The Medical Chaperone: Outdated Anachronism or Modern Necessity?

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The word “chaperone” derives figuratively from the French word *chaperon* meaning “hood” and later a kind of hat. The term was first borrowed into English in the 1700s and came to refer to an “escort,” commonly an older woman who accompanied a young, unmarried woman in public to provide protection. While the use of these social chaperones now seems quaint and has fallen out of practice, the use of medical chaperones has never been more hotly debated—owing, of course, to the increasingly consumerist and litigious nature of healthcare in the 21st century.

In this issue of the *Southern Medical Journal*, Santen et al1 report on a survey of patient and physician preferences regarding the use of chaperones during genitourinary examinations in the Emergency Department. This is one of very few published studies that has investigated chaperone practices in this setting where there is not likely to be a pre-established doctor-patient relationship—which is significant given that previous research has suggested a greater patient preference for chaperones when it is not the patient’s usual physician performing the examination.2

The results of the present study indicate that most intimate examinations in the ED are not chaperoned and, further, that patient preferences are not regularly solicited. And the data suggest great variability in patient preferences. Among female survey respondents, approximately equal proportions prefer to have a chaperone present during intimate examinations (45–47% depending on the specific examination) or do not care either way (44–45%). In stark contrast, the vast majority of male patients (81–88%) do not have a specific preference either for or against the presence of a chaperone. Gender differences aside, the majority of surveyed patients (73% of females; 52% of males) would like to be asked their preference for a chaperone. This is particularly salient in light of the finding that a significant minority of patients (9–16%) prefers that a chaperone not be present.

Previous studies2–4 have pointed to divergent perspectives for males and females, so the observed pattern of gender differences was not unexpected or surprising. On the other hand, it is always somewhat disconcerting to read about the expansive gulf that continues to separate physician and patient perspectives. In this era of patient-centered care, it is indeed striking that such a small minority of physicians—only 15%—report making it a practice to inquire about their patients’ preferences for a chaperone during intimate examinations. This extremely low percentage might well be explained by another striking finding: most of the physicians in the study sample stated that a patient’s preference “would not necessarily change their practice.” Clearly, there is not much point in asking a patient for his/her preference if it is not then to be accorded any weight in the physician’s behavior. Not surprisingly, the authors conclude that “there is a discrepancy between what physicians do and what their patients may desire.”

So, is the patient undergoing an intimate physical examination today’s equivalent of the young unmarried woman once deemed in need of a chaperone? For better or worse, physicians are increasingly viewed not as protectors of patients but rather as partners with patients. Concordance has replaced compliance as the new watchword. Given this profound social shift, the standard of practice regarding medical chaperones must likewise shift to align more closely with patient values, preferences, and expectations. It is noteworthy that most clinical practice guidelines now recommend not the use but the offer of a chaperone for intimate examinations.

Available data suggest that the offer of a chaperone by the physician is perceived by patients as a gesture of respect.2 The current paper and other past studies raise interesting ethical issues that require further exploration. Surveys and questionnaires provide sketches of views held by physicians and patients, but relatively little insight into the reasons underlying those views. Certainly, if personal integrity and security are motivating patients to prefer chaperones, then the finding by Santen et al that physicians would not change their practice despite clearly stated preferences could further undermine trust in the profession. And if respect for persons is an important value in healthcare, then opportunities to harmonize patient and provider perspectives should be seized. Patient perceptions of respect can only serve to foster an environment of trust and open communication that is more conducive to shared decision-making and truly patient-centered care.

As we have previously noted elsewhere, innovative multimethod research is needed to understand in greater depth the barriers and facilitators to the use of chaperones during intimate physical examinations.5 Based on research to date, patient-centered educational initiatives and clinical interventions could be developed, implemented, and systematically evaluated. This type of “in situ” research could do much to bring evolving medicolegal recommendations and current...
practice patterns into closer alignment with shifting patient values. By directly comparing physician and patient perspectives, the study by Santen et al moves us closer to this important goal.

References


Please see “Chaperones for Rectal and Genital Examinations: What do Patients and Physicians Want?” on page 24 of this issue.