



Chaperones in the exam room — who gets to decide?

By Jenni Gritters | November 30, 2017

A woman calls to schedule a Pap smear with her female ob-gyn, who is out on maternity leave. She arrives to discover that her procedure will be conducted by a male doctor and accepts the physician's offer to bring a third party — a chaperone — into the room.

A man schedules a prostate exam with a urologist and becomes visibly nervous when he finds out the doctor is female. She asks if he'd like her to bring a third party — a chaperone — into the room.

In both cases, the chaperone is a female nursing assistant who works in the office.

And therein lies the complication.

The practice of bringing chaperones into the doctor's office — as a way to protect both providers and patients during sensitive procedures — isn't new. Anecdotal evidence suggests that chaperones are most commonly offered in ob-gyn and urology practices.

Guidelines for their use, by such organizations as the London-based Medical Protection Society and the American Medical Association, have been around since at least the early 1990s. The AMA's Code of Medical Ethics says chaperones should be members of that clinic's care team, uphold professional standards, and be asked to leave the room if a patient wants to have a private conversation with the physician.

But as sexual assault allegations sit front and center in the public dialogue, the issue of chaperones feels more pressing — and the fuzzy standards around their use are apparent.

Outnumbered

Every practice seems to handle the process differently. Some ask patients if they want chaperones, while others use them routinely when the patient and doctor are different genders. Some practices don't offer chaperones at all.

Adding to the complexity are the gender dynamics of the healthcare workforce.

Chaperones tend to be nurses, nursing assistants, and office workers, which means they're most likely to be female: In 2015, according to the Kaiser Family Foundation, female nurses outnumbered male nurses by more than 9-to-1.

Some male patients have complained that bringing a second woman into the room, without their consultation, makes them uncomfortable.

"Many of us have experienced the 'ambush,' where that trust is broken, when the female doctor brings in another female chaperone to be in the exam and sees 'everything' without asking the man whether the presence of another female would be acceptable," wrote one anonymous male, commenting on an athenaInsight article about gender and physician-patient dynamics.

"What started off as a great exam now turns into an embarrassing disaster," he continued. "Contrary to the belief assumed, men do value their modesty and are just as vulnerable in medical exams as women."

"Many female doctors need to re-examine their exam procedures, to ask and not assume her male patient will be comfortable with it," wrote another male commenter. "The message needs to get out to the medical community, to start giving men equal modesty."

Who's vulnerable, and when?

Those concerns — echoed by other male patients — upend some common assumptions about patient vulnerability. Because data shows that more women than men are sexually assaulted, both in medical situations and in everyday life, medical offices have traditionally been more attuned to women's concerns.

"Sexual assault numbers are high, so chances are high that some people are coming into the office with negative experiences and traumas," says Danielle Ofri, M.D., an internist at Bellevue Hospital Center in New York. "We need to treat every patient

as if they might have some kind of trauma in their background. [For example] a pelvic exam could be re-traumatizing after a rape."

But men too can face discomfort in medical situations, such as during a digital rectal exam. And today, only about a third of practicing physicians are women — so older men, historically less used to seeing female physicians, may be less comfortable with them.

Data from the athenahealth network bears that out. A 2017 athenahealth/MedStatix study of 40,000 patients found that about 50 percent of patients returned to their doctor's office within 18 months of their first visit if they shared their physician's gender. And women returned to male doctors at about the same rate.

But only 40 percent of men returned to female doctors within that same time period.

Reading the room

Given the sensitivities, medical offices need to be attuned to patients' individual needs and frames of mind, professionals say.

"[When I was a chaperone], it was really about reading the room and doing what made sense based on what the patient needed," says Claire Biggs, a writer and editor who has worked as a chaperone in medical offices. "Some of [the patients] were nervous and wanted to talk. Others wanted to pretend I wasn't there. I took their cues."

Ofri suggests that doctors should leave the decision of whether to use a chaperone in the patient's hands — and always ask a patient's permission before bringing a chaperone into the room.

"A chaperone should be the expectation," she says. "Patients should know that — and if it doesn't come up, they should always know to ask for [a chaperone] if they want one."

And whether or not there's a third party in the room, Ofri says, doctors and nurses should treat intimate procedures with sensitivity.

“It’s also about how you do the exam,” she says. “Explain in advance, ask for permission, say ‘this is what you’ll feel.’ When you do that, patient feel like they are in control. That is the most important thing.”

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