Evelations of sexual misconduct have recently been making headlines with shocking regularity. Like all boundary violations, these stories are, at their core, about the abuse of power. How society will respond remains to be seen. In the world of health care, the response to such abuse has increasingly involved the use of medical chaperones. So while we have touched on the subject in earlier issues, we felt the time had come to focus our full attention on the questions swirling around physicians’ use of chaperones.

The articles below bring together information from a wide range of sources, both in this country and abroad (the UK health care system, in particular, has devoted a great deal of attention to the use of chaperones). We hope you find the issue enlightening and that you’ll share any questions and comments with us. Just click on the What Do You Think? icon below.

**“We can make two possible mistakes. We can simply assume everyone wants to have sex with everyone else, all the time; which is untrue and could not be monitored at all. Or we can pretend that it’s all a joke, because ‘nobody would do something like that.’ That’s a fool’s errand indeed. So I suspect it means we’ll be needing a lot more chaperones from here on out.”**

"MEDICAL CHAPERONES IN A BRAVE NEW WORLD”
by Edwin Leap, MD, edwinleap.com, April 14, 2015
It is less and less common these days for physicians to see patients without someone else in the room. It may be a nurse or physician's assistant. Sometimes it's a student or intern. Even when there is ostensibly no one else in the exam room, there is almost always the looming presence of a computer, which physicians seem to interact with at least as much as they do with their patients. There may also be a scribe, someone trained to take notes during the exam so that the doctor can focus more attention on the patient and spend more of the day seeing other patients.

What you rarely see in the exam room is a medical chaperone. No one is keeping track, but at least in this country, most experts agree that chaperones are generally employed only after a complaint has been filed against a doctor. Even then, the chaperone is often temporary, joining patient visits only for the time period mandated by the state medical board. (The exception, of course, is when a restriction is placed on the physician's license, requiring them to use a chaperone as long as they are in practice.)

continued on page 3

Why medical chaperones exist and why they are under utilized

UPCOMING LIVE COURSES

PBI PROFESSIONAL BOUNDARIES COURSE
JAN 19-21 | California

PBI MEDICAL RECORD KEEPING COURSE
JAN 20-21 | California

PBI PRESCRIBING COURSE: OPIOIDS, PAIN MANAGEMENT, AND ADDICTION
JAN 20-21 | California

MEDICAL ETHICS AND PROFESSIONALISM (ME15)
JAN 20 | Georgia

PBI PROFESSIONAL BOUNDARIES COURSE
JAN 26-28 | Georgia

PBI PRESCRIBING COURSE: OPIOIDS, PAIN MANAGEMENT, AND ADDICTION
JAN 27-28 | Georgia

PBI MEDICAL RECORD KEEPING COURSE
JAN 27-28 | Georgia

PBI MEDICAL RECORD KEEPING COURSE
JAN 27-28 | Georgia

MEDICAL ETHICS AND PROFESSIONALISM (ME22)
FEB 23-24 | California

MEDICAL ETHICS AND PROFESSIONALISM (PE22 PHARM)
FEB 24-25 | California
CHAPERONES ARE INTENDED TO SERVE TWO RELATED FUNCTIONS:

PROTECTION FOR THE PATIENT.
The chaperone's mere presence increases the physician's accountability, which reduces the likelihood that the doctor will behave inappropriately. And if the physician does or say anything unprofessional or irregular, chaperones can intervene before too much damage is done.

PROTECTION FOR THE DOCTOR.
The chaperone can defuse situations by reassuring patients who are uncomfortable with a normal part of an exam, or who may be misinterpreting something the doctor has said or done innocently. Chaperones can also intervene if patients themselves do or say anything inappropriate during an exam. And if a patient does file a complaint, the chaperone can testify as to what actually happened. (Of course, this protects the doctor only if he or she did nothing wrong.)

Despite these benefits, doctors who know about medical chaperones (and many do not), shy away from using them for a number of reasons. The most common complaint is cost: few practices and hospitals are keen on paying someone to stand around as a mostly silent observer. Chaperones are generally paid only around $15/hour, but having someone available whenever they might be needed still adds up to more than $30,000 a year.

Doctors who are required to have a chaperone often try to avoid this cost by making use of existing staff, including receptionists and other non-medical employees. Since these staff members don't have the training to know what is normal and customary in exams, their value as chaperones is decidedly limited.

The situation is much improved when a nurse or physician's assistant steps into the role, but taking them away from patient care is both undesirable and costly. Well-trained scribes, on the other hand, are in the room anyway, familiar with medical terminology and the basics of physical exams, and can actually pay for themselves, some say, by freeing physicians up to see more patients. The drawback to using scribes is that their attention is divided between taking accurate notes and observing the moment-to-moment interactions between doctor and patient—clearly not an ideal solution.

Physicians also worry that a chaperone’s presence may make the patient uneasy or interfere with the doctor-patient relationship. And patients do sometimes object to having another person in the room, especially one who does nothing but watch them being examined. Jon Porter, a health care attorney with more than 20 years experience, says that when that happens, doctors have to step up to their role as educators. “The onus is on the provider to explain to the patient that the chaperone is there in part to ensure their welfare.”

Defense attorneys have little patience with doctors’ reservations. Chaperones, they say, are like insurance policies, costly but invaluable the moment a physician is accused of unprofessional conduct. Not only do chaperones offer third-party verification of the physician’s claims, says Porter, but they are also becoming a “standard of care,” a legal term describing what patients have a right to expect.

“If I were a prosecutor, I would definitely argue that at least in the Ob-Gyn field, chaperones are now a standard of care for intimate exams,” - JON PORTER, Attorney

“IF I WERE A PROSECUTOR, I WOULD DEFINITELY ARGUE THAT AT LEAST IN THE OB-GYN FIELD, CHAPERONES ARE NOW A STANDARD OF CARE FOR INTIMATE EXAMS,”

- JON PORTER, Attorney
In other specialties, it’s less cut and dry, although Porter believes chaperones should be present whenever a patient is undressed, especially if sexual organs are being examined. That point of view is supported by the growing number of states that now mandate the use of chaperones during intimate exams (the number currently stands at seven).

Still, today the vast majority of physicians—at least those not complying with a consent decree—do not use chaperones. That tends to change, though, when a scandal heightens local sensitivity.

• When headlines in the UK focused national attention on the case of Dr. Clifford Ayling (convicted of assaulting 10 women), the National Health Service published “A Model Chaperone Framework,” offering “Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings.”

• When Delaware pediatrician Earl Bradley was convicted of sexually abusing or raping more than 100 children over 10 years, the state passed comprehensive legislation, known as the Bradley Bills, which among other things require a chaperone whenever a child under 15 is at least partially disrobed for an exam.

• And just this year, after Dr. Arun Aggarwal was indicted on charges of sexually abusing two teenage patients at Dayton’s Children’s Hospital, the hospital began requiring “that a staff chaperone be made available during all sensitive procedures,” according to the Dayton Daily News.

At a national level, the Harvey Weinstein case has generated intense public scrutiny of sexual abuse in all fields, from Hollywood to Silicon Valley. And at least one state medical board has cited the notorious case in a recent decision. As Porter continues to defend physicians against patient complaints, he cautions, “When things like this hit, it raises concerns not just for the patients, but also for the regulators.”

While physicians are well advised to consider chaperones no matter what the current headlines, says Porter, “Doctors need to be on heightened alert at times like this.”
Belinda Panganiban teaches the chaperone training workshop at MacEwan University in Alberta, Canada. As far as she knows, it is the only such program in North America, or the UK, for that matter. The workshop was launched in 2008 by the College of Physicians and Surgeons of Alberta (CPSA), which regulates the practice of medicine in the province. Eager to ensure the effectiveness of the chaperones it sometimes requires in disciplinary cases, the College has partnered with MacEwan University to offer the workshop twice a year.

At $15/hour, chaperoning is not generally considered a career path and almost no one enrolls in the MacEwan course on their own. Instead, physicians who are required to have chaperone as the result of a complaint, send office staff, who have other responsibilities as well, to the one day class. Workshop participants generally come from within Alberta and so far at least have been exclusively female.

While the attendees range in age and experience, virtually all have some medical training. Some are nurses and physician assistants, but according to Leanne Minckler, a CPSA Physician Health Advisor, more than 90% are trained as Medical Office Assistants (MOAs), which means they have graduated from a training program that combines business/office skills with medical administrative/clinical training, including basic instruction in medical terminology, anatomy and physiology, medical transcription, medical office procedures, and clinical procedures.

Such basic familiarity with clinical practice is extremely valuable since chaperones need to understand what is customary and appropriate in intimate examinations, understand the physician’s explanations well enough to help reassure patients when necessary and generally behave professionally during examinations that can be uncomfortable and embarrassing for patients.

What chaperones need to know. According to the General Medical Council (GMC), an independent organization that helps protect patients and improve medical education and practice across the UK, a well-trained chaperone should:

- Be sensitive and respect the patient’s dignity and confidentiality
- Reassure the patient if necessary
- Be familiar with the procedure involved in a routine intimate examination

continued on page 6
Stay throughout the examination and be able to see what the doctor is doing

Be prepared to raise concerns about a doctor’s behavior or actions.

The MacEwan workshop also stresses the rights of patients, in particular the importance of patient consent. The office policy regarding chaperones should be posted for all patients to see, explains Minckler, but it’s up to the physician to ensure that each patient understands the chaperone’s role and agrees to their presence throughout the examination. “If the patient objects and it’s a mandatory chaperone,” says Minckler, “then that examination can’t continue.” The doctor can give the patient options, such as seeing another physician, but the chaperone is taught not to remain without explicit patient consent.

In addition to such fundamental concerns as patients’ rights and confidentiality, workshop attendees also gain a clear understanding of such practical concerns as:

- Where to stand so they have an unobstructed view;

- How to properly document their role: Not only should the patient’s record note the presence of the chaperone, it should also include their name and full job title in case a complaint materializes years later;

- How to recognize common boundary issues, such as asking a patient for their private cell phone number during an examination;

- How to deal with something inappropriate in the moment. “Chaperones are often the silent observer in the corner,” says Minckler, “so we try to give them some measure of empowerment.”

The willingness to speak up is a challenge. “How comfortable is a chaperone going to be speaking up? That’s the big $100K question,” notes Porter. “I believe it might be easier in a larger practice, but in a smaller group, is a chaperone going to call out their boss?”

Minckler stresses that it’s important to address this issue with each participant individually. “Every clinic is independent and does things its own way, so we have to find out how comfortable that chaperone feels in their position. Do they feel they can interject, do they have recourse to the clinic manager?”

Minckler herself does chaperone audits and one of the key things she asks chaperones about is how they would deal with a physician who crosses a boundary.

To encourage workshop participants to come away with practical information customized to their individual situations, the chaperone course employs a number of scripted video vignettes designed to provoke student interaction and discussion. After watching the videos, which present real-world situations based on recurring themes, students tend to open up, telling each other what happens in their clinics and how similar situations have actually played out. These interactive sessions encourage students to work through with Panganiban how they will apply what they’ve learned once they are back in the office.

The MacEwan course trains only about 30 chaperones a year, in part, Minckler believes, because the College does not have the resources to promote it more widely. That may change and similar training programs may be started in this country as more physicians and hospitals become aware of the value of well-trained chaperones.

“IF THE PATIENT OBJECTS AND IT’S A MANDATORY CHAPERONE, THEN THAT EXAMINATION CAN’T CONTINUE.”

- LEANNE MINCKLER, Physician Health Advisor
WHAT IS A CHAPERONE?

Some physicians are more likely than others to be familiar with the concept of medical chaperones—those mandated to use them by their boards and those in particular specialties, such as Ob-Gyn and Dermatology. But many physicians have had no exposure to chaperones and still think the term refers to adults keeping an eye on teenagers. Those who look up the term are likely to find a definition like this one: “One who accompanies a physician during physical examination of a patient of the opposite gender (from the physician),” which leads to the next question...

DO I NEED TO USE A CHAPERONE IF MY PATIENT IS THE SAME GENDER AS ME?

Some experts, including those writing medical dictionaries, still say that chaperones are only needed when your patient is of the opposite gender and undressed. But this view is no longer shared by most in the field. “I know a lot of doctors won’t have a chaperone with a patient of the same sex, but I think that’s simply foolish,” says attorney Jon Porter, “because you don’t know the patient’s sexuality, the patient doesn’t know the provider’s sexuality, and gender doesn’t matter anyway, because anybody can make a complaint against anybody. It’s really a matter of perception.”

The UK’s General Medical Council agrees: “There have been cases where male doctors have been accused by male patients of inappropriate behavior. This suggests a chaperone should be considered irrespective of the doctor’s or the patient’s sex.”

The American Congress of Obstetricians and Gynecologists’ Committee on Ethics is of the same mind: “The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician’s sex.”

As Edwin Leap, MD points out in a provocative article, considering the fluidity of gender and sexuality, “Equality means that everyone gets distrusted just as much as everyone else.”

FREQUENTLY ASKED QUESTIONS
ABOUT MEDICAL CHAPERONES

AMA Policy on Chaperones

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients’ dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

PHYSICIANS SHOULD:

A. Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.

B. Always honor a patient’s request to have a chaperone.

C. Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.

D. In general, use a chaperone even when a patient’s trusted companion is present.

E. Provide opportunity for private conversation with the patient without the chaperone present.

F. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

continued on page 7
SEX ABUSE GETS A LOT OF PRESS, BUT ISN’T IT REALLY PRETTY RARE? WHY WORRY ABOUT SUCH AN UNLIKELY PROBLEM?
One study estimates that 90% of patients who have suffered sexual violations choose not to report them, which means no one really knows how common or uncommon the problem is. But even assuming it’s rare, as mentioned earlier, chaperones are akin to insurance—protection against rare but potentially catastrophic events.

ARE CHAPERONES REALLY EFFECTIVE?
There aren’t any rigorous studies proving that chaperones are effective, but the anecdotal evidence is compelling. “I can count on the fingers of one hand the number of times people with chaperones have been accused of boundary violations,” says Porter. “It can happen still, but it’s very rare.”

WHAT IF A PATIENT OBJECTS TO HAVING A CHAPERONE?
Many patients, both men and women, turn down chaperones when they are offered. (Men are especially resistant, presumably because most chaperones are women.) How you should respond depends on your situation. If you are under board orders to have a chaperone, then you must tell the patient that you cannot proceed with the examination. You may offer an alternative—referral to another doctor, for instance—and explain why both the exam and the chaperone are important. But if the patient still refuses a chaperone, you must end the visit.

If you are not legally obligated to use a chaperone, it’s up to you how to proceed. Most professional associations simply suggest that a chaperone be offered and that all requests for a chaperone be honored. Beyond that, you have to weigh the risk and make your own decision.

SOME PATIENTS ALWAYS HAVE A FAMILY MEMBER WITH THEM. CAN’T THEY SERVE AS CHAPERONES?
Adult patients with diminished capacity and pediatric patients often have family members with them during exams, as do patients from certain cultures. And many physicians assume that’s enough. But family members are not objective, nor are they concerned with protecting you, the doctor, which is why virtually all experts agree that family members should not be considered chaperones.

I’M CONCERNED SOME PATIENTS WON’T TELL ME THINGS THEY OTHERWISE WOULD IF THERE’S A CHAPERONE IN THE ROOM.
Many professional associations recommend offering patients the opportunity to talk with you privately before or after the physical exam. Here’s how the American Congress of Obstetricians and Gynecologists’ Committee on Ethics puts it: “The presence of a third party in the room may, however, cause some embarrassment to the patient and limit her willingness to talk openly with the physician because of concerns about confidentiality. If a chaperone is present, the physician should provide a separate opportunity for private conversation.”

RESOURCES
A LIST OF ARTICLES, REPORTS AND WEBSITES OFFERING MORE INFORMATION ON TOPICS IN THIS ISSUE.


“Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings: Model Chaperone Framework,” National Health Service, June 2005

“Best Practice in the Use of Chaperones,” MDU Journal, April 2014

“Use of Chaperones During the Physical Examination of the Pediatric Patient,” From the American Academy of Pediatrics, Policy Statement, Pediatrics, May 2011, Volume 127 / Issue 5