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Patients' attitudes towards chaperone use for intimate physical examinations in general practice

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Abstract
BACKGROUND: The objective of this article is to investigate patients' attitudes to the use of chaperones for intimate physical examinations (IPEs) in a sample of Australian general practices. METHODS: A cross-sectional survey of adult patients from 13 randomly selected general practices in regional New South Wales was conducted between September and November 2012. Generalised linear mixed models were used for analysis. RESULTS: Of 780 surveys distributed, 687 (88%) were returned; the age range was 18-91 years and 356 (52%) were from female patients. Most women had never had a chaperone present for a Papanicolaou (Pap) smear (82.6%). Between 23% and 33% of respondents preferred a chaperone with their usual general practitioner (GP) across IPEs and gender of the respondents. The odds of preference for a chaperone were significantly less with a GP whom the respondents did not know well, compared with their usual GP, for a Pap smear (female) or genital examination (male). DISCUSSION: Individualised discussion regarding chaperone use for IPEs is warranted, especially with patients seeing their usual GP.

Keywords
practice, general, examinations, physical, intimate, chaperone, towards, attitudes, patients'

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Background and objectives

The objective of this article is to investigate patients' attitudes to the use of chaperones for intimate physical examinations (IPEs) in a sample of Australian general practices.

Method

A cross-sectional survey of adult patients from 13 randomly selected general practices in regional New South Wales was conducted between September and November 2012. Generalised linear mixed models were used for analysis.

Results

Of 780 surveys distributed, 687 (88%) were returned; the age range was 18–91 years and 356 (52%) were from female patients. Most women had never had a chaperone present for a Papanicolaou (Pap) smear (82.6%). Between 23% and 33% of respondents preferred a chaperone with their usual general practitioner (GP) across IPEs and gender of the respondents. The odds of preference for a chaperone were significantly less with a GP whom the respondents did not know well, compared with their usual GP, for a Pap smear (female) or genital examination (male).

Discussion

Individualised discussion regarding chaperone use for IPEs is warranted, especially with patients seeing their usual GP.

Patient presentations that require intimate physical examination (IPE) are common in general practice.[1] Across a variety of clinical contexts, international studies investigating patients' attitudes to the use of chaperones for IPEs have found that female patients, in particular, are more likely to request a chaperone if they are being examined by a male practitioner.[2–5] Patients also want to be included in the decision-making process regarding the presence of chaperones.[6] These findings concur with evidence from the limited number of Australian studies.[4,7]

Recommendations regarding chaperone use for IPEs vary in different countries and even within jurisdictions in a given country;[8–11] therefore, having locally relevant evidence on which to base guidelines is important. Some countries, such as the UK, have long-established, clear guidelines for chaperone use.[12] Plausibly arising in association with those guidelines, male GPs in the UK report frequently offering chaperones. This practice was highlighted in a UK-based study involving 1246 GPs, which found that 68% of male GPs (and 5% of female GPs) 'usually' or 'always' offered a chaperone for an IPE.[13]

The Medical Board of Australia (National Board) makes no specific mention of chaperone use in its *Good medical practice: A code of conduct for doctors*.[14] Notably, however, in October 2011, the National Board released a supplementary document *Sexual boundaries: Guidelines for doctors*,[15] which states that:

> *When discussing what is to occur in an intimate examination … a doctor should explore with the patient the value of a chaperone being present during the examination or allow the patient to bring a support person of their choice, if this would make the patient feel more comfortable.*

At the time the *Sexual boundaries* document was released, the few published studies that investigated the attitudes of Australian patients to chaperones,[4,7] or patterns of chaperone use by Australian doctors,[16] were in the context of capital city sexual health clinics. A study of Australian sexual health practitioners reported that only a small number of them routinely provided

chaperones (19% for female and 9% for male patients).[16] This was despite the fact that many male practitioners believed it was appropriate, for medico-legal reasons, to have a chaperone present, especially when examining female patients.[16] There is little known about the pattern of chaperone use in Australian general practice.[17,18]

Recommendations from Australian authorities vary. Some insurers provide specific guidelines about appropriate times to offer chaperones and detail who can act as a chaperone;[19,20] at least one insurer advises that, ideally, a chaperone should be present for all IPEs.[20] The *RACGP position on the use of chaperones in general practice* suggests consideration of chaperone use should be on a case-by-case basis.[21]

Given the paucity of Australian data regarding chaperone use, our study aimed to investigate patients' attitudes to, and experience of, chaperone use for IPEs in a sample of Australian general practices. The objective was to help inform national and practice-based policy and practice.

Methods

Materials

Informed by a review of the literature and based on a previously used instrument,[2] two survey instruments were developed: one with 13 multi-item questions coded for female patients, and one with 12 multi-item questions coded for male patients. The instruments were coded by practice and collected demographic data and data regarding patients' preferences, including chaperone use, for gender-relevant IPEs. Response categories for attitude items were 'Yes', 'No' and 'Don't mind', and five-point Likert-type responses for 'Very uncomfortable' through to 'Very comfortable', or 'Strongly disagree' to 'Strongly agree'.

Recruitment

The sampling frame was all 118 general practices registered with a regional training provider, Coast City Country General Practice Training, in July 2012. This included metropolitan, inner regional and outer regional geographic classification areas located in south-eastern New South Wales and the Australian Capital Territory.[22] The practices were randomised and sequentially invited to participate, with a target sample size of 15 practices. In September 2012, each recruited practice was asked to provide surveys to 30 consecutive male and 30 consecutive female patients aged 18 years and older. Patients were invited to complete their anonymous survey at the practice and, if they consented, return the survey (completed or non-completed) to a secure receptacle at reception.

Analysis

Surveys were excluded if demographic data were incomplete or where only the demographic data and no further responses were entered. Generalised linear mixed models (GLMMs) were used for statistical analyses. For the GLMMs, the preference of respondents for the presence of a chaperone was collapsed into a binary response ('Yes' and 'No/Don't mind').

The first model tested for associations of preference for a chaperone for a Papanicolaou (Pap) smear (female survey) and genital examination (male survey) by the respondent's usual GP. The second model tested for differences between preferences for a chaperone when these examinations were performed by the respondent's usual GP, compared with a GP the respondent 'did not know well'. Independent variables (fixed effects) simultaneously entered in all models were the respondent's age, 'time seeing current GP' (binary: <5 years or ≥5 years in model 2 to permit model convergence) and 'gender of usual GP'. We excluded respondents from these analyses if they were not able to provide data for the latter two variables (ie they indicated they did not have a 'regular GP' in those items). We controlled for clustering of responses within practices and patients (random effects) as appropriate.

Statistical significance was set at $P < 0.05$. The lme4 package in R version 3.3.1 (R Foundation for Statistical Computing, Vienna, 2016) was used for statistical analyses.[23] The study was approved by the Human Research Ethics Committee of the University of Wollongong (reference number: HE11/462).

Results

Sample description

Of 21 practices invited, 13 participated (response rate: 62%). As defined by Australian Standard Geographical Classification – Remoteness Area, four practices were in metropolitan (RA1; 30.1%), eight practices in inner regional (RA2; 61.2%) and one practice in outer regional (RA3; 7.7%) locations.[22] The 13 practices distributed 780 surveys. Of these, 687 surveys with analysable data were returned (331 male and 356 female respondents), providing an 88% response rate. In the surveys analysed, missing data rates for individual items ranged from 0.8% to 15.7% for females and 0.3% to 18.1% for males.

Participants

The average age of male respondents was 56.2 years (range: 18–95 years; standard error [SE]: 2.2) and female respondents was 50.9 years (range: 18–91 years; SE: 2.4). Approximately 90% of respondents had a 'regular GP', and more than half (59.4%) had been seeing the same GP for five years or more. Nearly half of the female respondents (n = 168; 47.6%) had a female GP, compared with less than a quarter of male patients (n = 76; 23.0%). Three-quarters of respondents had never had a chaperone for an IPE. The time attending and gender of the respondent's usual GP are outlined in Table 1, and previous chaperone use in Table 2.

Participant preferences

For intimate presentations, 62.7% (n = 217) of women preferred a female GP for a Pap smear, and 52.2% (n = 165) of men indicated a preference for a male

Table 1. Time attending and gender of current GP and previous chaperone use

	Male respondent n (%)	Female respondent n (%)
Time seeing current GP		
I do not have a regular GP	34 (10.3)	32 (9.0)
<1 year	37 (11.2)	39 (11.0)
1–4 years	60 (18.2)	77 (21.6)
5–10 years	93 (28.2)	88 (24.7)
>10 years	106 (32.1)	120 (33.7)
Gender of usual GP		
Male	225 (68.2)	160 (45.3)
Female	76 (23.0)	168 (47.6)
I do not have a regular GP	29 (8.8)	25 (7.1)

Table 2. Previous use of chaperones during IPE

Examination	Never n (%)	Sometimes n (%)	Always n (%)	Not applicable n (%)
Male – genital (penis or testicles) examination	215 (73.1)	28 (9.5)	3 (1.0)	48 (16.3)
Female – Pap smear	281 (82.6)	40 (11.8)	4 (1.2)	15 (4.4)
Female – vaginal examination (no Pap)	265 (78.9)	45 (13.4)	2 (0.6)	24 (7.1)
Female – breast examination	276 (82.1)	32 (9.5)	5 (1.5)	23 (6.8)
Male – anal or rectal examination	217 (75.1)	25 (8.7)	1 (0.3)	46 (15.9)
Female – anal or rectal examination	261 (77.9)	16 (4.8)	4 (1.2)	54 (16.1)

GP for a genital problem. The proportion of patients preferring a chaperone with their usual GP was 23–33% across IPE types and patient gender. Preference for a chaperone was in the range of 5–20% across IPE types and patient gender when the examination was performed by either a GP whom the patient did not know well or a practice nurse in the Pap smear scenario. Three-quarters (n = 234; 73.1%) of male respondents had no gender preference for chaperones, compared with 42% (n = 141) of females. Table 3 shows the results of survey items regarding patients' preferences for the presence of a chaperone by examination type. Data for all respondents and data only from respondents with a regular GP (as a binary response) are presented in Table 3.

Slightly more than half of respondents felt 'Very uncomfortable' or 'Uncomfortable' with a reception staff member or practice manager as a chaperone. Approximately one-quarter of respondents 'Agreed' or 'Strongly agreed' that they would feel uncomfortable with a chaperone present for an IPE. Table 4 outlines respondents' attitudes to characteristics and roles of chaperones for IPEs.

There were no significant independent associations between respondent age, time with, and gender of, their usual GP, and preference for a chaperone for a Pap smear (females) or genital examination (males) by the respondent's usual GP. The odds of preference for a chaperone were significantly less with a GP they did not know well, compared with their usual GP for a Pap smear for female patients (odds ratio [OR]: 0.58; 95% confidence interval [CI]: 0.38, 0.89; $P = 0.01$) or genital examination for male patients (OR: 0.09; 95% CI: 0.02, 0.32; $P < 0.001$), adjusting for respondent age, time with, and gender of, their usual GP. These results were not significantly independently associated with patient age, time with, and gender of, their usual GP.

Discussion

To our knowledge, this study is the first to report the use of, and preferences for, a chaperone for IPEs among general practice patients in Australia. We found that patient-reported use of chaperones for IPEs in this sample of Australian general practices was uncommon. Consistent with previous international data from outpatient settings, the majority of female respondents preferred a female GP to perform their IPE.[5] In our study, male respondents' preferences regarding the gender of the GP for a genital examination were evenly distributed. Overall, only a minority of respondents would prefer to have a chaperone present. Consistent with international primary care[2] and Australian sexual health clinic data,[4] if a chaperone were to be present, the majority of female respondents preferred a female chaperone. We found that the majority of male respondents had no preference for the gender of the chaperone. However, our data demonstrated the novel and important finding that in this Australian context, both male and female respondents were significantly less likely to want a chaperone with a doctor they did not know than with their usual GP, for Pap smears or male genital examinations.

Initially, this finding appears counterintuitive as continuity of care is associated with patient trust in primary

Table 3. Patient preferences for presence of a chaperone by examination type

Preference	Yes n (%) total sample	No n (%) total sample	Don't mind	Not applicable n (%)	No/Don't mind n (%) patients with regular GP
Male patient genital (penis or testicle) examination by					
Usual GP	75 (23.3)	127 (39.4)	120 (37.3)	69 (24.6)	212 (75.4)
GP you don't know well	24 (8.7)	127 (46.2)	124 (45.1)	20 (8.4)	217 (91.6)
GP of the opposite gender	19 (7.0)	132 (48.4)	122 (44.7)	16 (6.8)	220 (93.2)
GP of the same gender	49 (17.2)	113 (39.6)	123 (43.2)	38 (15.6)	206 (84.4)
Female patient Pap smear or vaginal examination by					
Usual GP	103 (31.2)	148 (44.9)	79 (23.9)	91 (31.2)	201 (68.8)
GP you don't know well	50 (16.6)	152 (50.5)	99 (32.9)	46 (17.3)	220 (82.7)
GP of the opposite gender	48 (15.8)	144 (47.4)	112 (36.8)	39 (14.5)	229 (85.4)
GP of the same gender	81 (25.0)	132 (40.7)	111 (34.3)	66 (23.2)	219 (76.8)
Practice nurse	58 (18.7)	139 (44.8)	113 (36.5)	49 (18.1)	222 (81.9)
Female patient breast examination by					
Usual GP	99 (30.0)	142 (43.0)	89 (27.0)	87 (29.9)	204 (70.1)
GP you don't know well	45 (15.0)	140 (46.7)	115 (38.3)	41 (15.5)	223 (84.5)
GP of the opposite gender	44 (14.6)	139 (46.2)	118 (39.2)	38 (14.2)	229 (85.8)
GP of the same gender	69 (21.6)	129 (40.3)	122 (38.1)	57 (20.4)	223 (79.6)
Male patient anal or rectal examination by					
Usual GP	83 (26.0)	114 (35.7)	122 (38.3)	78 (28.0)	201 (72.0)
GP you don't know well	21 (7.8)	122 (45.0)	128 (47.2)	18 (7.6)	218 (92.4)
GP of the opposite gender	14 (5.2)	122 (45.0)	135 (49.8)	12 (5.1)	223 (94.9)
GP of the same gender	38 (13.7)	107 (38.5)	133 (47.8)	32 (13.2)	210 (86.8)
Female patient anal or rectal examination by					
Usual GP	108 (32.8)	151 (45.9)	70 (21.3)	96 (33.0)	195 (67.0)
GP you don't know well	48 (16.0)	153 (50.8)	100 (33.2)	41 (15.5)	224 (84.5)
GP of the opposite gender	46 (15.2)	151 (50.0)	105 (34.8)	38 (14.3)	228 (85.7)
GP of the same gender	75 (23.4)	136 (42.5)	109 (34.1)	59 (21.1)	220 (78.9)

care physicians.[24] However, the findings of reduced preference for a chaperone with a doctor not well known to the patient are supported by data from a metropolitan sexual health clinic. This study reported that less than 10% of males and 6–27% of females (depending on the gender of the treating GP) wanted a chaperone present for an IPE.[7] It is reasonable to assume that attendees of a sexual health clinic would, in general, not be regular patients. Therefore, building a long-term relationship between the patient and GP in that context may not be as likely as in general practice. We suggest that, possibly, the increased preference for a chaperone with their usual GP was a desire to 'medicalise' the examination, rendering the participants 'ungendered' at that moment,[25] to reduce embarrassment in an ongoing doctor–patient relationship. Of note, the gender of the doctor was not significantly associated with preferences for a chaperone. Non-clinical practice staff members were the least preferred option for a chaperone. In rural and remote areas, where there may be no alternative to a well-known GP for IPEs, these findings may be particularly important

in informing GPs' decisions to offer the presence of a chaperone for IPEs.

Our findings provide data that can assist with guideline implementation. In our sample, between a quarter and a third of patients would prefer a chaperone if they were to have an IPE by their usual GP, across IPE types. However, nearly a quarter of patients would feel uncomfortable if a chaperone were present. These findings broadly support the positions of the National Board[15] and The Royal Australian College of General Practitioners (RACGP), which encourage individualised joint decision-making with patients.[21] Blanket provision of a chaperone is not supported by our data, but exploration of the topic may be welcomed by patients.

Limitations

The findings should be interpreted within the limitations of the study and generalised with appropriate caution. The general practices in this study were sampled from a cohort of training practices from a single regional training provider, which may systematically differ from the population of practices in Australia. Our sample was biased towards practices from RA2 locations, compared with the nationally representative Bettering the Evaluation and Care of Health (BEACH) sample (RA1, 68.8%; RA2, 19.2%; RA3, 10.5%).[1] Furthermore, the nature of the survey construction may have excluded patients with low English literacy, reducing the socioeconomic and cultural diversity of the sample.

Future research

While we explored patterns of preference by gender in our study, we did not explore cultural associations of preference. International studies have provided some evidence of increased preference in some cultural groups,[5,6] and this should be a priority area for Australian research. Our data are unable to explain the underlying reasons for patients' preferences, or how patients make healthcare decisions as a result.

Qualitative research into these aspects is important, especially as these findings may have significant implications for areas of health workforce shortage, such as rural and remote Australia. We hypothesise that many patients may well see another provider rather than their usual GP for IPEs, while others may choose not to have an IPE. As approximately 90% of patients surveyed in this study had a regular GP, our findings give rise to important questions regarding the planning of sexual health services in general practice. Further research is needed to quantify patients' choices regarding the practitioners they see for IPEs and the implications for the health workforce.

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Table 4. Attitudes to characteristics and role of chaperones

Male patients **How comfortable would you feel with the following person as a chaperone?**					
	Very uncomfortable n (%)	**Uncomfortable n (%)**	**Neither uncomfortable nor comfortable n (%)**	**Comfortable n (%)**	**Very comfortable n (%)**
Practice nurse	18 (5.9)	29 (9.6)	83 (27.3)	118 (38.8)	56 (18.4)
Other doctor	19 (6.3)	19 (6.3)	84 (27.7)	121 (39.9)	60 (19.8)
Medical student	24 (8.2)	58 (19.7)	94 (32.0)	85 (28.9)	33 (11.2)
Reception staff/practice manager	66 (22.9)	87 (30.2)	76 (26.4)	37 (12.9)	22 (7.6)
Family or accompanying person	38 (12.9)	55 (18.6)	72 (24.4)	68 (23.1)	62 (21.0)
How strongly do you agree or disagree with the following statements? **The role of the chaperone is to …**					
	Strongly disagree n (%)	**Disagree n (%)**	**Neither agree nor disagree n (%)**	**Agree n (%)**	**Strongly agree n (%)**
Support the patient	11 (3.7)	11 (3.7)	60 (20.2)	170 (57.2)	45 (15.2)
Help the doctor	13 (4.5)	50 (17.2)	77 (26.6)	128 (44.1)	22 (7.6)
Protect the patient	9 (3.1)	18 (6.2)	69 (23.7)	156 (53.6)	39 (13.4)
Protect the doctor	10 (3.5)	23 (8.0)	72 (25.0)	142 (49.3)	41 (14.2)
How strongly do you agree or disagree with the following statements?					
I would like to be offered a chaperone	16 (5.3)	76 (25.3)	152 (50.5)	51 (16.9)	6 (2.0)
I would be embarrassed if a doctor offered a chaperone	18 (6.0)	90 (30.0)	137 (45.7)	45 (15.0)	10 (3.3)
I would feel comfortable requesting a chaperone if one wasn't offered	11 (3.7)	57 (19.3)	136 (45.9)	85 (28.7)	7 (2.4)
I would feel uncomfortable or embarrassed if a chaperone was present for my examination	13 (4.4)	67 (22.4)	137 (45.8)	67 (22.4)	15 (5.0)
Having a chaperone present would make me feel comfortable	16 (5.4)	77 (25.8)	152 (50.8)	47 (15.7)	7 (2.3)
I would prefer a chaperone to remain inside the curtain during an intimate examination	26 (8.6)	92 (30.6)	146 (48.5)	29 (9.6)	8 (2.7)
I would prefer a chaperone to remain outside the curtain during an intimate examination	9 (3.0)	30 (10.0)	146 (48.5)	101 (33.5)	15 (5.0)
Female patients **How comfortable would you feel with the following person as a chaperone?**					
	Very uncomfortable n (%)	**Uncomfortable n (%)**	**Neither uncomfortable nor comfortable n (%)**	**Comfortable n (%)**	**Very comfortable n (%)**
Practice nurse	33 (9.6)	17 (4.9)	53 (15.3)	135 (39.0)	108 (31.2)
Other doctor	28 (8.7)	27 (8.3)	58 (17.9)	129 (39.8)	82 (25.3)
Medical student	34 (10.6)	53 (16.5)	81 (25.1)	107 (33.2)	47 (14.6)
Reception staff/practice manager	76 (23.4)	117 (36.0)	58 (17.8)	51 (15.7)	23 (7.1)
Family or accompanying person	46 (14.0)	59 (17.9)	61 (18.6)	82 (24.9)	81 (24.6)

Table 4. Attitudes to characteristics and role of chaperones *(continued)*

How strongly do you agree or disagree with the following statements? The role of the chaperone is to…	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)
Support the patient	7 (2.1)	11 (3.2)	55 (16.2)	167 (49.3)	99 (29.2)
Help the doctor	21 (6.4)	39 (12.0)	90 (27.6)	140 (42.9)	36 (11.1)
Protect the patient	10 (3.1)	19 (5.9)	58 (17.9)	139 (42.9)	98 (30.2)
Protect the doctor	7 (2.2)	28 (8.6)	63 (19.5)	154 (47.7)	71 (22.0)
How strongly do you agree or disagree with the following statements?					
I would like to be offered a chaperone	23 (6.9)	52 (15.6)	160 (48.1)	89 (26.7)	9 (2.7)
I would be embarrassed if a doctor offered a chaperone	29 (8.8)	115 (35.0)	134 (40.7)	40 (12.2)	11 (3.3)
I would feel comfortable requesting a chaperone if one wasn't offered	17 (5.2)	55 (16.9)	115 (35.4)	119 (36.6)	19 (5.9)
I would feel uncomfortable or embarrassed if a chaperone was present for my examination	25 (7.5)	95 (28.7)	125 (37.8)	69 (20.9)	17 (5.1)
Having a chaperone present would make me feel comfortable	16 (4.9)	100 (30.8)	128 (39.4)	65 (20.0)	16 (4.9)
I would prefer a chaperone to remain inside the curtain during an intimate examination	29 (8.9)	107 (32.8)	132 (40.5)	45 (13.8)	13 (4.0)
I would prefer a chaperone to remain outside the curtain during an intimate examination	10 (3.1)	34 (10.4)	136 (41.7)	122 (37.4)	24 (7.4)

Percentages of valid responses are displayed

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