



Intimate Examinations and Chaperone Policy

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Summary

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 2016 edition now includes references to updated General Medical Council advice published in 2013 along with minor changes and additions to the advice given. There has also been updating of other references, particularly those linking to more recent Royal College of Radiologists, Medical Defence Union and UK government publications. This document has relevance for the SCoR's entire imaging and therapy workforce.

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 2016 edition now includes references to updated General Medical Council advice published in 2013 along with minor changes and additions to the advice given. There has also been updating of other references, particularly those linking to more recent Royal College of Radiologists, Medical Defence Union and UK government publications. This document has relevance for the SCoR's entire imaging and therapy workforce.

1. Introduction

This policy applies to the imaging and radiotherapy workforce and includes students. It applies equally to all genders of patients, practitioners and students and encompasses all forms of diagnostic imaging, radiotherapy planning and treatment. It has been developed from previous advice published by the Society and College of Radiographers^{1,2} and incorporates guidance published by the General Medical Council³ and Royal College of Radiologists.⁴ It is designed to be used in conjunction with local Trust, Health Board, Independent Provider or other employing authority policies on intimate examinations and the use of chaperones.

These policies should not contain arbitrary exclusions or assumptions on the basis of gender and will provide guidance on respecting individual patient's preferences such as ethnicity, gender, religious or cultural background, previous experiences or age. They should also provide guidance for students. Local policies often provide detailed considerations with respect to intimate examinations and chaperones that are tailored to suit local circumstances. All policies will need to comply with the Equality Act, 2010⁵ and with Department of Health policies on equality and diversity.⁶ Many

complaints relating to sexual assault arise from misunderstandings. The Medical Defence Union (MDU) has published helpful advice on protecting yourself against a sexual assault allegation and the use of chaperones. Taking these measures will lessen the risk of receiving a complaint. ^{7,8}

2. Intimate examinations

2.1 The General Medical Council (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'.³

2.2 The following are examples of what would be considered to be intimate examinations. The list is not meant to be definitive and, as discussed above, what is 'intimate' can vary between patients and cultures.

i) Examinations or treatments of the male genitalia.

ii) Examinations or treatments of the female reproductive system or urethra (e.g. endovaginal ultrasound scans, brachytherapy for gynaecological cancers, urethrograms, cystography).

Note: Transabdominal ultrasound examinations may be considered intimate by some patients as may some standard X-ray procedures.

iii) Examinations or treatments of the rectum and anus.

iv) Female breast examinations or treatments.

v) Ultrasound examinations for deep vein thrombosis that include the groin.

vi) Lateral projection 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 on a female is not considered an intimate examination but still requires sensitivity.⁹ Individual patients may, however, consider that for them it *is* intimate, as discussed above.

2.3 You should explain to the patient why the examination is necessary and give the patient an opportunity to ask questions. The explanation should include what the examination will involve in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort. It will be more meaningful if the patient has had time to consider the procedure through the use of, for example, verbal or written information given to them when they are referred.^{3,4} The Medical Defence Union advises:

'Careful communication with the patient is key to an effective consultation, as well as helping to avoid any misunderstanding that might trigger a complaint. 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, and you should explain what is involved, any equipment you will use, and any discomfort they may experience'.⁷

2.4 The conduct of intimate examinations must be considered together with obtaining informed consent. There must 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. A full discussion of consent for vulnerable adults and children is beyond the scope of this document and reference should be made to advice published by local Trusts and Health Boards, the GMC and professional bodies such as the SCoR and RCR.^{1,2,3,4}

2.5 Witnessed verbal consent will usually be sufficient for most intimate examinations⁴ including endovaginal ultrasound examinations (assuming 2.3 and 2.4 have been properly actioned). This should be recorded in the patient's notes, electronic record or report.¹⁰ Local protocols should also be consulted.

2.6 Patients coming for intimate examinations or treatments may feel unsure or vulnerable regarding the examination or treatment they are to undergo. Examinations requiring partial undressing and possibly 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 and to allay their fears by giving them an opportunity to ask any questions they may have and to have their questions answered.

2.7 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 pressurised into continuing. If possible the examination or treatment should be conducted by a practitioner of the requested gender. If one is not available on the day of attendance the patient may have to 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.

2.8 Patients should be offered the opportunity to have a chaperone (section 3) irrespective of the practitioner's gender and 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.

2.9 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 must include what part of the body will be touched and why it is necessary. For example, for an imaging examination of the hip, the radiographer might say:

'I will need to feel your hip bones so that I can position you correctly and get a good picture of your hip.'

An example relating to radiotherapy is:

'I need to do a vaginal examination to decide which the correct size brachytherapy applicator is for you.'

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.²

2.10 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 they are considered intimate or not. All staff present should also understand their role and it is good practice to keep the numbers present in the room as low as possible.

2.11 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. Do not assist the patient in removing their clothing unless you have clarified with them that your assistance is required.³

2.12 Intimate examinations must 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.

2.13 You should explain what you are doing as you proceed with the examination and, if this differs from what you have already outlined to the patient, explain why and seek the patient's permission.

2.14 Be prepared to discontinue the examination if the patient asks you to 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.

2.15 Keep discussion relevant and do not make unnecessary personal comments. Even if well intended, the wrong meaning can be inferred and can result in a serious complaint.³ It can occasionally be necessary during (for example) provocation 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.⁴

2.16 Give any results or further information to the patient after they have dressed again.

2.17 Depending on local policy, appointment letters may include information on the treatment or examination proposed and also (for example) information on training policy, equal opportunities policy, chaperones and a request for the patient to advise of any special needs.

2.18 Some patients may have great difficulty going through with the procedure. For example endovaginal ultrasound scans may be impossible for reasons such as vaginismus, radiation fibrosis etc. Patients may find rectal examination impossible either because of pain or sphincter spasm. The Royal College of Radiologists advise that it is, in most cases, appropriate to abandon the examination and discuss the problem and possible alternatives and solutions after the patient has dressed.⁴

2.19 Before you carry out an intimate examination on an anaesthetised patient, or supervise a student who intends to carry one out, you must make sure that the patient has given consent in advance. Consent must be in writing.³

3. Chaperones

3.1 The following advice is partly based on that written by the General Medical Council³ 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 and other employing authorities' policies. These often provide detailed considerations with respect to chaperones that are tailored to suit local circumstances.

3.2 You should offer the patient the security of having an impartial observer of the same gender as the patient (a chaperone) present during an intimate examination and the patient has a right to request that one is present. For professional integrity and safety you should give equal consideration to your own need for a chaperone irrespective of the examination being undertaken or the gender of the patient. This applies whether or not you are 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.

3.3 A chaperone will ideally be:

- i) a member of staff
- ii) the same gender as the patient

- 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 reassure the patient if they show 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 see what the practitioner is doing, if practicable
- viii) prepared to raise concerns about a practitioner or patient if misconduct occurs.

3.4 If a chaperone is offered for an intimate examination but declined, local policies may allow the practitioner to proceed with the examination. However, having a chaperone present can strengthen a practitioner's defence if an allegation of unprofessional behaviour is made.⁷

3.5 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 may apply particularly to children. This practice may, however, make any allegation more difficult to defend as the relative or friend is not an impartial observer. When 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. The 1999 Ionising Radiation Regulations¹¹ describes the management of comforters and carers where the procedure utilises ionising radiation. For all other attendances where a patient requests a comforter or carer to remain with them, a local policy should be in place to support this. For further information please see the SCoR advice document at:

<https://www.sor.org/learning/document-library/ionising-radiations-regulations-1999-irr99-guidance-booklet-0>

3.6 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 a later date when an alternative chaperone will be available, if this is compatible with the patients' best interests. Local protocols may also give advice on this situation which is unlikely to arise often. If any delay may be detrimental to the patient's care or treatment, this must be made clear and the patient's acceptance of this compromise recorded. The referring consultant/clinical team should be advised. All attempts should be made to resolve the situation within the resources available on the day. You should try and avoid making the patient feel under pressure to proceed against their wishes or to feel that they are inconveniencing you.⁷

3.7 A practitioner has a right to request that a chaperone is present during an intimate examination and may in any event normally 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.

3.8 A notice should be placed in the waiting room stating that a chaperone may be requested for any examination.

3.9 You should record any discussion about chaperones and the outcome in the patient's notes, electronic record or report. If a chaperone is present you should record that fact and make a note of their identity. If the patient does not want a chaperone you should record that the offer was made and declined.

4. Students

The Royal College of Radiologists gives the following advice:⁴

‘Teaching intimate imaging and treatment procedures is particularly challenging. Agreement that a student can be present 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 refused to have a student present. Patient consent for the student involvement should be recorded, usually in writing.

Patients may be reluctant to be examined by inexperienced individuals and the embarrassment and inexperience of the student may convey itself to the patient; sensitive handling of the student as well as the patient is required. Students must participate not only in the procedure itself but also the process of pre-procedural discussion. Careful supervision of the performance of all aspects of the procedure performed by the student is necessary until the trainer is confident that the student is capable of achieving a diagnostic examination in a sympathetic fashion.’

4.1 Students may be either undergraduates or postgraduates and represent the future of the various branches of the profession. As such, it is important that students are able to participate in intimate examinations but this must clearly be balanced against the wishes of the patient.

4.2 If the examination is of an intimate nature, it is good practice to ensure that the patient is aware of the gender of the student when gaining their consent for a student to be present. The student should verbally confirm any consent given personally with the patient and this should be recorded in the notes or on the report.

4.3 Patients should be informed and give their verbal consent if the examination is likely to have to be performed again by a qualified practitioner in order to confirm a student’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.

4.4 A notice should be placed in the waiting area stating that students, who will become the next generation of practitioners, are undergoing training in the department and making it clear that the patient will not be at a disadvantage if they decline to have a student present.

4.5 Where possible, students should gain experience of how to conduct an intimate examination using simulators or anatomical models. An example would be the use of computerised endovaginal ultrasound simulators to learn the basic principles of this technique.

4.6 A student must 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.

4.7 A student must not conduct an intimate examination on a child or an adult who lacks capacity to consent. If in any doubt, this specific capacity must be ascertained and recorded by a qualified practitioner before proceeding.

4.8 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 needs to agree to take on the responsibility and be authorised to do so. Higher Education Institutions who are responsible for the student’s training may also have policies that apply.

4.9 Students should consult written material produced for them by their parent Higher Education Institution on the subject of intimate examinations and chaperones.

4.10 In the case of patients undergoing a general anaesthetic, there must be written consent for a student to conduct an intimate examination on the patient.³ The patient must be treated with the

same degree of sensitivity and respect as if they were awake.

5. Summary

- Familiarise yourself with local and national guidelines
- Get consent for the examination, explain what will occur
- Offer a chaperone
- Give patients privacy to dress and undress
- Avoid light hearted or personal comments
- Stop if the patient asks
- Keep careful records

From Medical Defence Union, *Protecting yourself against a sexual assault allegation*.

<http://www.themdu.com/guidance-and-advice/latest-updates-and-advice/protecting-yourself-from-a-sexual-assault-allegation>

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