Use and offering of chaperones by general practitioners: postal questionnaire survey in Norfolk

Shaun Conway, Ian Harvey

Ten years ago in Norfolk, 65% of male general practitioners and 95% of female general practitioners never or rarely used a chaperone.¹ The figures for offering chaperones were almost identical. The General Medical Council advises offering a chaperone for intimate examinations (those involving the genitals, anus, or breasts).⁵ The Royal College of Obstetricians and Gynaecologists advises using a chaperone for every intimate examination.¹

A study of patients' preferences in Tyneside in 2001 found that 90% of women and 78% of men thought that a chaperone should be offered for intimate examinations.¹ Half (51%) of women wanted a chaperone to be used if their own male doctor was examining them. We wanted to see if the use of chaperones has changed in the past 10 years and as a result of the 2001 survey.

Participants, methods, and results

We invited a random sample of 200 (out of 348) male general practitioners and 95% of female general practitioners to complete a postal questionnaire. We used EpilInfo for data entry and SPSS for analysis.

Overall, 284 (87%) responded. Mean age was 46.3 (men) and 45.8 (women). Only 23 were not white. The mean number of partners per practice was six. More than half (155; 55%) were in dispensing practices. Three fifths of doctors (170; 60%) described their practices as either rural or market town, 60 (21%) as city, and 54 (19%) as mixed or other.

The usual chaperone was the practice nurse for 75% (155/208) of those GPs who use a chaperone, but 18% (37/208) of doctors used a receptionist. Three fifths of doctors (141/235; 60%) stationed the chaperone beside the patient and 56% (84/235) had the chaperone in the examination room but outside the curtain. Three fifths of doctors (115/197; 58%) said that if they had more understanding of the circumstances in which problems might arise in this delicate area.

Use of chaperones by general practitioners. Values are numbers (percentages) of doctors

<table>
<thead>
<tr>
<th>Examining chaperones by general practitioners</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male doctors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a chaperone (n=178)</td>
<td>10 (6)</td>
<td>70 (39)</td>
<td>51 (29)</td>
<td>47 (26)</td>
</tr>
<tr>
<td>Offers a chaperone (n=178)</td>
<td>7 (4)</td>
<td>33 (19)</td>
<td>58 (33)</td>
<td>78 (44)</td>
</tr>
<tr>
<td><strong>Female doctors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a chaperone (n=106)</td>
<td>72 (68)</td>
<td>25 (24)</td>
<td>9 (9)</td>
<td>0</td>
</tr>
<tr>
<td>Offers a chaperone (n=102)</td>
<td>48 (47)</td>
<td>27 (27)</td>
<td>19 (19)</td>
<td>8 (8)</td>
</tr>
</tbody>
</table>


(Accepted 10 February 2004)
Good enough general practice

I had admitted an elderly woman with severe sciatica to the community hospital. She needed care while her pain continued. During her second evening in hospital, nurses became concerned about her deteriorating mobility, and I found that she had developed a flaccid paraparesis suggestive of cauda equina compression. I needed urgent specialist advice and telephoned the neurosurgical registrar in the city 30 miles away. Suddenly I was struggling to survive detailed neurological examination. Were her hip flexion and extension equally weak? Just what did I mean when I said ankle dorsiflexion was “rather” weak? Was there a sensory level on the trunk? How weak was plantar flexion? What was her post-voiding residual urine volume? At what root level did I consider the deficit was?

This was a clash of medical cultures; he from the sharp peak of the super specialty and I from the broad plains of general practice. We were speaking different languages, and mine was clearly failing to impress him. Eventually, a sufficient number of stuttered responses allowed him to advise on immediate arrangements. As I put down the telephone, I felt deflated and prompted to the point of inadequacy. During my career, I’ve forgotten more than I know. Inevitably we lose skills that we seldom practise and retain those that we constantly need. Yes, my neurological examination technique had lacked precision, and I made a note to sharpen it up. But had it been “good enough” to allow recognition of the emergency with appropriate referral? I think so. As Richard Smith highlighted in his address to new medical students,1 contentment with being “good enough” is a prerequisite for a happy medical career—and that advice surely applies to the wide expanses of general practice as much as to any other medical discipline. The specialist registrar called back to discuss transfer arrangements. “Sorry about the poor performance in the viva,” I said. “I’m sure I’d easily fail a viva in general practice,” he laughed. “Yes,” I said, “I’m pretty sure you would.”

Malcolm Lindsay, general practitioner, the Health Centre, Galashiels (Malcolm@lindsaymk.fsnet.co.uk)


We welcome articles up to 600 words on topics such as A memorable patient, A paper that changed my practice, My most unfortunate mistake, or any other piece conveying instruction, pathos, or humour. Please submit the article on http://submit.bmj.com. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.