Who should be privy to your privates?

Uncertainty about who should chaperone intimate examinations may be undercutting the protections such attendants may afford patients and doctors, experts say.

Professional regulators and medicolegal societies are increasingly urging that physicians ensure a third party is present during sensitive procedures, as much for their own protection from allegations of impropriety as to put patients at ease (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4127).

But there are few clear standards as to who should serve in that position, so the role is often filled by whoever happens to be available, regardless of training, gender or relationship to the patient.

In hospitals, a nurse most often serves as a chaperone. But many physicians do not have a nurse on staff in their offices, so "anybody working for them" might be asked to attend, including clerical staff with no medical training, says Dr. Ed Schollenberg, registrar for the College of Physicians and Surgeons of New Brunswick.

Such makeshift arrangements are "probably not desirable" to patients, but their preferences are rarely solicited, says Dr. Ross Upshur, Canada Research Chair in Primary Care and professor of family and community medicine at the University of Toronto in Ontario.

That defeats the purpose if the aim is to reassure patients, critics say.

"It makes a farce of the supposed protection chaperones offer patients," says Dr. Joel Sherman, a cardiologist and advocate for patient privacy based in Waterbury, Connecticut. "My problem is the majority of patients don't want them in the first place. Some studies show nearly 50% of women would prefer not to have chaperones present even for pelvic exams with male doctors, yet the majority of doctors are going to use them anyway for their own protection."

Untrained chaperones can also serve as poor witnesses, adds Dr. Janet Wright, assistant registrar for the College of Physicians and Surgeons of Alberta. They "might not understand the professional responsibilities of the role or what to expect in terms of physician behavior."

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Selection of the gender of a chaperone during a physical examination can be tricky.

The Alberta college established Canada's first and seemingly only chaperone training program in 2008 to aid the staff of physicians with restricted licenses who are required to have a third party present during intimate examinations.

Many chaperones are unsure of their responsibilities beyond "just standing against the wall and just watching," Wright says. Ideally, a chaperone should be able to put a patient at ease and "help the physician pick up the nonverbal clues you sometimes get when a patient is uncomfortable," in addition to providing feedback after examinations, such as in a case where a physician joked excessively or didn't drape the patient adequately, she explains.

Much of what goes on during an intimate examination may look "odd" to an untrained chaperone, making it difficult for them to accurately recognize and report misconduct, Wright adds.

That's particularly true in cases where the act itself may be executed properly but was entirely unnecessary, Schollenberg says. For example, a physician might perform a breast exam when none was needed and he was "doing it for his own reasons," Schollenberg explains. "When a consultant is doing things outside the scope of what normally would be indicated, a chaperone's not really going to make a difference because they won't have the knowledge to say: 'It makes no sense why that's happening'."

Yet it would be "impractical" to mandate that physicians use nurses as chaperones as few in family practice could afford it, Schollenberg notes.

Similarly, financial constraints can make it difficult for physicians to provide patients with chaperones of their preferred gender.

Most chaperones are female, and consequently, their services are more often offered to female patients, says Dr. Samantha Kelleher, deputy regis-

trar for the College of Physicians and Surgeons of British Columbia. But that "doesn't mean men shouldn't be afforded the opportunity to have a chaperone present if they want."

Sherman contends that failure to provide male patients with a male chaperone, or to take their embarrassment seriously, can discourage them from agreeing to undergo necessary but uncomfortable screening. "Few men are comfortable refusing a female chaperone because it isn't macho to protest, but it doesn't mean they're not embarrassed and as a result, will avoid the exams."

There may be something to that, Schollenberg says. While some men may be comfortable with a female chaperone, "it's possible that perhaps we are a bit sexist about that in the sense we would expect a male patient to just live with it."

As it's not altogether clear whether men would prefer a male or female chaperone, some physicians suggest that their colleagues consult with the patient as to their preferences. "Really, that's the patient's right," says Dr. Victoria Davis, a member of the Society of Obstetricians and Gynaecologists of Canada's Social Sexual Issues Committee.

Physicians can also ask patients to bring along a friend or family member with whom they are comfortable, Davis adds.

But that presents a risk to physicians, Kelleher says, because such a friend or family member won't be a "neutral third party" and certainly won't understand what's taking place any better than an untrained secretary.

But Wright contends that nurses and office staff are equally conflicted, if not more so, because the physician is typically their employer. "There's that power differential."

The College of Physicians and Surgeons of Alberta's chaperone training program urges attendants to address misconduct or concerns with an office manager or raise those issues with licensing authorities if they are uncomfortable confronting their bosses.

BC is considering the launch of a similar training program. — Lauren Vogel, *CMAJ*

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Editor's note: Second of a two-part series.

Part 1: **Chaperones: friend or foe, and to whom?** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4127).