

## The 'intimate' examination: time for a name change?

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As examination of the sexual and genital areas of the body is obviously a complex area of health care, the ideal solution is for the adoption of professional guidelines to aid the clinician<sup>1</sup> and to remind them of some simple but vital actions.

Such guidelines have been produced by the Royal College of Obstetricians and Gynaecologists (RCOG)<sup>2</sup> and the General Medical Council (GMC),<sup>3</sup> and there have been responses from other professional bodies such as the Institute of Psychosexual Medicine (IPM)<sup>4</sup> and the National Collaborating Centre for Women's Health. These documents have been generated in response to some high-profile cases in which doctors were found guilty of professional misconduct,<sup>5</sup> thus throwing this complex clinical area into the spotlight. Despite this several problems remain, not least in relation to chaperones.

The use of chaperones has come full cycle, from the time when they were routinely used when a rich or important individual was being examined such as in the royal courts of Europe, until they were gradually removed in order to protect a patient's privacy or, as some would say, to increase the power of doctors! They are now recommended again by the defence organisations when genital examination is being performed, particularly by a member of the opposite sex. This is for the protection of both the patient and the doctor. Some patients, particularly men, find chaperones unnecessary<sup>6</sup> and indeed sometimes intrusive.<sup>7</sup> Women tend to like a chaperone, especially when being examined by a male doctor,<sup>8,9</sup> and find it more embarrassing, although no more painful, than being examined by a female.<sup>10</sup> Teenagers' preference for a chaperone depends on their own age and gender, not that of the clinician, and the younger ones prefer to be chaperoned by a family member.<sup>11</sup>

Physician gender preferences have been noted. Male patients have no gender preference whilst having genital examinations; they do, however, prefer male clinicians to do rectal examinations.<sup>12</sup> Preference for female doctors relates more to the psychosocial elements of the consultation rather than the physical,<sup>13,14</sup> thus emphasising that examination of the psyche can often be much more intimate than the examination of body parts.

Wide variation occurs in the use of chaperones in both general practice<sup>15</sup> and in departments of genitourinary medicine.<sup>16</sup> Chaperones are usually female nurses, but relatives of the patient, medical students or secretarial or clerical staff have been used. If patients are offered a chaperone before the examination they have the right to accept or refuse. A chaperone should never be imposed on the patient. In health care settings where this is impractical, the patient should be asked when booking the appointment and special arrangements can be made. A note can be made in the case notes about the offer of a chaperone, and whether or not one was used.

The main arguments against a chaperone are loss of privacy for the patient, a potential 'disempowering' of the

patient as the doctor therefore has an 'ally', and a disruption of the doctor–patient interaction at the time, which can lead to disclosure of some of the most private thoughts that concern the patient. This has often been cited in relation to psychosexual medicine, however a clinician trained in that field can continue to work effectively by taking into account the presence of a third person in the room.

In some countries, rejection of the genital examination for cultural reasons may contribute to high mortality rates for gynaecological cancers.<sup>17</sup> Minority groups such as lesbians<sup>18</sup> and obese patients<sup>19</sup> are less likely to undergo pelvic examinations, also putting themselves at higher risk. The cultural, religious and personal sensitivities of the patient should always be respected, and it should be remembered that in different cultures it may even be improper for areas of the body such as the ankle or shoulder to be revealed. Nobody welcomes a rectal or genital examination, but if carried out according to agreed ethical guidelines the interests of both the patient and the clinician should be protected.

Unfortunately some of the techniques used to desexualise the procedure, such as focus on the genitalia and lack of eye contact, can stir up painful issues such as child sexual abuse.<sup>20</sup> This can be avoided by the doctor explaining in advance what will be done, and why, and explaining that the patient can stop the procedure if they wish.<sup>21</sup> Treating patients with dignity, ensuring their full understanding of the procedure, and thereby obtaining informed consent, will help patients to feel more in control of their examination.

The issue of consent is integral to the performance of any physical examination otherwise it becomes assault. The same principle applies even when the patient is anaesthetised, and worryingly a recent study showed that this principle has not been applied in all medical schools.<sup>22</sup> Medical student teaching is an ideal time to impart good basic clinical examination techniques which comply with current patient-centred guidelines.<sup>23</sup>

One disturbing new development has been the insidious adoption of the term 'intimate examination'. The word 'intimate' in common usage implies a close, private and personal bond with a friend or lover. Examination of the genital, rectal or breast areas of the body undertaken by a doctor or nurse is a professional clinical examination done for a specific purpose. The patient expects, and should always receive, an examination carried out by someone bound by a strict professional code of ethics. Introducing intimacy into the examination crosses the bounds of the doctor–patient relationship, and should always be avoided. A return to the term 'genital examination' would therefore be welcome.

By adhering to the fundamental principle of respect for the autonomy of the individual, the examination of patients, irrespective of the body area(s) examined, should be able to be undertaken with dignity and with minimal discomfort to either the patient or clinician.

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## Journal of Family Planning and Reproductive Health Care

### CALL FOR PAPERS ON A EUROPEAN THEME

To coincide with the UK hosting the European Society for Contraception Conference in 2004 we plan to give the April 2004 edition of the Journal a more European flavour. We would welcome articles and papers from (or in collaboration with) European authors and/or dealing with aspects of reproductive health that are relevant throughout the continent. The deadline for receipt of submissions for the April 2004 issue is **30 November 2003**.

## ERRATA

### *Journal of Family Planning and Reproductive Health Care* 2003; 29(2)

The Publisher wishes to draw readers' attention to the fact that the April 2003 issue of the Journal was mispaginated (the page numbers appeared incorrectly as 1–64 instead of 53–116) and to apologise for this oversight and any inconvenience this error may have caused readers. This unfortunate error was made by the Publisher during the process of transferring the Journal to an alternative printer. The page numbers for the July 2003 issue of the journal (pages 117–176) have reverted to the correct pagination for Volume 29.

Correspondence with the major indexing and abstracting agencies (eg, MEDLINE, PubMed) has confirmed that such a pagination error is extremely unlikely to cause any confusion to individuals using such abstracting and indexing services to search for relevant articles since all articles included in these listings are referenced by both the volume and issue number. However, in order to minimise any possible confusion in the citation of articles from the January and April 2003 issues of the Journal, readers are requested to cite both the volume and issue number [ie, *J Fam Plann Reprod Health Care* 2003; **29**(1) or **29**(2)] when citing any articles published in these issues in their own scientific publications.

### 'FFPRHC Guidance on Emergency Contraception (April 2003)', *J Fam Plann Reprod Health Care* 2003; 29(2): 9–16

The Clinical Effectiveness Unit wish to apologise for an error that appeared in the above mentioned Guidance document. On page 13, in the right-hand column, in the uppermost blue-bordered recommendation box, the dose of doxycycline should read 100 mg twice daily and not 200 mg twice daily.

### 'Homeopathic treatment for premenstrual symptoms', Jones A, *J Fam Plann Reprod Health Care* 2003; 29(1): 25–28

In the light of the letter from Michael Cox on page 172, the Editor-in-Chief wishes to apologise to readers for the misleading key message point that was included in this paper, namely:

- A randomised, controlled double-blind trial published in 2001 has confirmed the positive outcome of the previous anecdotal experience.

This key message point is therefore deleted and the revised key message points for this paper are as follows:

- Premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) cause significant morbidity in the female population.
- Homeopathy relies on detailed analysis of symptomatology to identify a medicine with matching characteristics.
- Homeopathic physicians have reported anecdotally that homeopathic treatments for PMS are helpful.
- Many women are interested in complementary therapies and therefore an understanding of the possible role of homeopathy in the management of PMS is important.