

FEATURE

Consent and intimate examinations

The correct use of a chaperone can make the difference between a contented patient and receiving a complaint, a claim or even an allegation of sexual assault. Here's what you need to know.

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Learning objectives

- To allow doctors to have a greater awareness of the issues surrounding intimate examinations and the use of chaperones.
- To allow doctors to understand and review the scope of current GMC guidance relating to intimate examinations and chaperones.
- To give doctors a basic understanding of the law and ethical framework in relation to consent, as it relates to intimate examinations, and of how to apply it to their practice.

Most patients don't see a doctor on a regular basis. When they do, it's frequently because they are unwell, or because they believe they might be unwell, and as such it is often the case that the patient is feeling anxious or vulnerable.

On the other hand, when a doctor goes to work, either in a GP surgery or in a hospital setting, it is a routine matter; literally an everyday occurrence. On that basis, it's possible that a doctor might treat as routine something to which the patient attaches significance, particularly if they are already feeling anxious.

A doctor may carry out a physical examination many times on a given day and, depending on the nature of their work, in many cases this may include an intimate examination. For the patient, this is likely to be the time when they feel most anxious and vulnerable.

It is important for the doctor to remain aware of this and to make sure that the patient feels that their dignity has been respected; and, crucially, that they have not in any way been abused. Allegations can be made by patients even when the examination was clinically indicated and properly conducted.

In this article, we review the issues arising from intimate examinations and the use of chaperones.

Consent

It is generally accepted that a patient with capacity must give consent before a doctor starts an examination or embarks on a course of treatment. As long ago as 1914, it was said that:

'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without

his patient's consent commits an assault¹.

The law relating to consent has evolved significantly since then, with the most notable recent development being in the Montgomery case in 2015.

The legal position post-Montgomery is broadly consistent with the guidance issued by the GMC in its publication 'Consent: patients and doctors making decisions together' (2008). The Montgomery judgment and the GMC guidance (for example at paragraph 28) emphasise the need to take into consideration the particular patient's individual situation.

Therefore, before carrying out any examination or intervention, it is important to be sure that you have the patient's consent to do so. In some cases, consent can be implied; a patient offering their arm when you propose to check the pulse or blood pressure, for example.

For consent to be valid it must, by definition, be properly informed. Before proceeding with more sensitive or intimate examinations, it is likely that it will be necessary to share more information with a patient about the assessment and the reasons for it than might be necessary for more routine examinations.

It is also likely prudent in such cases to make sure that the patient has understood what information has been provided and that they are still happy to proceed.

Communication

Central to this is how you communicate with your patient. Before you carry out any intervention, including an examination, it is important that the patient understands what you are going to do and why you are going to do it. This is again consistent with GMC guidance:

'You must give patients the information they want or need about the purpose of any

proposed investigation...and what it will involve.'

The GMC makes it clear that a doctor should not make assumptions about what information a patient might want or need, or what factors (clinical or otherwise) they may consider significant.

It is unlikely that a 'one size fits all' approach to information sharing will be sufficient. How much information a doctor shares with a patient will usually need to be tailored to the patient's individual circumstances, taking into consideration such factors as their own needs and wishes, their level of knowledge and understanding of what is being proposed, and any concerns that they may have.

It is also important that before going ahead, you make sure that the patient has fully understood the information they have been given, and that they understand they can change their mind about any decision that they have made at any time.

The importance of tailoring any discussion to an individual patient was recognised in the Montgomery judgment, in which it was said that:

'The doctor's duty is not fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.'

It is important to record what a patient has been told about a proposed examination (for example, what the examination will involve and why it is being suggested), and that they have confirmed that they have understood what they have been told.

Explainer: Montgomery vs Lanarkshire Health Board



Chaperones

When you are satisfied that the patient has understood the nature and purpose of a

proposed examination, and has given consent for that to proceed, you may then need to consider if a chaperone should be offered.

The presence of an impartial chaperone during intimate examinations can provide both protection and reassurance for patient and doctor alike, and regardless of the gender of either.

The latest GMC guidance Intimate examinations and chaperones (2013) says that doctors should offer the patient the option of a chaperone wherever possible before conducting an intimate examination. The chaperone should usually be a trained health professional; friends or family members are not regarded as impartial. However, doctors should comply with 'a reasonable request' to have them present as well as a chaperone.

A chaperone's principal responsibility is to protect patients from abuse. But they can also reassure or comfort patients during examinations that they might find embarrassing or distressing.

This is reflected in the criteria listed by the GMC which says that doctors must be satisfied that their chaperone will:

- be sensitive and respect the patient's dignity and confidentiality
- reassure the patient if necessary
- be familiar with the procedure involved in a routine intimate examination
- stay throughout the examination and be able to see what the doctor is doing, and
- be prepared to raise concerns about a doctor's behaviour or actions.

The presence of a chaperone during intimate examinations may also help protect doctors themselves from false allegations of abuse. You should document both the presence of a chaperone and their identity (name and full job title rather than a

generic phrase such as 'duty nurse') in the records, in line with the GMC's guidance.

If an accusation is made several years later and there is no record of who acted as chaperone during the examination, the likelihood of the doctor remembering the name of this crucial witness is slim.

Doctors routinely offer patients a chaperone before conducting an intimate examination. But the circumstances in which a chaperone is required may extend beyond those which might conventionally be considered 'intimate' examinations, such as when the needs of the specific patient require it.



The presence of an impartial chaperone during intimate examinations can provide both protection and reassurance for patient and doctor alike.

For example, for particularly vulnerable patients or those who have been the victims of abuse, it might be appropriate to offer a chaperone for other examinations too. This could go beyond an examination of the genitalia, rectum or breasts to include, as the GMC puts it, 'any examination where it is necessary to touch or even be close to a patient'; for example, examination of the fundi using an ophthalmoscope in a darkened room.

In these circumstances, doctors will be expected to use their professional judgement about whether a chaperone should be offered, depending on the patient's previously expressed views and level of anxiety.

The gender of the doctor and the patient is irrelevant to whether a chaperone should be offered. The MDU's experience is that while most allegations of indecent assault are made by female patients against male doctors, this is not always the case

and we have seen cases that involve other gender combinations.

It is also important - bearing in mind the GMC advice to ensure that the patient understands what is being proposed - that they do understand what is meant by the word chaperone. In other contexts, it is a decorous term, reminiscent of the propriety and mores of another age.

Refusal of a chaperone

Some patients are adamant that they do not want another person in the room while they are being examined. However, this can leave the doctor in an uncomfortable position, especially if the patient has behaved in a sexualised way.

The MDU is regularly asked whether doctors can refuse to conduct an intimate examination without a chaperone. In these situations, doctors should follow the GMC's guidance and explain why they would prefer a chaperone present.

An alternative would be to refer the patient to a colleague who would be prepared to proceed without a chaperone. The patient's clinical needs must take precedence and this approach would not be appropriate if the delay would adversely affect the patient's health. If they go ahead with the examination without a chaperone, the doctor should make a note that one was offered but the patient declined.

The same option to delay non-urgent examinations applies if a patient wants a chaperone but no one is available, or they are simply unhappy with the choice; if they will only accept someone of the same gender, for example.

However, asking a patient to return another time could make them feel under pressure to proceed without a chaperone to avoid the inconvenience, cause an already anxious patient extra distress, and perhaps prompt a complaint.

Checklist for intimate examinations

Before the examination

- Explain to the patient why the particular examination is necessary and what it entails so they can give fully informed consent.
- Record the consent discussion in the notes, along with the identity of the chaperone or if a chaperone was offered but declined.
- If possible, use a chaperone of the same gender as the patient.
- Allow the chaperone to hear the explanation of the examination and the patient's consent.

During the examination

- Ensure patients' privacy during the examination and when they are dressing and undressing; eg, use screens and gowns/sheets.
- Position the chaperone where they can see the patient and how the examination is being conducted.
- Explain what you are going to do before you do it and seek consent if this differs from what you have told the patient before.
- Stop the examination if the patient asks you to.
- Avoid personal remarks.

After the examination

- The chaperone should leave the room after the examination so the rest of the consultation can continue in private.

Case study

A doctor, an experienced trainee in emergency medicine, saw a patient in the accident and emergency department in the early hours of the morning. The patient, a 22-year old man, presented with low back pain and new symptoms which raised a suspicion of cauda equina syndrome. The doctor explained that she would like to do an internal examination, to which the patient agreed.

The department was busy, and all of the other staff were attending to other patients, so no chaperone was offered. The findings of the examination and other investigations were reassuring and the patient was discharged.

Some time later, the doctor received a letter from the GMC advising her that the patient had complained to the GMC about the examination. The letter said that the doctor had not properly explained what she was going to do or why she was going to do it, and that she had not offered him the option of being accompanied by a chaperone.

The doctor was an MDU member and immediately contacted us for assistance. One of our advisers helped her to write a response to the GMC, wherein the doctor apologised for causing the patient distress and for not explaining to him adequately how and why she wished to examine him.

The doctor said that she had reflected on the issues which had been raised and that she had reviewed the GMC's guidance on intimate examinations and the use of chaperones.

She said that in future she would explain to patients more thoroughly about what an examination might involve, and why the examination was being suggested. She would, in future, offer a chaperone before carrying out such examinations and would wait until one was available unless that might adversely affect the patient's health.

The GMC case examiners appeared reassured by the doctor's reflective approach, and decided that the case could be closed with a letter of advice.

The doctor also shared her reflections with her clinical and medical directors, who decided that no further action was needed locally.

Follow this link to test your learning from the article and earn 1 CPD credit.

Before doing so, we recommend reading the GMC's guidance on intimate examinations and chaperones. The following links might also be helpful before you take the test:

GMC, 'Maintaining a professional boundary between you and your patient' (2013)

MDU guidance and advice video on using chaperones.

FOOTNOTES

[1] Cardazo J in *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 (NY 1914)

This article was correct at publication on 03/01/2018. It is intended as general guidance for members only. If you are a member and need specific advice relating to your own circumstances, please contact one of our advisers.

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