Letters

The role of chaperones: How involved is too involved?

Recent research by Stanford and colleagues (*AFP* November 2017)[1] on patient attitudes to chaperones brings attention to an important conundrum faced by busy general practitioners (GPs) on a daily basis. An area worthy of further consideration is the action of the chaperones themselves. Should they closely observe the examination? Should they position themselves away from the doctor in a supportive 'head of the bed' location? Or should they simply be a reassuring presence outside the curtained area? In the unlikely event of a misconduct claim, unless the first approach were followed, I do not see how the chaperone could greatly assist the doctor's defence, as they would have to concede they did not directly view the examination. Doctors are thus faced with the need to balance the patient's privacy and comfort with their own medico-legal considerations. As with many issues in our profession, I feel the way forward is a case-by-case 'judgement call' based on the GP's familiarity with the individual patient, the patient's stated preference and non-verbal cues.

Dr Jasper Morrison
General Practice Registrar
BSc (Hons I), BMed, MD, DCH

Reference

1. Stanford L, Bonney A, Ivers R, Mullan J, Rich W, Dijkmans-Hadley B. Patients' attitudes towards chaperone use for intimate physical examinations in general practice. Aust Fam Physician 2017;46(11):867–73.

Reply

We would like to thank Dr Morrison for his letter that refers to our article on patients' attitudes to chaperone use for intimate physical examinations. The letter raises some interesting points regarding the role of the chaperone, which are important considerations from the doctor's perspective. We agree this is an area worthy of further consideration, as looking at patients' attitudes in isolation ignores the equally valid opinion of the doctors performing intimate examination. Our team is very interested in this field and look forward to publishing the findings of research that we have conducted on Australian general practitioners' use of, and attitude to, chaperone use during intimate physical examinations.

The scope of our recently published study was confined to examining patients' attitudes. We would like to draw attention to several of our findings that are relevant to the comments made by Dr Morrison: the proportion of patients who 'Agreed' or 'Strongly agreed' that the role of a chaperone is to:

- support the patient – 78.5%
- protect the patient – 73.1%
- protect the doctor – 69.7%.

Ideally, all of these functions can potentially occur simultaneously, which benefit the doctor and patient.

Dr Morrison raises the valid point that a chaperone's ability to offer strong medico-legal protection for a doctor in the event of a misconduct claim may be reduced if the chaperone did not directly observe the examination. Perhaps some protection would still be granted for the practitioner, as a chaperone could hear what occurred on the other side of the curtain. It would also be imagined that inappropriate conduct is less likely to occur with a third party in the room. We believe that it is important to understand patients' preferences, and relevant findings from our study include 44.8% of patients preferring that a chaperone remain outside of the curtain during an examination and only 17.8% of patients preferring the chaperone inside the curtain.

Lucie Stanford, Clinical Senior Lecturer, Graduate Medicine, University of Wollongong, NSW

Andrew Bonney, Roberta Williams Chair of General Practice and Director, Illawarra and Southern Practice Network, Graduate Medicine, University of Wollongong, NSW

Judy Mullan, Deputy Director, Illawarra and Southern Practice Research Network, Graduate Medicine, University of Wollongong, NSW

Bridget Dijkmans-Hadley, Project Officer, Illawarra and Southern Practice Research Network, Graduate Medicine, University of Wollongong, NSW

You should get that mole checked out: Ethical and legal considerations of the unsolicited clinical opinion

Doctors often worry about intruding on a person's privacy in such situations. Privacy has been defined as the ability of a stranger to find out as much about you as you can about them. This is discussed in detail in the works of Arthur Conan Doyle (a doctor), especially when Sherlock Holmes and his brother Mycroft observe strangers on a street. A stranger such as one of the Holmes brothers can learn an incredible amount from mere observation.

General practitioners (GPs) are trained in pattern recognition and recognition of multiple skin conditions. It is a common ploy of medical tutors to suggest that their pupils use their powers of observation to determine why their next patient has attended that day – while the patient is walking from the waiting room to the consulting room.

Many GPs have seen a suspicious mole on a stranger, others have recognised complex endocrine conditions (Cushing's syndrome, acromegaly, Grave's disease) and others, neurological conditions. Indeed, Sir Billy Connolly is very grateful that an Australian doctor recognised that he had a form of Parkinson's and informed him of it.

The article by Adler, Mahar and Kelly (*AFP* December 2017)[1] states that we have no legal obligation to interrupt a stranger with a significant diagnosis, but there is the principle of noblesse oblige. This principle states that those with an advantage over others, in this case a higher knowledge,

have a moral obligation to assist those without that knowledge. While not a legal obligation, it is an ethical one.

I agree that you should be discrete and circumspect in your approach to the affected person, but it may save the person's life. I consider it being on a par with rendering cardiopulmonary resuscitation to a stranger. The stranger may not ask for assistance, but they most certainly need it. I remember a patient who came to me with a skin lesion that had been detected by a stranger who was standing next to him in a line at a beachside bakery. It took an excision biopsy to prove it was benign.

As for the exhortation to be certain in your diagnosis, there are but three certainties in a GP's life – death, taxes and paperwork. It would be better to say 'a high level of suspicion'.

Chris Hogan
Associate Professor
Department of General Practice
University of Melbourne

Reference

1. Adler N, Mahar PD, Kelly JW. You should get that mole checked out: Ethical and legal considerations of the unsolicited clinical opinion. Aust Fam Physician 2017;46(12):949–51.

Reply

We thank Dr Hogan for his considered letter in response to our recently published article. Our article described the legal, ethical and professional considerations surrounding proffering a dermatological opinion in the case of suspected melanoma outside of the clinical setting. We concluded that in such a scenario, the application of professional and ethical standards may require the doctor to act in some way to alert the person of their findings in a context whereby there is no defined positive duty to do so in Australian law. The degree to which the doctor is ethically obligated to provide an unsolicited opinion is affected by multiple and, often, competing factors.

We commend Dr Hogan for introducing the principle of noblesse oblige to this discussion, highlighting the role of social responsibility in this context. Our standpoint on the legal obligations remain, and are imposed by a legislative and judicial structure, which apply to society as a whole. The concept of 'wilful blindness' (ie noting something that could potentially cause harm, but deliberately ignoring it) is one that can be used to argue a breach in a duty of care in the legal context of negligence; however, as our article discussed, this is irrelevant if a duty of care does not exist in the first instance.

As detailed in our article, while doctors may not have a legal obligation to proffer an unsolicited opinion in the case of suspected melanoma outside of the clinical setting, doctors may have an ethical responsibility to do so. Indeed, we acknowledge strongly that a timely diagnosis may improve outcomes for patients with melanoma. We differ in our opinion that the scenario presented is 'on par with rendering cardiopulmonary resuscitation to a stranger', as suggested by Dr Hogan. The decision to provide an unsolicited dermatological opinion outside this setting requires a more nuanced approach, and the potential risks and benefits require careful consideration.

Ethical decision-making is often guided by certain underlying philosophies and principles, and responders may choose to take a particular ethical standpoint that they consider appropriate, with the understanding that it may and will not be shared by all.

Nikki R Adler, Clinical Fellow, Victorian Melanoma Service, Alfred Hospital, Melbourne, Vic

Patrick D Mahar, Conjoint Lecturer, Department of Medicine, St Vincent's Clinical School, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Vic

John W Kelly, Head, Victorian Melanoma Service, Alfred Hospital, Melbourne, Vic

Erratum

Barton E, Twining L, Walters L. Understanding the decision to commence a dose administration aid. Aust Fam Physician 2017;46(12):943–47.

The qualifications for Lydia Twining were incorrectly printed as BSc, BMed, BCh. The correct qualifications are BSc, BMBS.

The correction has been made to the HTML and PDF versions of these articles. We apologise for this error and any confusion it may have caused our readers.

correspondence **ajgp@racgp.org.au**