

Intimate Examinations and Chaperone Policy

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Foreword

This document is a new edition providing guidance on intimate examinations and the use of chaperones. It was first published by the Society and College of Radiographers (SCoR) in October 2011. This 2023 edition includes updated references and links to relevant guidance published by other organisations including the General Medical Council (GMC), the Royal College of Radiologists (RCR) and the Medical Defence Union (MDU) as well as papers by academics working in this field. Two new sections have been added to support trans patients and survivors of sexual violence when attending for intimate examinations.

This document has relevance for the entire diagnostic imaging and radiotherapy workforce. It should be viewed in association with the SCoR publication *Obtaining consent: a clinical guideline for the diagnostic imaging and radiotherapy workforce*.¹

1. Introduction

This policy is aimed at the diagnostic imaging and radiotherapy workforce, including students and trainees. It is of equal relevance to all patients and screening clients regardless of gender, to practitioners and students, and it encompasses all forms of diagnostic imaging, radiotherapy planning and treatment. It has been developed from advice published by the Society of Radiographers (SoR)¹⁻³ and incorporates guidance published by the GMC^{4,5} and RCR.⁶ It is designed to be used in conjunction with policies set out by local trusts, health boards, independent providers (or other employing authorities) on intimate examinations and the use of chaperones but not to override them. These policies should not contain arbitrary exclusions or assumptions based on gender and will provide guidance on respecting individual patient's needs regardless of factors such as ethnicity, gender, religious or cultural background, previous experiences or age. Local policies often provide detailed considerations with respect to intimate examinations and chaperones that are tailored to suit local circumstances; they should also provide guidance for students and trainees. All policies will need to comply with the Equality Act, 2010⁷ and with the Department of Health and Social Care policies on equality and diversity.⁸ Many complaints relating to sexual assault in healthcare arise from misunderstandings.⁹ The Medical Defence Union (MDU) has published helpful advice on protecting against sexual assault allegations and on the use of chaperones.⁹ Taking measures outlined by the MDU will lessen the risk of receiving a complaint^{9,10} and ensure that patients receive the best care possible.

2. Intimate examinations

- 2.1** The GMC advises that it is particularly important to maintain a professional boundary when examining or treating patients where intimate examinations may be involved as these examinations can be embarrassing or distressing for patients.

Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient.⁴

(GMC, *Intimate Examinations and Chaperones*)

2.2 The following examples would be considered intimate examinations. This is not a definitive list. Each patient should be treated as an individual and what is 'intimate' can vary between individual people and cultures.

- i.** Examinations or treatments of the scrotum and penis.
- ii.** Examinations or treatments of the uterus, ovaries, adnexae or urethra, e.g. endovaginal ultrasound scans, brachytherapy for gynaecological cancers, urethrograms or cystography. Transabdominal ultrasound examinations may be considered intimate by some patients, as may some standard x-ray procedures, e.g. abdominal x-ray or palpation of the pelvic bones for pelvic radiography.
- iii.** Examinations or treatments of the rectum and anus.
- iv.** Breast examinations or treatments.
- v.** Ultrasound examinations which involve scanning the groin region, e.g. for deep vein thrombosis.
- vi.** Lateral x-ray examination of the hip using a horizontal beam technique.
- vii.** Accessing the femoral artery prior to angiographic procedures.
- viii.** Endorectal MRI.
- ix.** A standard transthoracic echocardiogram is not considered an intimate examination but still requires sensitivity.¹¹ Individual patients may, however, consider that for them it is intimate, as discussed above.

2.3 Information should be provided prior to the examination. Depending on local policy, appointment letters may include information on the treatment or examination proposed. They may also include information on training policy, equal opportunities policy, chaperones, and a request for the patient to advise of any disabilities or special needs.

2.4 Permission should be sought from the patient after providing an explanation of the examination, including why it is necessary, and offering the opportunity to ask questions. The explanation should include what the examination will involve in a way the patient can understand so that they have a clear idea of what to expect, including any potential pain or discomfort they might experience. It will be more meaningful if the patient has had time to

consider the procedure using, for example, verbal or written information given to them when they are referred.^{4,6} The MDU advises that careful communication with the patient is key to an effective consultation, as well as helping to avoid any misunderstanding that might trigger a complaint.⁹ A patient may not understand why a symptom in one part of the body may require an examination of another area and it is essential to explain why this is necessary. The patient might not have any knowledge of how the examination will be performed; explanation should be given for what is involved, any equipment you will use and any discomfort they may experience.⁹

- 2.5** The conduct of intimate examinations should be considered together with obtaining informed consent. Obtaining informed consent involves providing patients with the information they want or need to make a decision and ensuring that information is objective, relevant and unaffected by assumptions.

There should be policies in place for situations when a patient does not have the capacity to give consent or is of an age where they are legally still considered to be a child (i.e. everyone under 18). A full discussion of consent for vulnerable adults and children is beyond the scope of this document; reference should be made to advice published by local trusts and health boards, the GMC, MDU and professional bodies such as the SoR and RCR.^{1,3,5,6,9}

- 2.6** Patients undergoing intimate examinations or treatments may feel unsure or vulnerable regarding the examination or treatment they are to undergo. Examinations requiring partial undressing and those conducted in reduced lighting may increase this sense of concern. It is therefore always important to give a full explanation of the examination or treatment in terms that the patient can understand, including reasons for undressing or reduced lighting, and to allay their fears by giving them an opportunity to ask any questions they may have and to have their questions answered.

Consideration should also be given to patients with other needs, such as visual or hearing impairment or learning difficulties. Explanations should be tailored to the individual, taking into account their personal characteristics and individual requirements.

- 2.7** Witnessed verbal consent will usually be sufficient for most intimate examinations⁶ including endovaginal ultrasound examinations (assuming points 2.4 to 2.6 have been actioned correctly). The witness should be a trained chaperone or healthcare professional. Consent should be recorded in the patient's notes, electronic record and/or report along with the name of anyone witnessing the consent process.¹² Local protocols should also be consulted.

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- 2.8** It is important to be aware that there may be patients who have capacity to consent, but for whom perceptions of intimacy may be affected by disinhibition, for example patients with dementia.
- 2.9** Some patients may have ethnic, religious, cultural or other concerns with respect to being examined or treated by a person who is not of the same gender. The patient has the right to decline the examination or treatment and should not feel pressured into continuing. If possible, a practitioner of the requested gender should conduct the examination or treatment. If such practitioner is not available on the day of attendance, the patient may be offered a new appointment. For many patients, however, their main concern is that the examination or treatment is conducted in a professional and timely manner. Chaperone considerations will apply as discussed in section 3.
- 2.10** Patients should be offered the opportunity to have a chaperone irrespective of the practitioner's gender and the examination being undertaken. For professional integrity and safety, the practitioner should give equal consideration to their own need for a chaperone irrespective of the examination being undertaken or the gender of the patient.
- 2.11** For all procedures which involve touching the patient in a place that they may deem to be intimate, or where such areas might be exposed, it is essential that an explanation be given to the patient before the procedure commences. The explanation should include what part of the body will be touched and why it is necessary. For example, for an imaging examination of the hip, the assistant practitioner or radiographer might say:

So that I can position you correctly and get a good picture of your hip, would it be possible to feel the bones around your hip?

For radiotherapy, the assistant practitioner or radiographer might say:

To decide which size of brachytherapy applicator is best for you I would need to do a vaginal examination; would that be possible?

For ultrasound, the sonographer might say:

It would be helpful to see if I can move the bowel gas to get a better view of your ovary. To do that I would need to push on your pelvis.

In some cases, this may need to be done before the patient is asked to lie on the couch so

that there can be no possibility of coercion. In this way, it is hoped that the likelihood of any misunderstanding is avoided.¹

- 2.12** It is advisable to ensure that the patient agrees with, and understands the role of, staff that might be present during examinations or treatments, whether these are considered intimate or not. All staff should understand their role and it is good practice to keep the numbers present in the room to a minimum. All staff present in the room should introduce themselves and state their role.¹³
- 2.13** The patient should be given privacy to undress and dress and it is good practice to keep the patient covered as much as possible to maintain their dignity. It is important not to assist the patient in removing their clothing unless it has been clarified with them that they would like assistance.⁴
- 2.14** Intimate examinations should be conducted in a room that affords the patient privacy. Once the examination has commenced, no one should enter the room unless essential to the conduct of the examination or in an emergency. It is advisable to have a sign on the door to this effect.
- 2.15** Prior to the examination, the patient should be informed that they can ask for the examination to be stopped at any point.
- 2.16** As the examination commences a clear explanation should be provided and, if this differs from what has already been outlined to the patient, an explanation given as to why; their permission should be sought at each stage of the examination. Consent is a continuum and ongoing communication is required.
- 2.17** Be prepared to discontinue the examination if the patient asks and be alert to any verbal or non-verbal signs of distress or discomfort. Be prepared to provide a chaperone if initially declined but later requested.
- 2.18** Keep conversation relevant and do not make unnecessary personal comments, to improve patient comfort and maintain professionalism. Even if well intended, the wrong meaning can be inferred.⁴ It can occasionally be necessary during, for example, endovaginal sonography to attempt to elicit the cause of a patient's symptoms during the examination and specific questions asked should be of a clearly technical nature.⁶
- 2.19** Some patients may have great difficulty going through with the procedure. For example,

endovaginal ultrasound scans may be impossible for reasons such as vaginismus or radiation fibrosis. Patients may find rectal examination impossible either because of pain or sphincter spasm. The RCR advises that in most cases it is appropriate to abandon the examination and discuss the difficulty, possible alternatives and solutions after the patient has dressed.⁶

- 2.20** Give any results or further information to the patient after they have dressed. In some instances, such as obstetric ultrasound, patients can be asked if they want to dress and discuss the findings or if they would prefer to see the images on the screen as the findings are discussed.
- 2.21** Before an intimate examination is performed on an anaesthetised patient, or a practitioner supervises a student or trainee who intends to carry one out, it is important to make sure that the patient has given informed consent in advance to both the intimate examination and the student or trainee performing it. The GMC states that consent should be in writing.⁴

3. Chaperones

- 3.1** The following advice is partly based on that written by the GMC⁴ and sets out good practice principles that apply to all who work within diagnostic imaging and radiotherapy. Reference should also be made to local trust, health board, independent provider or other employing authorities' policies. These often provide detailed considerations with respect to chaperones that are tailored to suit local circumstances.
- 3.2** Patients should be offered the security of having an impartial observer of the same gender as the patient or gender of their choosing (a chaperone) present during an intimate examination and the patient has a right to request that one is present. For professional integrity and safety, equal consideration should be given to the practitioner's own need for a chaperone irrespective of the examination being undertaken or the gender of the patient. This applies whether or not the practitioner is or identifies as the same gender as the patient. It is also good practice to be prepared to offer a chaperone even when the examination is not considered to be an intimate one. The name and role of the chaperone should be communicated to the patient as part of the consent process.
- 3.3** Ideally, a chaperone will be:
- i.** A member of staff.

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- ii. The same gender as the patient, where applicable.
 - iii. Someone who has had training for the role (training of chaperones is the responsibility of the healthcare provider).
 - iv. Sensitive and respectful to the patient's dignity and confidentiality.
 - v. Prepared to bring to the attention of the practitioner, reassure the patient or ask that the practitioner cease the examination if the patient shows signs of distress or discomfort.
 - vi. Familiar with the procedures involved in a routine intimate examination.
 - vii. Able to stay for the whole examination and observe what the practitioner is doing, if practicable.
 - viii. Prepared to raise concerns about a practitioner or patient if misconduct is suspected or occurs, in line with local policy.

3.4 If a chaperone is offered for an intimate examination but declined, local policies may allow the practitioner to proceed with the examination.^{14,15} However, having a chaperone present can strengthen a practitioner's defence if an allegation of unprofessional behaviour is made.⁹

When the practitioner feels that a chaperone is needed,¹⁵ or it is felt that the examination could be misinterpreted by the patient or the person accompanying them, it is always recommended to have an independent chaperone present. An independent investigation in 2004 recommended using only trained chaperones,¹⁴ which is supported by the GMC,⁴ RCN¹⁵ and RCR.⁶ The GMC advise:

If you don't want to go ahead without a chaperone present but the patient has said no to having one, you must explain clearly why you want a chaperone present. Ultimately the patient's clinical needs must take precedence. You may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as a delay would not adversely affect the patient's health.⁴

(GMC, *Intimate Examinations and Chaperones*)

3.5 A practitioner has a right to request that a chaperone is present during an intimate examination and may be required to have one present under local policies, which should always be consulted in addition to this guidance. These local policies often give advice on how

to proceed if a patient refuses to have a chaperone present and the practitioner feels they may be at risk. The general principle would be that the practitioner should not carry out the procedure and explain to the patient that it will only be carried out in the presence of a chaperone. Attempts should be made to agree a suitable chaperone with the patient.

- 3.6** In some departments and circumstances, a member of staff with chaperone training may not be available and local policies may allow a relative or friend of the patient to be used as a comforter, carer or 'informal chaperone' if this is acceptable to both the patient and the practitioner involved. This practice may, however, make any allegation more difficult to defend as a relative or friend is not an impartial observer. Children (i.e. anyone under 18) should not act as chaperones.

The 2017 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), SI 2017/1322¹⁶ and the IR(ME)R (Northern Ireland) 2018, SR 2018/17,¹⁷ both state that any exposure of comforters and carers to radiation must be justified. There should be a written employer's procedure for the management of comforters and carers to include consent, justification, recording of dose information and communicating the benefits and risks associated with the exposure, particularly where the benefit is not to the individual but to the person they are caring for. Further information can be found in the joint professional body guidance [IR\(ME\)R - Implications for clinical practice in diagnostic imaging, interventional radiology and diagnostic nuclear medicine](#) (section 16)¹⁸ and the SoR webinar [IR\(ME\)R 2017: The Implications for Carers and Comforters](#).¹⁹

- 3.7** If the patient does not wish to proceed with the chaperone offered and no other suitable chaperones are available, the examination may have to be delayed to when an alternative suitable chaperone will be available, if this is compatible with the patient's best interests following discussion with the patient. Local protocols may also give advice on this situation. If any delay may be detrimental to the patient's care or treatment, this should be made clear and the patient's acceptance of this compromise should be recorded. The referring clinician should be advised of this. All attempts should be made to resolve the situation using the resources available on the day of the examination. However, it is important to avoid making the patient feel under pressure to proceed against their wishes or to feel that they are an inconvenience.⁹
- 3.8** Patients should be advised in advance of the appointment that a chaperone may be requested for any examination and procedures should be in place to provide one. This could be a notice placed in the waiting room, information in an appointment notification or an information leaflet.

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- 3.9** A record should be made of any discussion about chaperones in the patient's notes, electronic record or report. If a chaperone is present, this should be recorded along with their identity and job title. If the patient does not want a chaperone, it should be recorded that the offer was made and declined.⁴

4. Students and trainees

- 4.1** Regarding students and trainees (learners), the RCR gives the following advice:

Teaching intimate radiological examinations is particularly challenging. Agreement that a trainee can be present or may perform the investigation should be obtained from the patient in advance of the examination, and it should be made clear that there would be no disadvantage to the patient if they refuse to have a trainee present. Patient consent for the trainee involvement should be recorded, usually in writing. Patients may be reluctant to be examined by inexperienced individuals and the embarrassment and inexperience of the trainee may convey itself to the patient; sensitive handling of the trainee as well as the patient is required. Trainees must participate not only in the procedure itself but also the process of pre-procedural discussion. Careful direct supervision of the performance of all aspects of the procedure performed by the trainee is necessary until the trainer is confident that the trainee is capable of achieving a diagnostic examination in a sensitive and sympathetic fashion...⁶

(RCR, *Intimate examinations and the use of chaperones*)

- 4.2** It is an important part of any clinical placement that learners can participate in intimate examinations, but this should clearly be balanced against the wishes of the patient.
- 4.3** If the examination is of an intimate nature, it is essential to obtain consent for a learner to be present. The learner should verbally confirm any consent given personally with the patient and this should be recorded in the notes or on the report.
- 4.4** Patients should be informed and give their verbal consent if the examination is likely to be repeated by a qualified practitioner to confirm a learner's findings; or if a qualified practitioner will need to undertake further examinations as part of the procedure. Examples include internal examinations associated with cervical brachytherapy or palpation of the testes for possible masses prior to ultrasound.

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- 4.5** A notice should be placed in the waiting area stating that students and trainees are undergoing training in the department, making it clear that the patient will not be disadvantaged if they decline to have a learner present.
- 4.6** Where possible, students and trainees should gain experience of how to conduct an intimate examination using simulators or anatomical models. An example would be the use of vaginal ultrasound simulators to learn the basic principles of this technique.
- 4.7** A learner should not conduct an intimate examination on a patient without a qualified practitioner being present, even if the patient is happy to proceed with the examination. It therefore follows that a student cannot formally chaperone another student.
- 4.8** A learner should not conduct an intimate examination on a child or an adult who lacks capacity to consent. This specific capacity should be ascertained and recorded by a qualified practitioner before proceeding.
- 4.9** A student who is familiar with the normal examination procedure may act as a chaperone for a qualified practitioner with the agreement of the patient. In such situations, the student should have been trained to act as a chaperone and should agree to take on the responsibility and be authorised to do so as per local policy. Commonly, the name and designation of the chaperone is documented in the patient's record. Education Institutions responsible for the student's training may also have policies that apply.
- 4.10** Learners should consult written material produced for them by their parent Education Institution about intimate examinations and chaperones.
- 4.11** In the case of patients undergoing a general anaesthetic, there should be written consent for a learner to conduct an intimate examination on the patient.⁴ The patient should be treated with the same degree of sensitivity and respect as if they were awake.

5. Trans patients

- 5.1** Transgender (trans) people should be offered equality of access to services, as stated in the government publication [Equality Act 2010: guidance](#);⁷ however, they may have additional needs and considerations when attending for intimate examinations. Healthcare professionals need to understand terminology to assist with person-centred communication and care.

Some terms and concepts are introduced here and in Figure 1.²⁰ Further information can be found in the documents [Inclusive pregnancy status guidelines for ionising radiation: diagnostic and therapeutic exposures](#)²¹ and [Gender inclusive language in perinatal services: mission statement and rationale](#).²²

Transgender is a broad term used for people whose gender identity or *gender expression* differs from their assigned sex at birth.

...sex is defined as the presence of specific anatomy or chromosomes.

Gender is a social construct, made up of attitudes, feelings, and behaviours that a culture associates with either males or females; terminology often varies by geographic region, culture, and individual preference.

Gender nonconformity is the extent to which a person's gender identity, role, or expression differs from the cultural norms described for a specific sex.

Sexual orientation refers to sexual attraction only and is separate from gender identity. It is important to differentiate these concepts and terms when caring for patients.²⁰

(ACOG, *Health Care for Transgender and Gender Diverse Individuals*)



Figure 1: Diagram to illustrate the different concepts of sex and gender. Adapted from ACOG, *Health Care for Transgender and Gender Diverse Individuals*.²⁰

The terminology used in Figure 1 is explained by the following definitions:

Biological sex: the chromosomal and biological/anatomic structure of a person. This will infer upon the sex assigned at birth which is always male or female. It is important to remember that some people will have variations in their sex characteristics (VSC) or have differences in sex development (DSD) and may also choose to identify with the label intersex.

Sexual orientation: a person's identity in relation to the gender(s) a person is sexually or romantically attracted to.

Gender expression: the way someone expresses their gender through, for example, the way they dress, their hair, make-up, body language, actions and behaviour. These expressions may also include a person's name and pronouns.

Gender identity: the internal sense of a person's gender, e.g. a sense of being male, female, or somewhere else along the gender spectrum. A person's gender identity may be the same (cisgender) or different (transgender) to their sex assigned at birth.

- 5.2 Trans patients may have additional needs and considerations when intimate examinations are being performed.
- 5.3 It is important to be aware that the terminology used can lead to gender dysphoria in some trans patients. Gender dysphoria refers to the intense psychological discomfort some trans people feel related to their gender incongruence.
- 5.4 Ensuring that trans patients feel safe and can trust the healthcare provider is important, as many have had negative experiences or faced discrimination in the past which can impact on their access to healthcare.^{20,23}
- 5.5 Obstetric and gynaecology settings can be particularly difficult for transmasculine patients because of the focus on women's health.²⁰
- 5.6 Where possible, e.g. for ultrasound examinations, trans patients should be offered the opportunity to have a support person in the room.
- 5.7 It is good practice to ask a patient for their pronouns and also their preferred language for intimate areas of their body that might be examined.²³
- 5.8 Practitioners should be aware of the "importance of not making assumptions about sex

registered at birth based on how an individual presents themselves”.²¹

5.9 Care should also be taken not to make assumptions about who is the person to receive care, particularly when two people attend together for an appointment.

5.10 Advice to support trans patients undergoing pelvic examinations includes:

- Providing contact details for patients who may have concerns and wish to discuss them confidentially prior to the examination.
- Having a discussion about the examination, including every step of the procedure, before beginning.²⁴
- Providing time for the patient to ask questions and “express any concerns before beginning the exam”.²⁴
- Providing a clear explanation at each step, including when touch, movement, pressure and/or sounds will be involved.²⁴
- Considering the number of healthcare professionals in the room for the appointment and checking whether the patient feels comfortable with this.
- Reminding the patient that they can ask to pause or stop the examination at any point.
- Asking the patient what terms they prefer to use, e.g. vagina may be called the “‘front’ or ‘front hole’”.²⁴
- Considering the terminology used. In the case of endovaginal ultrasound, it may be preferable to call the examination an internal scan, rather than endovaginal scan.
- Acknowledging any differences between clinical terms and personally preferred terms that may be used during the appointment and clearly explaining why this might occur.
- Being mindful not to phrase episodes of care as being within ‘men’s health’ or ‘women’s health’, as this may cause frustration or gender dysphoria in the patient.
- If relevant, checking if a transmasculine patient is experiencing any vaginal atrophy due to medical transition, which may make endovaginal ultrasound uncomfortable.
- Asking, where applicable, if the patient would like to insert the probe themselves.

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- Discussing with the patient where information related to the patient’s trans status might be recorded, who might see it and why.
 - Acknowledging the discordance and lack of trans-focused research in particular aspects of care when citing known incident rates, clinical data or patient experience anecdotes that do not correspond to the gender of the patient.

5.11 When a practitioner is providing a written report on an examination, factual anatomical terms will be used within the report. If a patient uses different terminology during face-to-face consultations, it may be helpful to explain that the clinical report will use anatomical terms in-line with national guidance to ensure consistency and reduce the chance of misinterpretation.

6. Survivors of sexual violence

[Note: It is important to recognise that a higher proportion of trans people (50%) have experienced sexual violence than cisgender people (20%).²³ Due to the terminology used in the crime survey report this section refers to women and men, however this section will also apply to trans patients attending for intimate examinations.]

- 6.1** According to the Crime Survey for England and Wales (CSEW) approximately 20% of women and 4% of men over 16 years of age have “experienced some type of sexual assault”.²⁵ Many of these cases (83%) are not reported. This would suggest that many patients attending for intimate examinations may be survivors of sexual violence.
- 6.2** Survivors of sexual violence have expressed concerns about accessing healthcare, particularly intimate examinations, which can lead to health inequalities.²⁶ Medical examinations and procedures, particularly intimate examinations, can lead to flashbacks, panic attacks and other responses.^{26,27}

Survivors have told us time and time again that one thing that would really help them get through their medical appointments would be for healthcare professionals to let them know what they need to do and why, and to ask for consent, for every step of the procedure.

...explaining what will happen and asking the person under their care if there is anything that makes them feel anxious about the procedure before and during it, enabling the person to feel more in control. It also aims to empower survivors to let their practitioner know what might

*help them to better cope with their appointment, whether or not they choose to disclose recent or non-recent abuse.*²⁶

(The Survivors Trust, #CheckWithMeFirst project)

- 6.3** A ‘trauma informed approach’ to sensitive practice will enable survivors of sexual violence to get the appropriate care they require, without divulging information that they may wish to keep private.
- 6.4** A [YouTube video](#) is available from the Survivors Trust as part of the #CheckWithMeFirst campaign.
- 6.5** Patients should be given a sense of control by ‘informing before performing’, to ensure that during each step of the process and throughout the examination the patient understands what will happen and can ask questions.²⁸
- 6.6** It is important to be aware of other aspects that might affect a patient’s comfort within an examination or treatment room, for example concern about anything touching the face or neck area. This could include the wearing of face coverings. Non-judgemental, individualised and open communication is required to assist patients in receiving the care they need.
- 6.7** Departments can reduce the anxiety associated with attending for an intimate examination in several ways; these include, but are not limited to:

Pre-appointment:

- Providing patient information in the appointment letter, via telephone call, on the department website or information app that explains the procedure and provides contact details for patients who may have concerns and wish to discuss them confidentially prior to an examination.
- Explicitly stating that patients who may find the examination difficult can call to discuss their individual requirements in advance of the appointment.
- Having several staff who are trained, confident and competent to have such conversations available to call patients back, discuss their requirements and make specific arrangements if necessary.
- Provide reassurance that the patient can specify their requirements for a practitioner

of a specific gender, subject to availability. Arrange the appointment to ensure patient requirements can be met where possible and there will be no surprises on the day. Care should be taken to avoid making assumptions about preference for gender of the healthcare professional. For example, a female gynaecologist may not be perceived as safer if violence has been committed against the patient by a woman.²⁹

- Where possible, invite the patient to bring an adult support person with them for the examination or procedure.
- Place a notice in the waiting area encouraging patients to speak to a member of staff if they are experiencing any concerns about the examination.
- It might be appropriate to offer an opportunity for a patient to write down their concerns if they are unable to verbalise them.³⁰

6.8 If having a call with a patient prior to their appointment, it might be helpful to ask for relevant information to reduce the need to ask when they arrive for the examination, e.g. for a patient of reproductive age attending for an endovaginal ultrasound examination:

- How often do you have periods? Are they regular? How long does a period last?
- When was the first day of your last period (if the appointment is booked for that week).
- Are you taking any hormonal contraception?
- Have you had any previous pregnancies?
- Have you given birth to a child. If yes – vaginal or caesarean section delivery?
- Have you had any pelvic surgery?
- What can we do to make sure things run as smoothly as possible for you? This might include questions about timing of the appointment to avoid busy waiting rooms or over-running lists; whether there is another entrance to reduce the need to walk through busy waiting rooms; if it is possible to have a longer appointment slot to provide time and support for the examination and whether there are any terms, phrases, words or actions that should be avoided.

During the appointment:

- Offer a chaperone and explain who the chaperone would be and what their role is.
- Ensure that the practitioner(s) involved in the examination are aware of the specific requirements before the patient arrives, so that the patient does not have to repeat them.
- Identify what terms the patient would prefer, to avoid using language that might cause distress.³⁰
- Ask the patient if they want to be shown the equipment to assist with explaining the procedure.
- In some cases, it might be possible to offer the patient an opportunity to be involved in the examination, for example with an endovaginal scan they can be asked if they want to insert the probe themselves.
- Ascertain whether there are any areas that the patient would prefer you not to touch, if possible.³⁰
- Remind the patient that they can ask you to stop or take a break at any time.³¹ This can give them a feeling of control over their situation.
- Check that the patient is ready for the examination to begin and give them time to ask any questions they may have.
- Check in with the patient during the examination to ensure that they are as comfortable as possible.
- Explain the process at each step.
- Be alert to non-verbal signals that might indicate patient discomfort.²⁸
- Take care with the language used, for example “it will not hurt” could be changed to “it may feel uncomfortable but let me know if you feel any pain”. “Please relax” should be avoided; it could be reframed as “if you could try and rest your X onto the couch/pillow/chair”.

6.9 Further advice and contact details of support groups that patients can be directed to are available via [Jo’s Cervical Cancer Trust](#).²⁷

7. Summary

This summary is based on advice given by the MDU.⁹

- “Familiarise yourself with local and national guidelines”.
- “Get consent for the examination” and explain what will occur.
- “Offer a chaperone”.
- “Give patients privacy to dress and undress”.
- Avoid unprofessional conversations or “personal comments”.
- “Stop if the patient asks”.
- Treat each patient individually.
- “Keep careful records”.

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Quality Standard for Imaging

This guidance relates to sections XR 1 05 and US 8 01 of the [Quality Standard for Imaging](#).