



Chaperone Review submission

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to:

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To: "ChaperoneReview@nhpopc.gov.au" <ChaperoneReview@nhpopc.gov.au>,

Cc: "Doodie (David) Ringelblum" <[REDACTED]>

Dear Professor Paterson

In response to your call for submissions to the Chaperone Review, I would like to submit the following thoughts/questions on the topic that I believe need to be answered before any guidelines can be useful.

I appreciate that your enquiry is specifically around the topic of chaperoning whilst a practitioner is being investigated for misconduct. However experience suggests that initially limited guidelines are later applied to a much broader range of circumstances as being "best practice". I therefore ask these questions with the broader scenario in mind, though I believe they are relevant to the specific terms of your enquiry.

- The use of chaperones in Australia is the exception not the rule. Will their introduction create an assumption amongst patients of wrongdoing or of potential wrongdoing? Will their introduction create an atmosphere that reduces the degree of trust between practitioner and patients?

- Which examinations warrant a chaperone?

- If the answer is "intimate examinations" can that please be clearly defined:

- Does the gender and/or sexual orientation of either the practitioner or patient have any bearing on whether an examination is considered intimate or in which body parts?
- Does the cultural background of the patient have any bearing on whether an examination is considered intimate?
- Does context matter? Will GPs and Gynaecologists doing the same vaginal examination have different chaperoning requirements?
- Does an intimate examination consist of any or all of
  - vagina, anus, penis, scrotum
  - inguinal lymph nodes
  - breasts
  - axillary lymph nodes
  - abdomen
- Does an ophthalmic examination count as an intimate examination? (For many patients having a doctor's face millimetres from their own is more confronting than the "cold clinical" nature of a Pap smear.)
  - If it does - will the same chaperone requirements apply to optometrists?
  - Will midwives - male or female - require chaperones during intimate examinations during labour?

- Could the guidelines please specify what the act of chaperoning actually consists of. Should the chaperone be in the corridor with the door open? Inside the room but outside the curtain? Inside

the curtain but at the "head of the bed" (assuming a genital exam)? Actively observing the actions of the doctor ("at the foot of the bed").

- Does the presence of a chaperone mean that the doctor cannot ask questions of the patient because of breach of privacy rules?

- Does a chaperone have to be of a particular gender depending on the gender and/or sexual orientation of the practitioner or patient. If so, will practices be expected to provide chaperones of both genders?

- Will the review take into account the financial and nonfinancial costs of providing chaperones?

Will a small practice - for example a solo GP - be required to have a chaperone separate from their receptionist? If not - will the practice continue to satisfy its accreditation requirements whilst the receptionist is acting as a chaperone? (A general practice is required to have a receptionist at all times while the practice is open. It could easily be argued that having the receptionist regularly leave the reception area to spend up to 15 minutes at a time in the doctor's office means they are not really fulfilling the role of receptionist). Again - would a small practice be required to provide both male and female chaperones?

Should you wish to contact me to elaborate on any of these comments, I can be contacted by email or by phone [REDACTED].

Yours sincerely

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