

# Intimate examinations and the use of chaperones

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## Foreword

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This is an update to the guidance on the intimate examinations issued by The Royal College of Radiologists (RCR) in 1998.<sup>1</sup> The guidance has been designed to supplement the updated General Medical Council (GMC) guidance on these areas of clinical practice and should be read in conjunction with the GMC's *Good medical practice* guidance.<sup>2,3</sup> The document applies to clinical radiologists but would also be applicable to other healthcare practitioners\*, such as sonographers.

The Royal College of Radiologists (RCR) would like to acknowledge the contribution of the Faculty of Clinical Radiology, the Professional Support and Standards Board and, in particular, Dr Raman Uberoi and Professor David C Howlett for their individual work on the revision of these standards.

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## 1. Executive summary

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- Explain to the patient why the examination needs to be done in a way they can understand including using up-to-date leaflets.
- Explain what the examination will involve and whether there may be associated pain or discomfort.
- Obtain the patient's permission and record that they have given it.
- Good practice dictates that a chaperone should be present and introduced as such to the patient. If the patient specifically states that they do not wish to have a chaperone, this should be recorded in the notes or report with a counter signature by another healthcare professional.
- Give the patient privacy to undress and to dress.
- Keep all discussion relevant and avoid unnecessary personal comments.
- Encourage questions and discussion.
- Special circumstances may arise when dealing with ethnic minorities and children and procedures should be in place to accommodate these wherever possible.

## 2. Introduction

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Many examinations, especially those affecting anatomical areas of the chest (female), pelvis and upper thigh are potentially stressful or embarrassing to the patient. Examinations involving the breasts, genitalia, anus or rectum are particularly intrusive and may make the patient feel vulnerable.

Intimate radiological examinations may include:

- Transvaginal, trans-anal and trans-rectal ultrasound
- Scrotal, penile and perineal ultrasound
- Examinations in around the groin area
- X-ray and ultrasound hysterosalpingography

- Contrast enema examination and defaecating proctography
- X-ray mammography and breast ultrasound
- Urethrography and cystography
- Endorectal MRI.

Other examinations involving the anatomical areas mentioned above would be considered within the scope of this guidance, for example, echocardiography and Doppler femoral vein studies.

### 3. General considerations

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Patients should be provided with private, warm, comfortable and secure changing facilities. All intimate examinations should be preceded by a careful and sympathetic explanation of the proposed procedure, including the benefits and any potential risks, including discomfort. Witnessed informed verbal consent should be obtained before all intimate examinations and that this has been obtained should be recorded, either in the patient notes or in the examination report. The examination will normally be performed in a room that cannot be entered while the examination is in progress, except in an emergency.

Patients should be offered a chaperone of their gender, present during the examination, and this applies whether or not the examination operator is the same gender as the patient. The chaperone would normally be another healthcare practitioner\* and, in most cases, will act as a witness to verbal consent. The chaperone should:

- Be familiar with the procedure involved
- Be sensitive and respect the patients dignity
- Reassure the patient if they show signs of distress or discomfort
- Stay for the whole examination and be in a position to observe the examination if practical
- Be prepared to raise concerns if they feel the behaviour or actions of the examination operator are inappropriate.

If the patient refuses the offer of a chaperone, the examination operator should clearly explain why they would wish a chaperone to be present. It may be reasonable, at this stage, to consider referring the patient to a colleague who would be willing to undertake the procedure without a chaperone; alternatively it may be appropriate to reschedule the examination after discussion with the referring consultant/clinical team. Any such referral should not, however, adversely affect the health of the patient. All discussions about chaperones should be recorded, including the presence and identity of the chaperone. If the patient declines a chaperone and the examination operator decides on clinical grounds, that the examination should still occur, it must be recorded that the offer of a chaperone was made and declined.

A friend or relative is not an impartial observer and would not usually be considered suitable as a chaperone, however, they may accompany the patient for the examination at the patient's request, if practicable, in addition to the chaperone. The examination should be performed as gently and carefully as possible, care must be taken to observe both verbal and non-verbal signs to minimise patient discomfort. Occasionally, as in provocation vaginal sonography, it may be necessary to attempt to provoke the cause of the patient's discomfort. If this relates to dyspareunia, specific questions should be of a clearly technical nature.

All non-relevant personal comments should be avoided during the course of the examination.

## 4. Special circumstances

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The ethnic, religious or cultural background of some patients can make intimate examinations particularly difficult.

Wherever possible, in such circumstances, a radiologist, radiographer or other suitably trained healthcare professional of the same gender as the patient should perform the examination.

If clinically appropriate, all patients should be allowed to limit the degree of nudity by, for example, uncovering only that part of the anatomy that requires investigation by ultrasound or X-ray.

## 5. Patients who experience difficulty with the procedure

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Vaginal examination may be impossible for reasons such as vaginismus, radiation fibrosis and so on, both sexes may find rectal examination impossible either because of pain (for example from an anal fissure) or sphincter spasm. In most cases it is appropriate to

abandon such an uncomfortable examination, then to invite the patient to dress and discuss the problem. Often the examination can then be reattempted at a later date, although some patients will require an alternative procedure or sedation prior to the investigation.



## 6. Patients with learning difficulties or mental illness

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In these situations, an attending familiar individual such as a family member or carer will be a valuable adjunct to a chaperone. A careful, simple and sensitive explanation of the proposed investigation is vital. A full discussion of consent

in these circumstances is beyond the scope of this document and referral is suggested to relevant *Mental capacity act 2005*, GMC and local trust guidance.<sup>4,5</sup>

## 7. Children

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When dealing with a child or young person, the examination operator must assess their capacity to consent, offering a chaperone in addition

where appropriate. Refer to GMC and local trust guidance for further advice on this issue.<sup>5-7</sup>

## 8. Training issues

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Teaching intimate radiological examinations is particularly challenging. Agreement that a trainee can be present or may perform the investigation 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 refuse to have a trainee present. Patient consent for the trainee involvement should be recorded, usually in writing. Patients may be reluctant to be examined by inexperienced individuals and the embarrassment and inexperience of the trainee may convey itself to the

patient; sensitive handling of the trainee as well as the patient is required. Trainees must participate not only in the procedure itself but also the process of pre-procedural explanation, eliciting verbal consent and post-procedural discussion. Careful direct supervision of the performance of all aspects of the procedure performed by the trainee is necessary until the trainer is confident that the trainee is capable of achieving a diagnostic examination in a sensitive and sympathetic fashion and operating unsupervised.

## 9. Consent

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Informed consent is mandatory for all intimate imaging procedures.

Recorded and witnessed verbal consent will suffice for most intimate examinations.

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. Careful explanation of the procedure and the indications

for its performance with, verbal consent in the presence of the chaperone, are required at the time of the procedure. Please refer to relevant GMC and local trust guidance for further information on these issues.<sup>2,3</sup>

*\*A healthcare practitioner is a person who has undergone appropriate training in providing any form of healthcare. This would include radiographers, nurses and healthcare assistants.*

## References

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