Intimate Examinations and Chaperone Policy

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Summary

This policy applies to the imaging and radiotherapy workforce and includes students. It applies equally to both male and female patients and staff and encompasses all forms of diagnostic imaging, radiotherapy planning and treatment. 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 deal equally with the intimate examination of women by men and men by women as well as intimate examinations where the practitioner and patient are the same sex: they should not contain arbitrary exclusions on the basis of sex alone. There should also be an accompanying chaperone policy that applies equally to both male and female members of the imaging and radiotherapy workforce.

1. Introduction

This policy applies to the imaging and radiotherapy workforce and includes students. It applies equally to both male and female patients and staff 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 Council[3] and the 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 deal equally with the intimate examination of women by men and men by women as well as intimate examinations where the practitioner and patient are the same sex: they should not contain arbitrary exclusions on the basis of sex alone. There should also be an accompanying chaperone policy that applies equally to both male and female members of the imaging and radiotherapy workforce. An intimate examinations policy will provide guidance on respecting individual patient's preferences. These may relate to factors such as ethnicity, religious or cultural background, previous experiences or age. It will also provide guidance on 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, 2010[5] and with Department of Health policies on equality and diversity[6].

2. Intimate Examinations

2.1 The General Medical Council advises that it is particularly important to maintain a professional boundary when examining or treating patients where intimate examinations may be involved. These examinations or treatments can be embarrassing or distressing for patients.

'Whenever you examine or treat a patient, you should be sensitive to what they may perceive as intimate. This will include the examination or treatment of the breasts, genitalia and rectum but could also include any examination or treatment 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. It 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, cystograms).

NB 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; this applies to either sex.

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. A standard transthoracic echocardiogram is not considered an intimate examination but still requires sensitivity[7]. Individual patients may, however, consider that for them it is intimate, as discussed above.

2.3 The conduct of intimate examinations must be considered together with obtaining informed consent. The SCoR has previously published detailed policies on consent[1]. Trusts, Health Boards, Independent Providers and other employing authorities will also have written policies available. 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[2].

2.4 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 an adequate 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.

2.5 Some patients may have ethnic, religious, cultural or other concerns with respect to being examined or treated by a person of the opposite sex. 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 be offered a new appointment. For most 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.

2.6 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. Chaperones are further discussed in sections 3. They will ideally be trained members of staff and are separate to 'comforters and carers' that the patient wishes to have with them during their attendance. Chaperones should not be

expected to remain in the imaging or treatment room while an ionising radiation exposure is being delivered but can of course remain during ultrasound examinations. The 1999 Ionising Radiation Regulations describe 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. Please see the SCoR advice document at https://www.sor.org/learning/document-library/ionising-radiations-regulations-1999-irr99-guidance-booklet-0 for further information.

2.7 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 is the correct size brachytherapy applicator for you.'

This needs 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].

2.8 Advice specific to the conduct of gynaecological and breast examinations was published by the Royal College of Obstetricians and Gynaecologists in 2002[8]. This document contains detailed advice on a range of subjects related to intimate gynaecological procedures, including endovaginal ultrasound and ethnic minority considerations.

2.9 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. Once the examination has commenced, no- one should enter the room unless essential to the conduct of the examination.

2.10 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].

2.11 Intimate examinations must be conducted in a room that affords the patient privacy.

2.12 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.

2.13 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.

2.14 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].

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

2.16 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.

2.17 Consent must be obtained in writing for the intimate examination of patients who are having a general anaesthetic[3]. Patients must be treated with the same degree of sensitivity and respect as if they were awake[8].

2.18 If a patient is having a general anaesthetic and you are supervising a student, you must ensure that written consent for the named student to perform an intimate examination has also been obtained[3].

3. Chaperones

3.1 The following advice is partly based on that written by the General Medical Council[3] 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 authority's 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 (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. of the same sex as the patient

ii. a member of staff

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. prepared to raise concerns about a practitioner or patient if misconduct occurs.

3.4 If a chaperone is offered but declined, local policies may allow the practitioner to proceed with the examination; this is a common situation with endovaginal ultrasound examinations. In this situation, should a complaint or allegation of unprofessional conduct be made against them the practitioner will not have available the impartial evidence that a chaperone can provide.

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 chaperone if this is acceptable to both the patient and the practitioner involved. This practice may make any allegation more difficult to defend as the chaperone may not be impartial, with potentially serious consequences for the practitioner.

3.6 If the patient does not wish to proceed with the chaperone offered and no other suitable chaperones are available, the examination may be delayed to a later date when an alternative chaperone will be available, if this is compatible with the patients' best interests. If this 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.

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. Local policies should be consulted in addition to this guidance.

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. 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

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.

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 The following is advice given by the Royal College of Radiologists:[4]

'Teaching intimate imaging and treatment procedures is particularly difficult. Agreement that a student can be present should be obtained from the patient prior to 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. Patients are understandably reluctant to be examined by inexperienced individuals and the embarrassment and inexpertise of the student may convey itself to the patient. The procedure requires sensitive handling of the student as well as the patient.Students must observe not only the procedure itself but also the process of explanation, eliciting verbal consent and post-procedural discussion. Careful direct 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 or treatment in a sensitive and sympathetic fashion.'

4.5 Detailed advice specific to the conduct of gynaecological and breast examinations was published by the Royal College of Obstetricians and Gynaecologists in 2002[8]. This document also contains advice on the conduct of intimate gynaecological examinations by both undergraduate and postgraduate students.

4.6 A notice should be placed in the waiting area stating that both male and female 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.

4.7 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.

4.8 A student must not conduct an intimate examination on a patient without a qualified practitioner

being present.

4.9 A student who is aware of 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.

4.10 In the case of patients having a general anaesthetic there must be personal written consent for a student to conduct an intimate examination on the patient. The patient must be treated with the same degree of sensitivity and respect as if they were awake[8].

References

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