

To chaperone or not to chaperone?

In March this year, the Independent Online published an article entitled 'SA's dodgy doctors'. This was sparked off as a result of a spate of high-profile cases involving practitioners and patients, several of which were claims against practitioners of sexual impropriety or misconduct. At around that time there was also extensive media coverage on the conduct of a former Cape Town orthopaedic surgeon who had been found guilty in the Bellville Magistrate's Court of raping and indecently assaulting a female patient. He had also been found guilty on 14 counts of indecent assault of 9 female patients. This case is just one of several that have received widespread media coverage with far-reaching consequences for practitioners at large.¹

South Africa is not alone in allegations of this nature, e.g. in July this year the General Medical Council (GMC) in the UK struck off a Derbyshire GP after complaints of inappropriate sexual conduct towards female patients spanning a period of 12 years. Among the allegations were that he had made indecent photographs of a child, possessed indecent photographs of a child for distribution, and had examined a patient's breasts in an inappropriate manner without a chaperone being present, despite this being out of line with normal practice as required by the GMC.² The GMC ruling was a result of the Ayling Enquiry, an independent investigation by the UK Department of Health into how the National Health Services handled allegations about the conduct of the said practitioner. Ayling was convicted of 12 counts of indecent assault in respect of 10 of his female patients. It was found that he had repeatedly convinced his female patients that they needed intimate examinations. Thirty-one women testified against him and he was sentenced to 4 years in prison for indecent assault.³

So, what is an intimate examination, what is a chaperone, and what are the implications of chaperones being present during these examinations? The Medical Protection Society (MPS) states that defining an intimate examination is '... trickier than it would first appear ...'. This is because patients can easily misconstrue a legitimate clinical examination. Examples quoted are examinations of the breasts, genitalia or rectum and any examinations where it is necessary to be close to the patient, e.g. conducting eye examinations in dim lighting. As most allegations of sexual assault against practitioners are due to inadvertent touching, practitioners are cautioned to be vigilant in situations of vulnerability, e.g. when listening to the chest, taking the blood pressure using a cuff and palpating the apex beat, as all these could involve touching the breast area.⁴

'Chaperone' derives figuratively from the French 'chaperon', which initially meant hood and later a type of hat. The word 'chaperone' was used by the English in the 1700s in a social milieu to refer to an escort, usually an older woman accompanying a younger, unmarried one in public to provide protection for the latter's reputation.⁵ With time the role of the 'social' chaperone has dwindled and a new category has emerged – the 'medical' one, which is hotly debated, with a divergence of opinion as to its role and need. Several studies on the topic have revealed that practitioners in the main do not see a need for chaperones to be present during an intimate examination. Chaperones are viewed as being obstructive during the consultation and an intrusion on the practitioner-patient relationship. Moreover, in some situations



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allegations of sexual impropriety were reported despite the presence of a chaperone. Patient preferences, on the other hand, are gender-based, with women preferring to have a chaperone present when the examiner is male.⁶

It could be stated that a chaperone is necessary in certain situations to protect the practitioner-patient relationship. While some practitioners have indeed been guilty of boundary violations and boundary crossings in the relationship, there are also instances where patients have falsely accused their practitioners of sexual impropriety, including rape. Hence the presence of a chaperone would provide protection to both the patient and the doctor. The chaperone could be a member of staff, or even someone accompanying the patient.

As allegations of sexual assault are on the increase, it is necessary for us in South Africa also to consider the use of chaperones during intimate examinations. While many practitioners may oppose this recommendation, using resource constraints as justification, it is important to recognise that chaperones serve to protect the practitioner as well. In addition, adequate communication during the consultation as to why certain probing and sensitive questions are asked of the patient and why the particular examination is necessary may go a long way in avoiding these complaints, as often it is failure on the patient's part to understand what the doctor was doing in the process of diagnosis and treatment that is at the root of such allegations. At the least, all patients undergoing intimate examination should be offered a chaperone. The practitioner should also record all instances where a patient declines having a chaperone present. In short, the time has come for chaperones to be regarded as a risk management strategy.

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4. Silent witness. <http://www.medicalprotection.org/uk/publications/your-practice-autumn-2009/silentwitness> (accessed 13 December 2010).
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6. Newton DC, Chen MY, Cummings R, Fairly CK. Recommendations for chaperoning in sexual health settings. *Sex Health* 2007;4:207.