

What is already known on this topic

Attitudes and behaviour of medical professionals are often at odds with the recommendations of the royal colleges and other bodies regarding the universal use of chaperones for intimate examinations

What this study adds

Use of chaperones by male doctors since the 1980s and '90s has substantially increased, but use by female doctors remains low

More flexible guidance is needed for general practice as well as further research into patients' views and wishes on the use of chaperones

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Competing interests: None declared.

Ethical approval: South East Multicentre Research Ethics Committee.

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gain more understanding of the circumstances in which problems might arise in this delicate area.

Use and offering of chaperones by general practitioners: postal questionnaire survey in Norfolk

Shaun Conway, Ian Harvey

Ten years ago in Norfolk, 65% of male general practitioners and 95% of female general practitioners never or rarely used a chaperone.¹ The figures for offering chaperones were almost identical. The General Medical Council advises offering a chaperone for intimate examinations (those involving the genitals, anus, or breasts).² The Royal College of Obstetricians and Gynaecologists advises using a chaperone for every intimate examination.³

A study of patients' preferences in Tyneside in 2001 found that 90% of women and 78% of men thought that a chaperone should be offered for intimate examinations.⁴ Half (51%) of women wanted a chaperone to be used if their own male doctor was examining them. We wanted to see if the use of chaperones has changed in the past 10 years and as a result of the 2001 survey.

Participants, methods, and results

We invited a random sample of 200 (out of 348) male general practitioners in Norfolk and every female

general practitioner (124) to complete a postal questionnaire. We used EpiInfo for data entry and SPSS for analysis.

Overall, 284 (87%) responded. Mean age was 46.3 (men) and 43.8 (women). Only 23 were not white. The mean number of partners per practice was six. More than half (155; 55%) were in dispensing practices. Three fifths of doctors (170; 60%) described their practices as either rural or market town, 60 (21%) as city, and 54 (19%) as mixed or other.

The usual chaperone was the practice nurse for 75% (155/208) of those GPs who use a chaperone, but 18% (37/208) of doctors used a receptionist. Three fifths (141/235; 60%) stationed the chaperone beside the patient and 36% (84/235) had the chaperone in the examination room but outside the curtain. Three fifths of doctors (115/197; 58%) said that if they

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Use of chaperones by general practitioners. Values are numbers (percentages) of doctors

		Never	Rarely	Sometimes	Always
Examining female patients					
Male doctors	Uses a chaperone (n=178)	10 (6)	70 (39)	51 (29)	47 (26)
	Offers a chaperone (n=176)	7 (4)	33 (19)	58 (33)	78 (44)
Female doctors	Uses a chaperone (n=106)	72 (68)	25 (24)	9 (9)	0
	Offers a chaperone (n=102)	48 (47)	27 (27)	19 (19)	8 (8)
Examining male patients					
Male doctors	Uses a chaperone (n=178)	141 (79)	31 (17)	6 (3)	0
	Offers a chaperone (n=167)	122 (73)	37 (23)	6 (4)	2 (1)
Female doctors	Uses a chaperone (n=106)	53 (50)	40 (37)	11 (10)	3 (3)
	Offers a chaperone (n=104)	39 (38)	32 (31)	17 (16)	16 (15)

thought that a chaperone should be used but the patient declined then they would insist on a chaperone anyway (table).

Nearly half of male general practitioners (45%) never or rarely use chaperones when intimately examining women. Chaperones are used rarely or never for the other three permutations of intimate examinations—only 2% (3/178) for male doctors examining men, 8% (9/106) for female doctors examining women, and 13% (14/106) for female doctors examining men.

We asked participants to state what factors influenced their use of chaperones. Themes related to a patient's reputation were the most commonly given reasons. Supporting the patient was also important. However, the second, third, and fourth most common reasons given for use of chaperones were that the patient was a youth or minor, patient choice, and patient anxiety or need for comfort.

Comment

In the past 10 years offering of chaperones by general practitioners has increased. The proportion of male general practitioners never or rarely offering chaperones when examining female patients has fallen from 65% to 23%. Norfolk is more rural than much of the United Kingdom, but these temporal changes may reasonably be extrapolated.

We found high rates for offering of chaperones. The Tyneside study indicates that patients want to be offered a chaperone, so general practitioners may be responding to societal demand.⁴ Merely offering a chaperone does not protect either the patient or the doctor. Stern said that even when a qualified nurse chaperone is present the patient is not protected.⁵ Given that in most cases (58%) the final decision as to

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A survey 10 years ago showed that most general practitioners did not offer and use chaperones for intimate examinations

What this study adds

Offering of chaperones has increased in the past decade, but use of chaperones shows less change

whether or not to have a chaperone rests with the doctor it seems that ultimately the chaperone is there for the protection of the doctor rather than the patient.

We thank the doctors who completed the questionnaires, Jon Cooke, Sheila Ward, and Sheila Hawkins.

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Ethical approval: Norwich Local Research Ethics Committee.

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Good enough general practice

I had admitted an elderly woman with severe sciatica to the community hospital. She needed care while her pain continued. During her second evening in hospital, nurses became concerned about her deteriorating mobility, and I found that she had developed a flaccid paraparesis suggestive of cauda equina compression. I needed urgent specialist advice and telephoned the neurosurgical registrar in the city 30 miles away.

Suddenly I was struggling to survive detailed neurological interrogation. Were hip flexion and extension equally weak? Just what did I mean when I said ankle dorsiflexion was "rather" weak? Was there a sensory level on the trunk? How weak was plantar flexion? What was her post-voiding residual urine volume? At what root level did I consider the deficit was?

This was a clash of medical cultures; he from the sharp peak of the super specialty and I from the broad plains of general practice. We were speaking different languages, and mine was clearly failing to impress him. Eventually, a sufficient number of stuttered responses allowed him to advise on immediate management. As I put down the telephone, I felt deflated and experienced a pang of inadequacy.

During my career, I've forgotten more than I know. Inevitably we lose skills that we seldom practise and retain those that we constantly need. Yes, my neurological examination technique had lacked precision, and I made a note to sharpen it up. But had it been "good enough" to allow recognition of the emergency with

appropriate referral? I think so. As Richard Smith highlighted in his address to new medical students,¹ contentment with being "good enough" is a prerequisite for a happy medical career—and that advice surely applies to the wide expanses of general practice as much as to any other medical discipline.

The specialist registrar called back to discuss transfer arrangements. "Sorry about the poor performance in the viva," I said.

"I'm sure I'd easily fail a viva in general practice," he laughed. "Yes," I said, "I'm pretty sure you would."

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We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com>. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.