care and clinical judgment.

8. Document all encounters involving chaperones in the electronic health record, including names, time, and date.

Personally, I [Dr. Pimienta] find the notion of a chaperoned exam troubling because I feel it implies that the physician has ulterior and possibly harmful motives that require third-party supervision. However, in light of the recent string of high-profile physician misconduct cases, I recognize the importance of chaperones. I hope that one day in my career, we physicians will be able to win back the trust of the public and remedy the malpractice of the small minority of our profession. FPM

> Having a local or enterprise-wide consensus on the use of chaperones will improve the quality of care from the perspectives of both the physician and the patient.

1. Henderson JA. Gynaecological examination and equipment in the surgery. *Br Med J.* 1971;1(5743):273-274.

2. Sanders JM Jr, DuRant RH, Chastain DO. Pediatricians' use of chaperones when performing gynecological examinations on adolescent females. *J Adolesc Health Care.* 1989;10(2):110-114.

3. American Medical Association. Code of Medical Ethics. Opinion 1.2.4. Use of Chaperones. 2016. https://www.ama-assn.org/delivering-care/use-chaperones. Accessed July 23, 2018.

4. Singh H. Data Analysis Tool. National Practitioner Data Bank. https://www.npdb.hrsa.gov/analysistool. Accessed July 23, 2018.

5. Segal J. When seeing patients, is three a crowd? *Medscape.* Dec. 2, 2015. https://www.medscape.com/viewarticle/852865. Accessed July 30, 2018.

6. DuBois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: a mixed-methods, exploratory analysis of 101 cases [published online ahead of print June 19, 2017]. *Sex Abus.* 2017.

7. Arora KS, Douglas S, Dorr Goold S. What brings physicians to disciplinary review? A further subcategorization. *AJOB Empirical Bioethics.* 2014;5(4):53-60.

8. Whitford DL, Karim M, Thompson G. Attitudes of patients towards the use of chaperones in primary care. *Br J Gen Pract.* 2001;51(466):381-383.

9. Sinha S, De A, Jones N, Jones M, Williams RJ, Vaughan-Williams E. Patients' attitude towards the use of a chaperone in breast examination. *Ann R Coll Surg Engl.* 2009;91(1):46-49.

10. Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct [published errata appears in *J Forensic Sci.* 2001;46(2):421]. *J Forensic Sci.* 2000;45(6):1184-1189.

11. Committee on Ethics, American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion No. 373: sexual misconduct. *Obstet Gynecol.* 2007;110(2 pt 1):441-444.

12. Committee on Practice and Ambulatory Medicine. Use of chaperones during the physical examination of the pediatric patient. *Pediatrics.* 2011;127(5):991-993.

13. Snyder L, American College of Physicians Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med.* 2012;156(1 pt 2):73-104.

14. Ohio Administrative Code §4731-26-01.

15. Official Code of Georgia Annotated §360-3-.02(12).

16. Vogel L. Chaperones: friend or foe, and to whom? *CMAJ.* 2012;184(6):642-643.

17. General Medical Council. Ethical Guidance for Doctors: Intimate Examinations and Chaperones. 2013. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones/intimate-examinations-and-chaperones. Accessed July 25, 2018.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.