SHOULD THE ROUTINE USE OF CHAPERONES FOR INTIMATE MEDICAL EXAMINATIONS BE COMPULSORY?

This research project is submitted
in partial fulfilment of the requirements
for the LLM Degree at the
University of Kwa Zulu-Natal

By: Dr SB Fayers

Supervisor: Dr Steve Naidoo

STATEMENT OF ORIGINALITY

I, Samantha Fayers certify that the entire research paper, unless specifically indicated to the contrary in the text, is my own work. It is submitted as the dissertation component in the partial fulfillment of the requirements for the degree of Masters of Medical Law in the School of Law, University of KwaZulu-Natal.

Signature: …….

Samantha Fayers

Student number: 993227280

January 2016

This project is an original piece of work which is made available for photocopying and for inter-library loan.

…….

ACKNOWLEDGEMENTS:

My Lord and Saviour is Jesus Christ. Without The Lord in my life, I would not have made it. I dedicate this LLM, being cognisant of the road it took me to get here, to my precious Saviour. I know that this degree will be used for His honour and glory.

To my amazing husband, Mr Wesley Govender, thank you for always supporting me and helping me along our life journey together. I am truly blessed beyond words to have you as my life partner. Thank for assisting me with the formatting of this dissertation and allowing me to pursue an academic career. I love, appreciate and cherish you, my darling.

To my adorable baby girl Eliana Jerusha Govender and the little one on the way, you have been the reason I have continued to study and become empowered with knowledge. I love you immeasurably.

To my family, thank you for your never-ending support over the many years that I have studied. Your encouragement has helped and motivated me to press on.

To my supervisor, Dr Steve Naidoo, thank you for the wealth of knowledge that you have made freely available to me. I appreciate your time and invaluable input into this study. Your passion for forensic medicine is not only inspiring, but also contagious.

ABBREVIATIONS:

AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association
CC	Constitutional Court
CLA	Criminal Law (Sexual Offences and Related Matters) Amendment Act
DOH	Department of Health
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
MHA	Mental Health Act
MPS	Medical Protection Society
NHA	National Health Act
NHS	National Health Services
POPI	Protection of Personal Information Act
RCOG	Royal College of Obstetricians and Gynaecologists
RSA	Republic of South Africa
SAMA	South African Medical Association
SAPS	South African Police Services
STI	Sexually Transmitted Infection
UDHR	Universal Declaration on Human Rights
UK	United Kingdom
USA	United States of America

*The term 'healthcare provider' will be used and includes all medical staff, nurses, medical students, allied health professionals as well as non-medical staff such as the administrative staff.

TABLE OF CONTENTS:

CHAPTER 1: INTRODUCTION TO DISSERTATION

1) Background

The relationship between a medical doctor (or any health professional) and his/her patient is a profoundly distinctive and exceptionally professional one. It is built on foundations of trust and honour; a common interest in giving and receiving care respectfully; as well as the ethics of confidentiality; mutual respect for the dignity of the patient and a respect for boundaries. These are values that the practitioner primarily wields and influences because of the imbalance of power in the relationship.

1.1) Breaching boundaries

What happens when the boundaries are breached? Consider the scenario below:

> *A young married female patient seeks medical care at the doctor's practice for the main complaint of a painful lump in her breast and lower abdominal pain. The male practitioner takes a medical history and proceeds to perform a comprehensive medical examination. A year later the doctor receives a letter from the patient's lawyer as well as his medical regulatory body, accusing him of sexual assault and sexual misconduct respectively. The allegations are that the doctor during the examination touched her breasts suggestively, performed a vaginal examination and also made suggestive remarks about her sexual history.*
>
> *The practitioner advises his own medical insurance company that he denies the allegations. In a subsequent professional regulatory council hearing the practitioner testifies that he does not use a chaperone when doing intimate examinations on female patients.*

Is this an unusual scenario in medical practice? The figures from the Health Professions Council of South Africa (HPCSA) show that it isn't. This research paper considers the use of the medical chaperone in intimate medical examinations of patients to reduce the risk of allegations of sexual misconduct on the part of healthcare providers.

a) Regulatory Council litigation

The HPCSA (and its forerunner the South African Medical and Dental Council) is a statutory body established with the aim of promoting the health of all people of South Africa as well as providing guidelines for professional conduct within the profession.[1] According to the HPCSA, there has been an increase in the number of complaints against healthcare workers with regard to sexual misconduct.[2] There were 35 complaints lodged from 2006 until 2010. Twenty three of these reached the formal enquiry stage with 13 practitioners being subsequently found guilty.[3] This trend is noted internationally with many health and regulatory bodies making recommendations in an attempt to decrease the risk of sexual misconduct claims and to protect the patient.[4,5] Although this increasing trend is noted by the HPCSA, they have no specific policy relating to chaperone use in their published ethical guidelines. Needless to say, healthcare providers have an ethical duty and responsibility to act in the patient's best interest and maintain high standards of integrity and personal conduct.[6]

b) Ethical Considerations

The Hippocratic Oath (taken by all healthcare practitioners) states that healthcare providers should keep themselves away from seduction and sensual pleasures with the men and women they are treating.[7] Furthermore, ethical guidelines assist healthcare providers in defining their duties and obligations as well as ensuring the patient's wellbeing is protected. Dhai and McQuoid-Mason provide some of the main reasons that professionalism in health care should be regulated.[8] They state that it is to ensure accountability on the part of the practitioner, to provide quality services and to protect the public from harmful practice. The patient is considered vulnerable as there is an unequal position of power in the doctor-patient

1 A Dhai & B Mkhize 'The Health Professions Council of South Africa and the medical practitioner'. *CME* (2006) 24 (1): 8-11.
2 A Dhai 'Why do I need a chaperone'. *HPCSA: The Bulletin* 2011: 28-29.
3 Ibid 2
4 Medical Board of Australia 'Sexual Boundaries: Guidelines for doctors' October 2011. www.medicalboard.gov.au/documents/default.aspx?record...dbid. (Accessed January 2016).
5 General Medical Council 'Intimate examinations and chaperones'. March 2013. www.gmcuk.org/guidance. (Accessed May 2015).
6 'Ethical and Professional Rules of the Health Professions Council of South Africa' GN R717 *in Government Gazette 29079* (4 August 2006), as amended by GN R68 in *Government Gazette 31825* (2 February 2009).
7 T Mappes & D Degrazia 'The Hippocratic Oath' *Biomedical Ethics*, 5th ed. Boston: McGraw-Hill (2001): 66.
8 A Dhai & D.McQuoid-Mason 'Professionalism in the health practitioner-patient relationship' *Bioethics, Human Rights and Health Law, Principles and Practice*. Cape Town: Juta & company (2011) 61.

relationship.[9] This could predispose the patient to exploitation. The use of a chaperone is considered to be one of the risk reduction resources available where the risk of allegations of sexual impropriety may exist.[10]

c) Professional Guidelines

The South African Medical Association (SAMA) has published guidelines on good clinical behaviour and conduct, but as yet, has not published clear guidelines on chaperone use.[11] Sadly, healthcare providers have thus far, seemingly been unable to manage or properly regulate clear professional boundaries as evidenced by the statistics mentioned above.[12] This has resulted in an increase in the publicity surrounding medical misconduct and a call by the Health Minister for the regulating council (HPCSA) to be overseen by a body that will ensure the competence of registered healthcare providers.[13] It is further recommended that the healthcare provider set and control the relationship boundaries (due to their position of power and influence in the relationship).[14] The maintenance of professional boundaries serves not only to protect the patient from possible violation, but also to protect the healthcare provider from misconstrued interpretation of events and possible false claims of sexual misconduct.

1.2) Retaliatory litigation

The challenges abound further with litigation that results from practitioners whose conduct have been under scrutiny. There is the resultant loss of prestige and professional reputation that follows, and responding lawsuits may occur. Consider the scenario below:

> *After numerous years of hearings, public scrutiny and eventual bankruptcy, the same practitioner is found not guilty of the sexual misconduct charges made against him by the patient and he proceeds to lay a charge of defamation of character against the patient.*

---

[9] Ibid 8
[10] A Dhai & Gardner Y, et al 'Professionalism and the intimate examination – are chaperones the answer?' *SAMJ* (2011) 110: 814-816.
[11] SAMA Guidelines and Policies https://www.samedical.org/legal-governance/sama_guidelines. (Assessed December 2015).
[12] Note 2 above
[13] E Naidu 'South Africa's dodgy doctors'. http://www.iol.co.za/news/south-africa/sa-s-dodgy-doctors (Accessed May 2015).
[14] R Simon 'The natural history of therapist sexual misconduct: Identification and prevention' *Psychiatric Annals* (1995) 25: 90-93.

a) Burden of Proof

In a recent article, McQuoid-Mason advised against doctors suing patients when a civil or criminal case, or a complaint made to the HPCSA, had been withdrawn or dismissed.[15] The author states that the negative publicity would further defame the healthcare provider. Malicious intent and that the charge was made without reasonable and probable cause would need to be proven.[16] In order to bring a successful case against the defamer, one would need to provide substantial evidence of malicious intent which is not an easy element to prove.[17] A preponderance of evidence or proof by clear and convincing evidence would be required in these civil cases. These are lower burdens of proof than in criminal cases where one would need to prove guilt beyond a reasonable doubt. The damages ordered by the courts in these civil cases would usually be the payment of the doctor's legal costs by the patient, should the doctor succeed in proving his/ her case. Unfortunately this does little to improve the reputation of the defamed healthcare provider as once doubt has been created through negative publicity; it can never truly be reversed.[18]

b) Constitutional and Statutory Legal Provisions

The law and the HPCSA encourages the public to report alleged crimes or misconduct and in response, protects the reportee from being sued for defamation, even if their report is based on a false but honest belief.[19] This 'qualified privilege' is afforded due to the moral, social and legal obligation on a person to report suspicion of a crime or misdemeanour having been committed. The law is there to protect and uphold the rights of all people. The Universal Declaration of Human Rights (UDHR) states that all people have an inherent right to dignity by virtue of being human.[20] The right to dignity is also enshrined in Section 10 of The Bill of Rights of the Constitution of South Africa (hereafter known as the Constitution).[21] According to Section 7(2) of the Constitution, the State must protect and fulfil the rights of all people in

[15] D McQuoid-Mason 'Is it ever justified for doctors to sue their patients whose allegations against them have been dismissed by the courts or the Health Professions Council of South Africa' *S Afr Med J* (2015) 105 (12): 1010-1011.
[16] *Joubert v Venter* 1985 (1) SA 654 (A).
[17] *Basner v Trigger* 1946 AD 83.
[18] J Segal 'When doctors sue patients – defamation is devastating – but a lawsuit could make it worse' *Medical Justice* (2015) http://medicaljustice.com/when-doctors-sue-patients-defamation-isdevastating-but-a-lawsuit-could-make-it-worse (Accessed August 2015)
[19] J Neethling & J Potgieter, et al 'Damage' *Law of Delict.* 4th ed. Durban: Butterworths, (2001): 338-350.
[20] The Universal Declaration of Human Rights, 1948.
[21] The Constitution of the Republic of South Africa, 1996. (Act 108 of 1996)

South Africa. Section 14 and 27 respectively, states that everyone has the right to privacy and the right to have access to healthcare. The right to privacy and healthcare are in line with The National Health Act, 2003 (Act 61 of 2003) (NHA).[22] As doctors and law abiding citizens, we are governed by these Acts as well as the different ethical and professional guidelines for the betterment of the patients we serve.

Every provision needs to be made in order to protect the patient as well as improve on the quality of service rendered. A positive step that could assist in ensuring that the rights of patients and healthcare providers are protected is the implementation of the use of a chaperone for intimate medical examinations. The chaperone would serve a dual function of not only protecting the vulnerable patient from possible exploitation, but also to protect the doctor from possible litigation. Although the extent of the problems mentioned in the above scenario's are difficult to accurately estimate, most regulatory boards recommend reporting of such behaviour or suspicion by the public as well as fellow work colleagues.[23] Every possible pitfall needs to be avoided in order to preserve the sanctity of the doctor-patient relationship.

2) OUTLINE OF THE RESEARCH PROBLEM

The issues that arise in respect of the use of chaperones for intimate medical examinations include:

1. Is there a need for risk reduction mechanisms to be in place?
2. What is the prevalence of the use and non-use of chaperones for intimate medical examinations?
3. What are the obstacles for their enforcement?
4. How can we overcome these obstacles?

With this in mind, this study will seek to identify the extent of the problem, the possible risk reduction mechanisms available and make recommendations on how to implement these risk reduction strategies in our local setting.

[22] The National Health Act, 2003 (Act 61 of 2003).
[23] R Simon 'Therapist-patient sex. From boundary violations to sexual misconduct' *Psychiatry Clin North Am* (1999) 22: 31-47.

3) RATIONALE FOR THE STUDY

This aspect relates to the choice of the research topic by the author who is herself a specialist obstetrician and gynaecologist. The subject area affects her daily practice in a busy hospital setting which has had its share of medical litigation relating to sexual misconduct by health staff.

Modern-day healthcare not only considers correct diagnosis and safe prescribing of medications as being important, but also advocates good ethical principles and respect for essential professional boundaries. The saying 'it has never been safer to have a baby and never been more dangerous to be an obstetrician'[24] is a constant thought in the subconscious mind of this author who is faced daily with the daunting realisation that the medical climate has changed. The old paternalistic approach by doctors has been replaced with the more accommodating and welcomed patient-centred approach. Patient autonomy coupled with the technological age of 'Doctor Google' has however had a negative impact on modern-day practice.[25] Doctors now tend to practice defensive medicine to the detriment of patient care.

Unnecessary investigations and surgical procedures may be performed in an attempt to appease patients and prevent dissatisfaction and litigation. The South African Minister of Health has recently publically criticised lawyers who encourage litigation against hospital services and healthcare professionals stating that they are more concerned about money than patient safety.[26] The state is also clearly concerned that doctors should be adequately insured or indemnified to meet their responsibilities. [27]

As a result of the rising insurance premiums, many private obstetricians are opting not to perform deliveries while young doctors prefer not to specialise in obstetrics and gynaecology.[28] Although difficult to quantify, there were as many as 136 934 private

24 A MacLennan & K Nelson, et al 'Who will deliver our grandchildren? Implications of cerebral palsy litigation' *JAMA* (2005) 294 (13): 1688-1690.
25 This refers to the nowadays-frequent tendency for internet searches by patients in respect of their symptoms and the tendency towards patient self-diagnosis.
26 A Motsoaledi 'Doctors call for lawyers to get out of hospitals' *S Afr J Bioethics Law* (2015) 8 (1): 4-6.
27 C Bateman 'Clumsy patient-friendly regulations could strip 25 000 of MPS cover' *S Afr Med J* (2010) 100 (11): 696-697.
28 G Howarth 'Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade?' *S Afr Med J* (2013) 103 (8): 513-514.

deliveries in South Africa in 2010[29] while the total number of livebirths for 2010 was 1 294 694.[30] Thus, on average, 10% of deliveries occur in the private sector.

Considering the present trend, there may be a migration of not only the workload, but also the litigation risks to the already struggling public sector in the near future. Successful litigation cases are paid directly from the state's health budget. Every rand paid in a successful litigation case is a rand lost to providing public health care.[31] The choice by government not to act decisively will have serious implications on the health of our nation. Every effort to decrease litigation risks needs to be made by government in the form of policies and guidelines and these should be filtered down and managed at grassroots levels.

A noticeable gap is the lack of clear guidelines concerning chaperone use in South Africa. This study will look at the present situation in the health system with particular focus on the risks and possible shortcomings in the system relating to the use of chaperones. The paper will consider the reasons for and against chaperone usage as well as consider the obstacles faced in their implementation. It will also take a closer look at the South African legislature and scarce guidelines available on this important topic. The need for risk reduction mechanisms to be in place, enforced and monitored will be addressed and recommendations for their implementation will be made.

It is with this background that the author embarks on this study.

4) CONCEPTUAL/ THEORETICAL FRAMEWORK

This study will take a comparative approach where the present situation will be compared with the situation in other African countries as well as 1st world countries. Legal and medical aspects will be looked at especially from the perspective of provisions of the Constitution of South Africa. A Human Rights approach will be used

29 M Meyer & D Swanepoel 'Newborn hearing screening in the private health care sector – a national survey' *S Afr Med J (*2011) 101 (9): 665-667.
30 Statistics South Africa. Livebirths (2015) http://www.statssa.gov.za/publications/P0305/P03052014.pdf (Accessed December 2015).
31 J Malherbe 'Counting the cost: The consequence of increased medical malpractice litigation in South Africa' *S Afr Med J* (2013) 103 (2): 83-84.

5) RESEARCH METHODOLOGY AND ETHICAL ISSUES

This study will take the form of desk-top based research project. Ethical clearance was granted by The University of KwaZulu-Natal Ethics committee.

6) LIMITATIONS

The study is purely desk-top based and as such, use will be made of those resources readily available. Only articles written in English have been analysed. Therefore other studies that may have been relevant but in other languages have not been included.

7) SYNOPSIS OF THE DISSERTATION

Chapter 2: The extent of litigation for sexual misconduct

This chapter will consider the global pandemic of rising litigation cases against healthcare providers. International studies identifying the main charges as well as the penalties and repercussions of these damning charges will be studied.

Chapter 3: The chaperone and challenges to their use

Chapter 3 defines and examines the role of chaperones as well as the many challenges influencing their routine use in clinical practice. The definitions, job description as well as the numerous benefits of routinely using a chaperone for intimate examinations will be discussed. Numerous studies will be considered and the advantages and disadvantages considered. Obstacles such as patient and doctor apprehension as well as the scarcity of adequately trained staff will be addressed. The importance of maintaining confidentiality, dignity and obtaining informed consent will also be emphasized. Chaperone use and guidelines will be provided with regard to special circumstances such as an examination of a rape survivor, a child or a mentally impaired individual. This chapter will conclude by stating how these obstacles can be overcome.

Chapter 4: Recommendations

Chapter 4 considers numerous international council policies and guidelines and compares their similarities and differences. The author will make recommendations for chaperone use in our local context. A checklist will be drawn up as a safe guard. Suggestions on the implementation of these recommendations as well as the importance of monitoring will be discussed. The salient points of the dissertation will be summarized, recapping on the rising litigation risks, the need for risk reduction tools and then recommendations. The importance of dignity as a fundamental human right will be emphasized as well as optimising a healthy doctor-patient relationship.

Chapter 5: Consummation

The author declares that there has been no conflict of interest on the part of the candidate nor the supervisor. The resources used completing this dissertation will be listed in the bibliography.

CHAPTER 2: THE EXTENT OF LITIGATION FOR SEXUAL MISCONDUCT

1) Introduction

a) Sexual relations between a doctor and patient

Sexual relations between a doctor and his/ her patient has traditionally been prohibited.[32] The doctor-patient relationship is a professional one guided by established ethical standards.[33] The American College of Obstetricians and Gynaecologists (ACOG) Committee on Ethics[34] endorses the American Medical Associations (AMA) ethical principles[35] against sexual relations between physicians and patients. The Canadian Society of Obstetricians and Gynaecologists have adopted a similar position and further recommend prompt discipline and rehabilitation of "offenders".[36] According to these bodies, a sexual relationship with a present patient is always unethical behaviour on the part of the doctor, and even relations with a past patient may be considered unacceptable by most regulatory bodies.[37]

Consent by both individuals is not considered a justification for sexual relations as there is a disparity in regards to power, vulnerability, need and status.[38] This invalidates meaningful consent on the part of the patient as there may be feelings of obligation and subjugation as a result of the previous dependant relationship.[39] Such considerations also include the former patient's feelings of gratitude, dependency and vulnerability to manipulation as a result of personal information disclosed to the doctor, the age difference, the time lapsed and duration of the previous professional relationship.[40] The relationship also places the doctor in a vulnerable position should the sexual relationship end on an unpleasant note.

---

32 M Campbell 'The Oath: an investigation of the injunction prohibiting physician-patient sexual relations' *Perspect Biol Med* (1989) 32: 300-08.
33 T Beauchamp & J Childress 'Professional-patient relationships' *Principles of biomedical ethics*. 5th ed. New York (NY): Oxford University Press (2001) 283.
34 American College of Obstetrians and Gynaecologists Committee Opinion No 372 'Sexual Misconduct' *Obstet Gynecol* (2007) 110: 441-44.
35 Council on Ethical and Judicial Affairs, American Medical Association. 'Sexual misconduct in the practice of medicine' *JAMA* (1991) 266: 2741-45.
36 Society of Obstetricians and Gynaecologists of Canada Policy Statement No 134 'Sexual abuse by physicians' *J Obstet Gynaecol Can* (2003) 25: 862.
37 Note 34 above.
38 Note 35 above.
39 K Hall 'Sexualization of the doctor-patient relationship: is it ever ethically permissible?' *Fam Pract* (2001) 18: 511-15.
40 Note 34 above.

b) Intimate examinations

Intimate examinations according the Medical Protection Society (MPS) include the examination of the genitalia, rectum, breasts and any other examination in which the practitioner would touch the patient in close proximity.[41] Patients find pelvic examinations embarrassing and stressful.[42] These examinations may be misinterpreted and considered as a sexual advance, should the purpose and need for the particular examination be poorly understood by the patient. Good communication is thus essential, as well as obtaining informed consent from the patient before any such examination is performed. There is also the risk of the healthcare provider not adhering to sound clinical practice and may use the examination as an opportunity for sexual gratification.

Intimate examinations are by nature intrusive. Intrusive has been defined as an interference of one's privacy[43], an invasion of one's space[44] and even as causing a disruption due to being unwelcome and uninvited.[45] It is therefore vital that 'intimate examinations' are only performed when they are warranted and that this is effectively communicated to the patient. Proper communication and trust have been highlighted as being the cornerstone of the doctor-patient relationship and according to MPS, the key to preventing litigation.[46] Poor communication is said to be the cause of seventy per cent of litigation following an adverse event.[47]

2) Overview of the increasing trend of sexual misconduct charges against healthcare providers

a) The effect of the increasing trend of medical litigation locally

[41] http://www.medicalprotection.org/uk/for-members/general-practice/gp-articles/gp-articles/silent-witness (Accessed May 2015).
[42] J Baber & S Davies SC, et al 'An extra pair of eyes: Do patients want a chaperone when having an anogenital examination?' *Sex Health* (2007) 4: 89-93.
[43] http://www.merriam-webster.com/dictionary/intrusive (Accessed May 2015).
[44] http://www.vocabulary.com/dictionary/intrusive (Accessed May 2015).
[45] http://www.oxforddictionaries.com/definition/english/intrusive (Accessed May 2015).
[46] http://www.medicalprotection.org/newzealand/casebook/casebook-january-2012/improving-communication-cutting-risk (Accessed May 2015).
[47] H Beckman & K Markakis, et al 'The doctor–patient relationship and malpractice: lessons from plaintiff depositions' *Arch Intern Med (*1994) 154: 1365-70.

There has been a notable increase in the number of healthcare providers facing litigation.[48] This trend is noted in 1st world countries[49] as well as in South Africa.[50] The media and newspapers seem to thrive on a diet of accused doctors 'assaulting' patients.[51] The South African Minister of Health, Dr Aaron Motsoaledi, has recently made a public statement saying that many doctors are now practicing defensive medicine.[52] His reasoning was that doctors are now treating the possibility of a legal claim, instead of practising sound medicine.

The size and frequency of medical malpractice claims has increased in both the public and private sector; both locally and internationally. A possible reason for this could be the change in the doctor-patient relationship from a previously paternalistic approach to a more patient-determined approach. Accompanying this is an increased awareness of patients' rights as well as the responsibilities of the doctor.[53] In South Africa, amendments to the road accident fund legislature have made damages claims from motor vehicle accidents a less lucrative source of income for lawyers. Many have now turned to other types of personal injury litigation such as medical malpractice.[54]

The cost of health care is increasing due to this rise in malpractice litigation. Basically, increased malpractice litigation results in an increase in insurance premiums resulting in a fee hike. In South Africa, the fee for medical insurance in a high risk discipline such as Obstetrics and gynaecology is in excess of R50000 per month for private obstetricians and gynaecologists. This may lead to a large number of unnecessary procedures being performed in order to cover not only the running expenses of the practice, but also the high insurance fees. These unnecessary procedures may result in undue harm to the patient. Furthermore, above medical aid rates may be charged to further supplement their income. Specialists may not be able to generate enough income in small and rural areas which may result in doctors relocating to urban areas and the communities being left without their expertise.

---

[48] C Bateman 'Medical negligence pay-outs soar by 132% - subs follow' *S Afr Med J* (2011) 101 (4): 216-17.
[49] http://www.themdu.com/about-mdu/annual-report-and-accounts (Accessed December 2015).
[50] M Pepper & M Slabbert 'Is South Africa on the verge of a medical malpractice litigation storm?' *South African Journal of Bioethics and Law* (2011) 4 (1): 29-35.
[51] G Hinsliff 'Betrayal: the sex-hungry doctors who prey on patients' *The Observer* January 28, 2007. http://www.guardian.co.uk/medicine/story/0,2000434,00.html. (Accessed October 2015).
52 www.medicalchronicle.co.za/motsoaledi-wages-war-against-lawyers (Accessed May 2015).
53 Note 1 above.
54 Note 34 above.

The rampant rise in litigation and the perceived liability risk could cause young people not to choose medicine as a career and junior doctors not to choose a career in the high risk specialities. This will result in a shortage of skills and an increased burden being placed on the already overburdened public health system. The perception of the treating doctor is being tarnished and the previously trust based doctor-patient relationship is being lost. In response, the doctor tends to move away from compassion-centred medicine to defensive-medicine. There is an urgent call being made to government to start taking more drastic steps to improve on the current situation. Instead of being reactive, doctors and medical boards need to become more proactive. The old saying, prevention is better than cure needs to become our mantra in the provision of health care.

The State's ability to fund the public health system is far from ideal and with this increase in litigation trend, this already compromised system is further destabilised. According to Section 27 of The Constitution, government has the duty to progressively realise (within its available resources), the right of all South Africans to access health care services. Increased legal costs and patient payouts result in less money being available for efficient, good quality service delivery and ultimately, the poor patients suffer while tax payers foot the bill. Unfortunately, for those utilising the public sector, their right to equality (Section 9) is seemingly infringed upon as they sadly end up with a seemingly inferior quality of health care. This is due in part, to limited funds which result in staff shortages, drug outages and sometimes preventable deaths. Tort law has become distributive (economic resources being redistributed) and punitive, instead of being corrective.[55] The present tort system is failing both the patients and doctors.[56]

b) The effect of medical litigation in general

An analysis of the medical malpractice claims addressed by the Ethiopian Health Professional Ethics Committee between January 2011 and December 2013 found that more than three quarters of complaints were wrong or unfounded.[57] This is in keeping with a similar study conducted in Mexico where they found that the rise in claims cost, has negatively resulted in

55 S Bhagwan 'A time for reform in health care litigation' *American Journal of Surgery* (2004) 187: 319-22.
56 S Rachagan & K Sharon 'The Patient's view' *Med J Malaysia* (2003) 58 Suppl A: 86-101.
57 B Wamisho & M Abeji, et al 'Analysis of medical malpractice claims and measures proposed by the Health Professionals Ethics Federal Committee of Ethiopia: review of the three years preceeding' *Ethiop Med J* (2015) 53 Suppl 1: 1-6.

a rise in malpractice premiums, an increase in healthcare providers stress levels and essentially distrust between the patient and the doctor.[58] Unavoidable negative outcomes have become grounds for malpractice suits which further perpetuate the problem.

The possibility of negative outcomes needs to be clearly communicated to the patient. Dr Graham Howarth, a medico-legal advisor and Head of Medical services with MPS, emphasizes that good communication and trust is the cornerstone of the doctor-patient relationship and that patient expectations as well as realistic outcomes need to be discussed. He goes on to provide examples of possible clinical examinations that may be misunderstood by the patient, if not counselled properly. For example, one would need to counsel a patient on the need to perform a vaginal examination in a female with lower abdominal pain;or why the testes would need to be examined in a male child complaining of abdominal pain; or why one always examines the both breasts even though the patient only complains of a lump in the one. A thorough explanation of the need for the examination as well as exactly what the examination will entail is vital, in a bid to decrease the patient's perception of sexual impropriety. Furthermore, during the counselling process, one needs to consider the literacy level of the patient as well as their preferred language.[59]

A Canadian database was recently constructed which reviewed the characteristics of physicians that were disciplined by professional colleges in Canada from 2000 to 2009.[60] They found that 20 per cent (the highest percentage of disciplined offenses) were for sexual misconduct. This was followed by 19 per cent for substandard care and 16 per cent for unprofessional conduct. The most common penalties were fines, suspensions and formal reprimands. A similar result was found in a retrospective analysis of disciplinary cases adjudicated between 2000 and 2009, conducted in Australia and New Zealand.[61] As in the Canadian study mentioned above, male doctors were found to be disciplined more often than their female counterparts. Similarly, the most common charge was for sexual misconduct (24 per cent of cases). This was followed by 21 per cent for unethical prescribing of drugs and 20 per cent for inappropriate medical treatment. The penalties were notably severe with 43

58 R Morales & S Gonzalez 'Most of the complaints in gynaecology and obstetrics care are generated by perceptions stemming from unavoidable results' *Ginecol Obstet Mex* (2001) 69: 108-17.
59 Note 22 above.
60 A Alam & J Klemensberg, et.al. 'The characteristics of Physicians disciplined by professional colleges in Canada' *Open Medicine* (2011) 5 (4) E: 166.
61 K Elkin & M Spittal, etc al. 'Doctors disciplined for professional misconduct in Australia and New Zealand 2000-2009' *MJA* (2011) 194: 452-56.

per cent being struck off the role and 37 per cent having their practice rights restricted.[62] Numerous bodies have thus recommended the implementation of risk reduction tools in an attempt to curb the rising litigation trend. MPS issued an updated fact sheet in 2015 on the use of chaperones for intimate examinations.[63] This followed the infamous case of Dr Clifford Ayling who was found guilty of sexual misconduct spanning numerous decades.[64] In their report on the handling of the case by the National Health Services (NHS), the investigators called on the Department of Health (DOH) to assist in drawing up guidelines, recommending the use of chaperones at the tax payer's expense, for intimate examinations.[65] More than 10 years later, a quantitative questionnaire based study found that only 56.5 per cent of hospital trusts had actually implemented those recommendations and had chaperone policies available.[66] This study suggests that recommendations not only need to be made, but they also need to be implemented and then adhered to. So, what is a chaperone?

62 Ibid 61.
63http://www.medicalprotection.org/docs/default-source/pdfs/factsheet-pdfs/england-factsheet-pdfs/chaperones.pdf?sfvrsn=7 (Accessed June 2015).
64 HMSO 'Report into the professional behaviour of Clifford Ayling' (2004) http://www.bipsolutions.com/docstore/pdf/8221.pdf (Accessed August 2015).
65 Ibid 64
66 N Mecalfe & K Moores, et al. 'The extent to which chaperone policies are used in acute trusts in England' *Postgrad Med J* (2010) 86: 636-40.

CHAPTER 3: THE CHAPERONE AND CHALLENGES TO THEIR USAGE

1) Introduction

From the literature, it seems that there are various responses to the use of chaperones for intimate examinations by patients as well as healthcare providers. Regardless of the healthcare providers or the patients' opinion, numerous professional bodies have advised the use of chaperones for intimate examinations (see chapter 4 below). That being said, a wide variety of poorly defined obstacles, ranging from limited human and financial resources to ethical conundrums have been cited as affecting implementation. In this chapter, we will consider some of the obstacles affecting the implementation of chaperones in daily clinical practice as well as a few circumstances requiring special mention.

2) Chaperones as a risk reduction tool

a) What is a chaperone?

A 'chaperone' may have different connotations for different people. For example, a teenager may consider an accompanying adult on a date a chaperone;[67] whilst to a scientist, a chaperone may be a protein that aids in the unfolding and folding of proteins.[68] The English used the term 'chaperone' during the 1700's to describe the person that would accompany or escort a young woman to protect her public reputation.[69] These were also known as 'social chaperones'.

The modern term 'medical chaperone' has been used to describe an individual accompanying a medical practitioner whilst they perform a medical examination (particularly for intimate examinations).[70] MPS has noted that the presence of a medical chaperone serves to protect the patient from possible sexual assault, as well as protect a doctor from possible allegations of sexual misconduct. Furthermore, they may serve as a support for vulnerable patients, offering reassurance and emotional comfort, as well as act as an interpreter during an

67 http://www.learnersdictionary.com/definition/chaperone (Accessed July 2015).
68 http://medical-dictionary.thefreedictionary.com/Chaperone+proteins (Accessed July 2015).
69 T Shewn & R Upseh 'The medical chaperone: outdated anachronism or modern necessity' *Southern Medical Journal*. (2008) 101 (1): 9-10.
70 A Dhai 'Editorial' *SAJBL* (2010) 3 (2): 54.

examination.[71] With all the benefits of having a chaperone present, one wonders why they are not present during all intimate examinations.

b) Types of chaperones

According to their roles, a chaperone may be passive (providing support for the patient) or active (actively involved in the examination), formal (specifically trained clinical or non-clinical staff member) or informal (a friend or relative of the patient).[72] A novelty in clinical practice is the use of a virtual chaperone.

A virtual chaperone is a technological device that makes visual and audio recordings of patients' examinations and consultations.[73] It is unlikely to replace the human chaperone but is of benefit as it is discreet and by nature, able to record a consultation as well as examination verbatim. The information is encrypted for security reasons and cannot be manipulated.

A study done at a genitourinary medical clinic found that the majority of staff respondents (71 per cent) did not support their use. They felt uncomfortable performing examinations that were being recorded and sited a fear that they could not guarantee confidentiality if the encrypted recordings were insufficiently protected. Furthermore, 67 per cent felt that if they were the patient, they would have the camera switched off for the examination.[74] The patients also had a similar response with 88 per cent of respondents stating that they would not agree for an examination to be recorded. In contrast, 96 per cent of patients at a plastic surgery unit in London and 88 per cent of patients at a private hospital in Cambridge approved of the device.[75] Analysing the significant difference in patient's responses to the use of virtual chaperones from the studies above, one wonders what the effects of positive or negative counselling by the doctor could have on the patients' opinions. From a legal perspective, the device could potentially prevent protracted court cases and prove an invaluable resource.

71 Note 63 above.
72 NHS Clinical Governance Support Team 'Guidance on the role and effective use of chaperones in primary and community care settings. Model Chaperone Framework' June 2005.
73 R Jones & S Barton, et al. 'Is it time for the virtual chaperone in genitourinary medicine clinics?' *International Journal of STD & AIDS* (2007) 18: 458-60.
74 Ibid 73.
75 L Clarke & S Bann et al. Black box. *Student BMJ* (2003) 11: 43-86.

Although an initial investment would be required, in the long run, it may prove more cost and time efficient.

c) Chaperones in sexual offences examinations

It is recommended that a chaperone be offered whenever an intimate examination is required.[76] According to The Criminal Law (Sexual Offences and Related Matters) Amendment Act No 32 of 2007 (Criminal Law Amendment Act), the unlawful and intentional sexual violation or penetration of a person without their consent constitutes sexual assault and rape, respectfully.[77] Therefore, a breast examination, without consent would be defined as sexual assault while a speculum examination without consent would be defined as rape; even in the presence of a chaperone. Although the presence of a chaperone does not preclude sexual impropriety accusations, it may assist in supporting a defence.

d) Chaperone characteristics

The characteristics of a good chaperone are kindness, compassion, gentleness, patience and a willingness to always act in the patient's best interest. The chaperone would also need to be assertive by nature, being prepared to confront a doctor if possible misconduct is witnessed. In practice, the chaperone should be present for the explanation of the examination as well as the entirety of the procedure. In order to protect the doctor-patient relationship, the chaperone should be excused from the clinical consultation unless the patient requests for them to be there. The chaperone should also be aware of the nature and accepted norms associated with the intimate examination.

e) Chaperone gender

There are no clear guidelines on the specific gender of the person serving as the chaperone. The concept of the chaperone being the same gender as the patient cannot be supported in this era where it is estimated that three to ten percent of people have a homosexual preference.[78] The gender of the available chaperone should be discussed and accepted by the patient.

76 G Howarth 'Keeping out of trouble – the 12 Cs'. *Obstet and gynae forum* (2014) 4: 15-20.
77 The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
78 Department of Health (2007) 'Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People' http://tiny.cc/healthineq (Accessed December 2015).

Historically, the doctor was a male and was accompanied by a female nurse chaperone. Worldwide, this has changed with medicine becoming more gender neutral. In the United Kingdom (UK) approximately 50 per cent of medical graduates are female and there is an increase in male nurses.[79] In South Africa, the female to male ratio of graduating doctors in 2012 was 1.4:1.[80]

In a recent case supported by the Equal Opportunities Commission in the UK, it was found that although school studies showed that one in four boys were interested in 'caring' professions, only one in ten nurses were male.[81] This case was a gender discrimination case brought by a former male nurse against Barts and London NHS. He claimed that there was a different policy being applied to male as opposed to female nurses. Male nurses were required to be chaperoned while performing electrocardiograms on patients, while female nurses had no such obligation. He initially lost his case but won it on appeal at the Employment Appeal Tribunal. Unfortunately, he subsequently left the profession.[82] This case highlighted the fact that the old, non-valid stereotype mould needs to be broken, especially in this modern day of globalisation.[83]

Some have gone on to advocate that female doctors *offer* a chaperone to all their patients; male doctors *offer* a chaperone to all their male patients while male doctors *have* a chaperone present for all examinations of female patients.[84] This is an unfounded double standard of practice and is not supported by the author. A chaperone should be used by all doctors performing intimate examinations and their use/ non use needs to be documented.

f) Chaperone usage record

Although many say that they make use of chaperones[85], the old colonial saying "if it is not written, it has not been done" could be applied here. Unfortunately, very few healthcare

[79] K Rogstad 'Chaperones: Protecting the patient or protecting the doctor' *Sexual Health* (2007) 4: 85-87.
[80] N Mjamba-Matshoba 'Numbers of medical students and doctors registering with The Health Professions Council of South Africa' (2013) http://www.hpcsa.co.za/Publications/Statistics (Accessed January 2016).
[81] 'Former nurse wins chaperone case' *Mailonline* (June 2006) http://www.dailymail.co.uk/news/article-389911/Former-male-nurse-wins-chaperone-case.html (Accessed July 2015).
[82] Ibid 81.
[83] A Prideaux 'Male nurses and the protection of female patient dignity' *Nursing Standard* (2010)25 (13): 42-49.
[84] Note 79 above.
[85] D Price & C Tracy, et al 'Chaperone use during intimate examinations in primary care: postal survey of family practitioners' *BMC Fam Pract* (2005) 21 (6): 52.

providers write good clinical notes, let alone religiously document chaperone use.[86] The importance of scrupulous documentation cannot be over emphasized. A healthcare provider would have difficulty remembering a case years later when litigation faces him/ her. A study reviewed patient's case notes and found that only four per cent had documented evidence that they had used a chaperone even though that unit, performing augmentation mammoplasty, had a chaperone policy in place.[87] The study authors go on to suggest the chaperone records their own details in the patient's notes at the time of the examination. Other suggested tools to assist documentation include the use of a stamp and in practices utilising electronic means of documentation, electronic pop-ups can be installed. Another suggestion is that a proforma approach to medical chaperones is an effective means of ensuring adherence to best practice guidelines.[88]

3) Obstacles to chaperone use:

a) Doctors:

i) United Kingdom

Although The Royal College of Obstetrics and Gynaecology (RCOG) recommends a chaperone should be offered for every intimate examination, a cross-sectional survey conducted in the UK, found that almost a quarter of respondents never or only occasionally offered a chaperone.[89] According to the questionnaire response, 40 per cent of Fellows and Members of the RCOG were either unaware of, or had no agreed upon policy for their NHS unit. Only 31 per cent of private practitioners used chaperones as compared to 77 per cent of those in the NHS.[90] This study clearly shows the disparities of practice and also highlights the urgent need for adequate monitoring. Furthermore, most respondents agreed that a chaperone is very important but reported numerous barriers, negatively affecting implementation.

---

[86] I Afaneh & V Sharma, et al. 'The use of a chaperone in obstetrical and gynaecological practice' *Ir Med J* (2010) 103 (5): 137-39.
[87] A Molajo & P Vaiude, et al. 'Are we documenting chaperone use?' *Journal of Plastic, Reconstructive and Aesthetic Surgery* (2011) 65 (2): 275-76.
88 K Rose & S Eshelby, et al. 'The importance of a medical chaperone: a quality improvement study exploring the use of a note stamp in a tertiary breast surgery unit' *BMJ Open* (2015) 5: 7.
89 J Rymer J & S Durbaba, et al. 'Use of chaperones by obstetricians and gynaecologists: A cross-sectional survey' *Journal of Obstetrics and Gynaecology* (2007) 27 (1): 8-11.
90 Ibid 89

ii) Nigeria

A similar study, conducted in Nigeria, found that among female gynaecologists, 76.9 per cent would only use a chaperone under special circumstances such as rape. None of the female respondents always or often (defined as more than 50 per cent of the time) made use of a chaperone, whilst from the male gynaecologists, 12.6 per cent and 23.2 per cent, respectively made use of a chaperone.[91] This questionnaire-based study could be biased as the majority of respondants were male (n=237) as compared with females (n=13). A possible explanation for this could be that there are fewer female specialists as compared to males.[92] The main reasons cited by doctors in Nigeria for the non-use of chaperones, were a shortage of personnel and patient refusal.

iii) Republic of South Africa

In South Africa, a study was conducted in the form of a questionnaire to determine the opinions of medical practitioners and particularly gynaecologists, on the use of chaperones during intimate examinations and consultations.[93] Most of the respondents were gynaecologists (82 per cent) and most were from the private sector (59 per cent). Most practitioners (72 per cent) supported the use of a chaperone for an intimate examination, although less than a third (27 per cent) always used one. There were similar responses from male and female respondents. Being the same gender as the patient should not however, give one a false sense of protection as complaints are often made against same gender practitioners.[94]

From the writer's personal practice as a gynaecologist in a busy SA government hospital, limited time and availability of a chaperone similarly affects one's daily use of chaperones for intimate examinations. However, as was appropriately stated by the American Academy of Orthopaedic Surgeons, the benefits of having a chaperone or a scribe present during an

91 P Nkwo & C Chigbu, et al. 'The perceptions and use of chaperones by Nigerian gynaecologists' *International Journal of Gynecology and Obstetrics* (2013) 120: 46-48.
92 World Health Organisation. 'Global Health Observatory Data Country Statistics' http://www.who.int/gho/health_workforce/physicians_density_gender/en/ (Accessed October 2015).
93 Y Guidozzi & J Gardiner, et al. 'Professionalism in the intimate examination: How healthcare practitioners feel about having chaperones present during an intimate consultation and examination' *SAMJ (*2013) 103 (1): 25-27.
94 K Pydah & J Howard 'The awareness and use of chaperones by patients in an English general *practice' J Med Ethics* (2010) 36 (8): 512-13.

examination, outweigh the negative cost factor. [95] Another factor noted by the author from her teaching experience as a clinical associate with the university is that many medical students and junior doctors seem to lack insight about the need for chaperones being present and also the possibility of medico-legal malpractice claims. The author was recently called to assist an intern during an intimate examination and when she arrived, he was using his mobile phones torch for light as the clinics torch had no batteries. Nurses similarly have volunteered the use of their cell phones torch when a hospital torch has been misplaced or is in need of batteries. This lack of insight of possible risks associated with this practice need to be continuously reinforced and good clinical practice encouraged.

b) Patient perspectives

There is a scarcity of published studies on patients' views of chaperone use in clinical practice.[96] The greatest objection by patients to chaperone use is their fear of a potential breach in confidentiality.

According to the NHA, a user's information is confidential (this includes their health status, treatment and hospital admission) and unless consent is given in writing or as a result of a court order, no information may be disclosed to a 3rd party unless there is a serious risk to public health.[97] The patients' concern about confidentiality could result in a lack of disclosure and substandard care of the patient; infringing on the sanctity of the doctor-patient relationship.

A study conducted at an oncology breast clinic in the UK found that the majority of patients (52 per cent) did not feel that they needed a chaperone present but 33 per cent felt that they preferred to have one present.[98] In a recent qualitative review of patients view in primary health care settings, it was found that the majority of patients wanted a chaperone present.[99] The review found that patients' preferences varied depending on numerous factors such as

95 G. Klaud Miller 'The benefits of using medical scribes' *American Academy of Orthopaedic Surgeons* (June 2012) http://www.aaos.org/ (accessed November 2015)
96 R Baker R & O Mulka, et al. 'Patients' view on professionals' use of chaperones during intimate examinations in primary health care: a review' *Quality in Primary Care* (2007) 15: 337-44.
97 Note 22 above.
98 S. Sinha, A De, et al. 'Patients' attitudes towards the use of a chaperone in breast examination' *Ann R Coll Surg Engl* (2009) 91: 46-49.
99 Note 96 above.

the sex of the doctor and patient, their age, sexual orientation, the examination being carried out, etc. The review also commented on the finding that patients preferred practise nurses as chaperones over receptionists or administrative staff. It was found that more male general practitioners than female practitioners were routinely using chaperones for intimate examinations and raises the question as to why is there this inequality. There seems to be a gender-based preference amongst patients, with women preferring to have a chaperone present when being examined by a male.[100]

Bignell found that most women wanted to at least be offered a chaperone[101], while Webb and Opdahl[102] reported that 8 per cent of women in their study felt that the doctor had been unprofessional (for example, by over exposing their body) and would have benefitted from having a chaperone present.

A gender-based preference was also noted in a Canadian study, with women preferring a chaperone to be present when examined by a male. This study, showed as low as 35 per cent of females wanting a chaperone present and only 10 per cent of male patients.[103] Similarly, a south-east Nigerian study found that more women preferred to be examined by a female and when examined by a male physician, would prefer a nurse chaperone being present.[104] Medicine is considered to be gender-neutral and yet there seems to be strong underlying gender specific practises. This inequality or double standard should not exist.

c) Confidentiality

Section 14 of The Constitution, provides that everyone has the right to privacy.[105] The Protection of Personal Information Act (POPI) further promotes the protection of personal information and confidentiality.[106] Healthcare providers, according to the NHA, have a responsibility to maintain the confidentiality of the user, except with the consent of the user,

100 D Newton & M Chen 'Recommendations for chaperoning in sexual health settings' *Sexual Health* (2007) 4:.207.
101 C Bignell 'Chaperones for genital examinations' *BMJ* (1999) 319: 137-39.
102 R Webb & M Opdahl 'Breast and pelvic examinations: easing women's discomfort' *Can Fam Phys* (1996) 42: 54-58.
103 Ibid 102.
104 P Nkwo & C Chigbu, et al. 'Presence of chaperones during pelvic examinations in southeast Nigeria: Women's opinions, attitude, and preferences' *Niger J Clin Pract* (2013) 16 (4): 458-61.
105 Note 21 above.
106 The Protection of Personal Information Act No 4 of 2013

by a court order, or where non-disclosure poses a threat to public health.[107] Healthcare providers not only have a legal duty as recognised by common law, but also an ethical duty to respect the confidentiality of patients. The HPCSA as well as SAMA, endorse the adherence to strict confidentiality in one's clinical practise. Oosthuizen, Shapiro and Strauss document Sanskrit, Greek and Egyptian writings pre-dating Hippocrates that stress the importance of confidentiality in the doctor-patient relationship.[108]

By nature, the doctor-patient relationship is a contractual agreement. A breach in confidentiality results not only in a delictual liability, but also in a breach in the rights and duties of the professional relationship. Should action be taken against the perpetrator, it would be as a violation of the actio iniuriarum.[109] As in the well known South African case of *Jansen van Vuuren and Another NNO v Kruger* (675/91) [1993] ZASCA 145; 1993 (4) SA 842 (AD); [1993] 2 All SA 619 (A) (28 September 1993), the courts found that the defendants abused their position of privilege by casually disclosing a patients medical information to other healthcare providers for no legitimate reason.[110]

In principle, by virtue of presenting oneself to a doctor, one emanates trust in the doctor. Patients may however feel uncomfortable with sharing personal information due to their lack of trust in the chaperone as the relationship that they have entered into is not directly with the chaperone. It is therefore vital that non-professional staff be made aware of the importance of adhering to strict confidentiality principles and one may need to bind them to a contract with severe repercussions if they breach it. There are also clinical implications if there is a lack of trust in the relationship as patients may feel insecure to divulge personal and possibly important information which could have negative implications on their clinical management.

d) Dignity

Patients are sensitive to verbal and non-verbal communication and may sense when their dignity is not being prioritized. Particularly for intimate examinations, healthcare providers

107 Note 22 above.
108 G Oosthuizen, H Shapiro, et al. 'Professional Secrecy in South Africa: A Symposium' (1983) S Strauss New York: Oxford University Press: 98.
109 *Lillicrap, Wassenaar & Partners v Pilkington Brothers* (SA) (Pty) Ltd 1985 (1) SA 475.
110 *Jansen van Vuuren and Another NNO v Kruger* (675/91) [1993] ZASCA 145; 1993 (4) SA 842 (AD); [1993] 2 All SA 619 (A) (28 September 1993).

are in a privileged position where a patients most private and vulnerable information is revealed. The importance of maintaining dignity cannot be over emphasized.

Article 1 of the UDHR[111] affirms that all humans have the inherent right to dignity by virtue of being human. Human dignity is considered the most important basic human right from which all other rights are derived[112]. Whereas other human rights may be limited as a law of general application or denied in a state of emergency, human dignity is independent of the state and is inalienable.

The South African Constitution (Section 10) recognises this fact and bodies such as the HPCSA and SAMA have published guidelines for healthcare providers to encourage their respect for human dignity. The Constitutional Court (in *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) at para 28) stated that dignity is a "difficult concept to capture in precise terms" and that there is "little difference between the right to dignity as it is comprehended under the Constitution and its common-law counterpart".[113] Duhaime's Law Dictionary defines human dignity as "an individual or group's sense of self-respect and self-worth, physical and psychological integrity and empowerment".[114]

It is important to treat the patient as a person deserving of respect and not as a disease or sickness. Simple practical displays could be seen as drawing the curtains and covering the patient when an intimate examination is performed. A subjective view would be to treat the patient in a manner in which you would want to be treated. Legally, there may be difficulty in defining when an individual's dignity has been wrongfully infringed upon. Prior to the case of *Delange v Costa*[115], the judicial system was undecided as to how injury to dignity could be tested.[116,117] It subsequently decided on an objective and subjected test. The boni mores or

111 The Universal Declaration of Human Rights, 1948. http://www.un.org/en/documents/udhr/
112 L Hawthorne 'Constitution and Contract: Human Dignity, the Theory of Capabilities and Existenzgrundlage in South Africa' *SUBB Jurisprudentia* (2011): 27 (Accessed September 2015).
113 *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC).
114 Duhaime's Legal Dictionary. http://www.duhaime.org/LegalDictionary/H/HumanDignity.aspx (Accessed September 2015).
115 *Delange v Costa* 1989 (2) SA 857 (A) 860I-861A.
116 *Walker v Van Wezel* 1940 WLD (66) 71.
117 *Jackson v SA National Institute for Crime Prevention and Rehabilitation of* Offenders [1976 (3) SA 1 (A) at 12].

legal convictions of the community, as well as the plaintiffs subjective impression would be needed in order prove a violation of this fundamental right.[118]

e) Consent:

"No decision about me, without me"[119] concisely sums up the principle of respect for patient autonomy. There has been a shift away from paternalism and patients are entitled to fulfil their right to self determination. This is in keeping with The Constitution (Section 15), and even if the patient's opinion differs from oneself, one should respect it. The NHA and the National Patients' Rights Charter,[120] both attempt to give effect to these values. Consent needs to be voluntary and un-coerced and made by an individual with independent decision-making abilities. The patient should have the mental capacity to understand the procedure (what the intimate examination entails) and the possible risks and benefits of having a chaperone present. By virtue of them having entered into the doctor-patient relationship, should not be seen as implicit consent to an intimate examination.[121]

The consent needs to be comprehensive and the doctor should encourage an ongoing dialogue. In *Castell v De Greef* the courts ruled that the doctor needs to disclose the material risks associated with the proposed treatment.[122] In our context, one would ask what would a reasonable person consider to be acceptable behaviour and how would a reasonable healthcare provider conduct the examination in such a way that the patient finds their behaviour is acceptable. The attachment of significance to the inherent risks and benefits of having a 3rd party present would be the issue to note. Documentation of the consent procedure as well as whether or not a translator was used is important. The patients response to the offer of a chaperone, whether accepted or declined also needs to be clearly noted.

---

[118] *Dendy v University of the Witwatersrand* [2007] SCA 30 (RSA) (6).
119 A Coulter & A Collins 'Making shared decision making a reality: No decision about me, without me' E Rowling (ed) *The Foundation for Informed Decision Making.* The Kings Fund (2011): 7.
120 HPCSA 'National Patients' Rights Charter' (May 2008).
121 R Thomas. 'Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure' *PhD candidate UCT*.: 191.
122 *Castell v De Greef* 1994 (4) SA 408 (C).

f) Limited resources:

Limited human and financial resources is important. Most studies cite limited resources as a major deterrent to chaperone use. The financial implications of having another person on staff dedicated to serving as a chaperone may seem unjustifiable in our present financial climate. The position is also not a lucrative one and training is poorly defined. Furthermore, regulatory bodies that have chaperone policies in place are divided as to whom the chaperone should be.

While the GMC allows for non medical persons to fulfil this role, other bodies such as the RCOG and MPS suggest, trained medical personnel such as a nurse to fulfil this role. Patients may also find a nurse a more appropriate chaperone than a non-clinical staff member (such as a receptionist). In resource limited countries such as South Africa, many nurses are now examining patients independently and are considered central to healthcare, especially in rural areas where doctors are often reluctant to practice.[123] Between 2003 and 2012, the total number of nurses in the South African Nursing Register increased by more than 40 per cent in all categories.[124] There is still a shortage of qualified nurses even though the population growth from 2002 to the mid 2013 was 14 per cent.[125] A reasonable question would be to ask whether or not these nurses would also need chaperones? Based on the principles discussed above, the answer would be to the affirmative. Due to the global shortage of medical staff and nurses in particular, this would lead to added waiting times as there will be a duplication of staff in one consultation, added cost for the patient and a delay if no chaperone was available.[126]A possible solution could be the training and use of community health workers. They are a well recognised means of improving access to healthcare in peri-urban and rural areas.[127]

123 B Mayosi & S Benatar 'Health and Health Care in South Africa – 20 years after Mandela' *NEJM* (2014) 371 (14): 1344-53.
124 South African Nursing Council. Growth in the Registers and growth in students/ pupils. Pretoria: South Africa Nursing Council, 2014 (http://sanc.co.za/stats/stat_ts/Growth/Growth%202004-2013_files/frame.htm) (Accessed October 2015).
125 Statistics South Africa Home page (http://beta2.statsa.gov.za) (Accessed May 2015).
126 G. Howarth & F Backer 'Chaperone use in obstetrics and gynaecology' *Obstetrics and gynaecology forum* (2002): 14-17.
127 Human resources for health South Africa 2030: Draft HR strategy for the health sector: 2012/2013-2016/2017. Consultation document V5. Pretoria: South Africa Department of Health 2011 (https://www.k4health.org/toolkits/hrh/human-resources-health-south-africa-2030-draft-hr-stratergy-health-sector-201213-201617) (Accessed June 2015).

4) Special Circumstances:

a) Children

International instruments such as the UDHR,[128] the African Charter on the Rights and Welfare of the Child[129] and the Geneva Declaration on the Rights of the Child,[130] amongst others,[131] affirm that children are entitled to special care and assistance. The South African government, in the Children's Act 38 of 2005 (hereafter referred to as the Children's Act), further states that laws need to be effected in order to provide the necessary protection and assistance that children need in order to develop optimally and function harmoniously in society.[132] The effects of rape and sexual exploitation have damning long term effects on anyone, children being particularly vulnerable.

These sentiments were echoed by former patients of former paedophile paediatrician, Dr Michael Salmon who was recently sentenced to 18 years imprisonment for raping and sexually assaulting numerous of his patients decades earlier.[133] Dr Earl Bradley is another example of a paediatrician who was recently found guilty of rape, sexual assault and the sexual exploitation of children, namely, his patients.[134] The courts heard how Dr Earl Bradley inappropriately touched, kissed, undressed, carried and did vaginal examinations on his patients. He also recorded and manipulated these recordings in his offices. He was sentenced to 14 life sentences and 164 years at a level V prison.[135] The fact that the fiduciary relationship is completely disrespected is cause for concern. More concerning though, is the fact that these children were mostly brought to this harmful environment by their parent seeking help and through some manipulation, were permanently harmed.

128 Note 20 above.
129 The African Charter on the Rights and Welfare of the Child, 1990.
130 Geneva Declaration on the Rights of the Child, 1924.
131 United Nations Declaration on the Rights of the Child, in the Convention on the Rights of the Child, 1989.
132 The Childrens Act No 38 of 2005.
133 C Dyer 'Former paediatrician thought he was 'bomb proof' against sex charges, court hears' *BMJ (*2015): 350.
134 M Helgrin. '$123M Settlement:Paediatrician molests patients after drugging them with candy' (2012) http://baltimore.cbslocal.com/2012/12/10/123m-settlement-pediatrician-molests-patients-after-drugging-them-with-candy/ (Accessed June 2015).
135 Ibid 134.

Where child abuse is suspected and the parent's presence may interfere with the examination, a chaperone should be present.[136] The best interest of the child is always of paramount importance. According to the Childrens Act, a child needs to be assessed as having the mental capability to comprehend, in order to give consent. If the child lacks this ability, a proxy, as defined in the Childrens Act can give consent on their behalf.[137] A shared decision should be made on the use and gender of the chaperone in the case of adolescents. For adolescents going through significant physiological and psychological changes, an intimate examination could be very distressing. There is a scarcity of studies in this age group,[138] and the few that do exist, have produced conflicting results.[139,140] The examination must be clearly explained to the patient and should be carried out in a sensitive manner. Respect for privacy and dignity are of paramount importance as well as contemporaneous documentation.

Adolescent sexual relations were recently the focus in the Constitutional case of *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35). Judge Sisi Khampepe determined that Sections 15 and 16 of the Criminal Law Amendment Act were unconstitutional as the rights of adolescents to dignity and privacy are infringed upon. According to the Criminal Law Amendment Act, should a teenage girl become pregnant, her healthcare provider is obliged to report her to the police. This exposed minors to the harshness of the criminal justice system and possibly negative development and attitudes towards sexual behaviour. This case highlighted the fact that all constitutional rights of children need to be protected. Children's right to access healthcare and education as well as their right to privacy and dignity need to be protected. Healthcare providers need to be cognisant of all children's rights and in the context of this dissertation, ensure that privacy and dignity during examinations is maintained. The child's decision for or against a chaperone being present during an intimate

136 Committee on Practice and Ambulatory Medicine. 'Use of chaperones during the physical examination of the pediatric patient' *Pediatrics* (2011) 127: 991.
137 Note 132 above.
138 A Toulany & D Goldberg, et al. 'Chaperoning adolescents: A bygone era or modern medical necessity?' *Paediatrics and Child Health* (2012) 17 (6): 305-306.
139 S Philips & M Seidenberg, et al. 'Teenagers preferences regarding the presence of family members, peers and chaperones during physical examination of the genitalia' *Paediatrics* (1981) 68: 665-69.
140 R Buchta 'Adolescent females' preferences regarding the use of a chaperone during a pelvic examination' *J Adolesc Health Care (*1986) 7: 409-11.

examination should be respected. Non-consensual sexual acts with or between children of any age remains illegal and is prosecutable under the law.[141]

b) Mentally Incompetent:

The Constitution states that persons with disability should not be discriminated against. Their rights of dignity, privacy and confidentiality should be respected and maintained. The Mental Health Act, 2002 (Act No 17 of 2002) (MHA) further elaborates on the rights of mentally ill persons and prescribes regulations to ensure that the best possible mental health care, treatment and rehabilitation services are available for mental healthcare users.[142] The best interest of the mental healthcare user is paramount within the limits of available resources. The United Nations Convention on the rights of persons with Disabilities also favours a human rights approach.[143] The World Bank and World Health Organisation's report on Disability sheds some light on how disability should be perceived.[144] Traditionally, persons with disabilities and mental illnesses have been viewed by paternalistic healthcare providers and the general population as being ill, when in fact they are not ill by the common understanding of the term.[145]

According to the MHA, "mental illness" means "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis". Similarly, other conditions such as hypertension or asthma mean that a positive diagnosis has been made but does not necessarily mean that the individual is presently ill or unwell. Mental-age appropriate information needs to be provided to persons with mental disabilities and this need should not be overlooked or ignored.[146] Sexual education is vital as this group of people are considered vulnerable particularly in South Africa with our high rates of HIV/ AIDS and sexual violence.[147] The

141 *Teddy Bear Clinic for the Abused Children and Another v Minister of Justice and Constitutional Development and Another* (73300/10) [2013] ZAGPPHC 1 (4 January 2013)
142 The Mental Health Act, 2001 (Act No 17 of 2002).
143 United Nations. Convention on the Rights of Persons with Disabilities. http://www.un.org/disabilities/convention/conventionfull.shtml (Accessed December 2015).
144 World Health Organization and World Bank. World Report on Disability. Geneva: WHO, 2011.
145 L Salvador-Carulla & S Saxena'Intellectual disability: between disability and clinical nosology' *The Lancet* (2009) 374: 1798-99.
146 S Mall & L Swartz 'Sexuality, disability and human rights: Strengthening healthcare for disabled people' *S Afr Med J (*2012) 102 (10): 792-93.
147 National Strategic Plan HIV, STI's and TB, 2012-2016. http://www.hst.org.za/publications/national-strategic-plan-hiv-stis-and-tb-2012-2016 (Accessed December 2015).

Western Cape Forum for Intellectual Disability has developed guidelines to assist with HIV prevention education and sexuality for intellectually disabled adolescents and adults. They recognise that sexuality is in the nature of all human beings and that intellectually disabled persons have a right to positive sexuality. The manuals use visual illustrations to display appropriate sexual expression, information on how to access HIV testing and how to timeously disclose sexual abuse.[148]

Patients with mental disabilities should be counselled about the procedure in an intellectual-age-appropriate manner. Consent should be given by the patient if they are able to understand and appreciate the implications of the examination and their consent. It is important to build rapport and every effort should be made to have the patient co-operate, bearing in mind their cognitive ability. A chaperone should always be present during intimate medical examinations on mentally impaired patients. The chaperone should be made aware of the reason for and the nature of the examination and should be in full view as this is carried out. Depending on the institutions policy, a medical or non-medical individual may serve this purpose. The caregiver, whom the patient should be comfortable with, should serve as a support for the patient while an independent person serves as a chaperone.

c) Sexual Assault

South Africa has been labelled the rape capital of the world by the Human Rights Watch.[149] According to the Criminal Law Amendment Act, a person that incites the belief of, or sexually violates another person without their consent is guilty of sexual assault.[150] Rape is defined as the act of sexual penetration without consent.[151] According to the South African Police Services (SAPS), 53 617 sexual offenses were reported from April 2014 until March 2015.[152] This translates to 1 person being raped every 17 seconds.[153]

148 R Johns 'Step by Step: A Sexuality and HIV/AIDS Education Programme for Young Adults with Intellectual Disability: A Facilitator's Manual' Cape Town (2005): 1-157.
149 Human Rights Watch. https://www.hrw.org/world-report/2010/country-chapters/south-africa
150 Note 77 above.
151 Note 77 above.
152 SAPS. http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2015/crime_stats.php
153 C Everett "South Africa Progressive on LGBT Rights But Gays Still Battle for Social Reform." *International Business Times* (2014) http://www.ibtimes.co.uk/south-africa-progressive-lgbt-rights-gays-still (Accessed May 2015).

Due to the recent trauma suffered by the survivor, an examination should not be performed without the presence of a chaperone, ideally the same gender as the survivor.

The sexual assault examination of the rape survivor is both a medical/therapeutic and a forensic/medico-legal one. The survivor of rape has already been violated and requires an extra dimension of care. Specialised services, including social, medical, legal and psychological services, necessitating a multi-professional/ disciplinary approach is essential.[154] Rape is considered a medical emergency and according to The Constitution[155] and the NHA,[156] all persons are entitled to emergency treatment. This principle is endorsed by the ethical obligation as prescribed by the HPCSA.[157] Should rape survivors present to a healthcare facility, they should not be sent back to a police station to open a case first.[158]

The risk of re-traumatisation of a rape survivor is high. Similar to other patients seeking medical care, they require the protection of their dignity and safety. The harsher environment of police stations and forensic examination centres that are not in "softer" hospital or health-care environments are often places where the health rights of a patient may easily be overlooked. Violence against women and children seem to be a normalised part of our society, particularly in intimate relationships.[159] These vulnerable groups are often physically, financially and socially disempowered and may maintain secrecy due to their restricted worldview and limited resources. There is a high risk of repeated sexual traumatisation where attitudes of police and medico-legal examiners may be sanctimonious and self-righteous, derisory and insulting.[160] The victim may be looked upon as less likely to allege sexual assault because of their assigned victimhood-status and because the clinical medico-legal examination centred principally around the sexual activity alleged. This often creates a more brutalising experience for the victim/survivor. The author believes that medical chaperones are critical for rape medical examinations and should be stressed in the National Sexual Assault Policy guidelines for South Africa.

---

[154] S Grabe 'Child sexual abuse exacerbated by inadequate services' *S Afr Med J* (2013) 103(8): 499.
[155] Note 21 above.
[156] Note 22 above.
[157] Health Professions Council of South Africa. Health Professions Act: Ethical Rules of Conduct. www.info.gov.za/gazette/regulation/2008/30952_390.pdf (Accessed December 2015).
[158] K Naidoo 'Rape in South Africa – call to action' *S Afr Med J (*2013) 103(4): 210-11.
[159] J Clarke 'Why is sexual violence so endemic in South Africa and why has it been so hard to combat' *South African History Online*. http://www.sahistory.org.za/article/why-sexual-violence-so-endemic-south-africa-and-why-has-it-been-so-hard-combat-jessica-clark#sthash.K3cT37Zl.dpuf (Accessed October 2015).
160 Personal communication (confidential) with clinical forensic examiner, Durban, SA, January 2016.

d) Under the influence of alcohol, recreational or anaesthetic drugs:

Alcohols 'psychic' effects are well known and may be considered pleasant as well as unpleasant. It affects most organs of the body and may affect the clinical interpretation of findings. Due to the effects on the central nervous system, it is recommended that unless an intimate examination needs to be performed in life threatening circumstances, it should be postponed until the patients mental faculties are of normal functioning. Consent becomes an issue as well as the risk of misunderstandings and misinterpretations.

Similarly, anaesthetised patients mental capacity is decreased when under the influence of drugs. It is therefore recommended that prior to anaesthetising a patient, one should consider the possibility that an intimate examination may be required. Included in these intimate examinations is the insertion of urinary catheters and post-operative vaginal and rectal drugs. Consent for this, needs to be obtained before the anaesthetic is commenced.[161] In a recent experience by the author in her clinical practice, she encountered a female patient who presented to the gynaecology outpatient clinic complaining of vaginal bleeding after a laparoscopic procedure was performed on her. On further enquiry it was found that the operating surgeon had failed to fully explain the procedure to her or the fact that a uterine manipulator would need to be inserted per vagina. After careful counselling, the patient's fears were arrested and a possible negative response prevented.

161 General Medical Council. 'Intimate examinations and chaperones' (2013) http://kssdeanery.ac.uk/sites/kssdeanery/files/Intimate_examinations_and_chaperones%20pdf_51449880_0.pdf

CHAPTER 4: RECOMMENDATIONS

1) Introduction

The HPCSA has no specific guidelines concerning chaperone use in South Africa. The HPCSA spokesperson, Bertha Peters-Scheepers was noted as saying that although there is no HPCSA chaperone policy in place, the HPCSA fully supports the call for chaperones to be used.[162] This non-committal statement seems disingenuous considering the reported increase in number of sexual misconduct cases against doctors and the fact that a third of those accused are found guilty. Definite policies and guidelines are needed rather than simple statements of support. Furthermore, clearly defined steps need to be taken in order to curb this unprecedented harm.

The HPCSA general rule Booklet 1 states that improper financial and sexual relationships between practitioners and their patients (including patients' relatives and friends) should be avoided.[163] This is in keeping with the Hippocratic Oath that is taken by all healthcare practitioners at the completion of their degree.[164] The UK GMC states that one must not use their professional position in order to pursue a sexual relationship with a patient.[165]

In an article published in the Obstetrics and Gynaecology Forum, Dr Graham Howarth discusses the importance of "Keeping out Of Trouble".[166] He discusses the protective benefit of having a chaperone present but cautions that the presence of a chaperone does not necessarily preclude impropriety allegations. He suggests that healthcare providers become more aware of the risk of litigation and provides examples of some basic procedures, which are often overlooked as being intimate, but which could become grounds for litigation. He advises a discussion with the patient about the insertion of a urinary catheter and post operative analgesic suppositories, before the patient is anaesthetised, in order to prevent a possible misunderstanding of an invasion of privacy. He emphasizes the importance of

162 Z Mapumulo 'Watchdog supports chaperones as sexual complaints against doctors rise' (February 2013) http://www.news24.com/Archives/City-Press/Watchdog-supports-chaperones-as-sexual-complaints-against-doctors-rise-20150429
163 HPCSA Booklet 1: General Ethical guidelinesfor The Healthcare Professions. Pretoria. HPCSA. 2008:6.
164 Note 7 above.
165 General Medical Council 'The duties of a doctor registered with the General Medical Council' (2013) Good Medical practice. http://www.gmc-uk.org/static/documents/content/GMP_.pdf (Accessed September 2015).
166 Note 76 above.

informed consent and alludes to the fact that even a speculum examination in a patient that has not consented to the examination could be defined as rape.[167]

This is according to the new definitions as set out in the Criminal Law Amendment Act.[168] According to the Criminal Law Amendment Act, a person who intentionally sexually violates another person, without their consent is guilty of committing a sexual assault. The definition goes further to state that should a person "unlawfully and intentionally" inspire the belief that a sexual violation will occur, that person is guilty of a sexual assault. The charge of a sexual assault against a healthcare practitioner can have detrimental consequences and every effort must be made to protect the patient and the doctor. While the South African regulatory bodies have failed to establish and implement chaperone guidelines, most countries have.

In the UK the NHS governance support team published guidelines in June 2005 where they stated that every facility conducting intimate examinations should have a written, visible policy on the availability of a chaperone in place.[169] The RCOG recommends a chaperone be offered for all intimate examinations, irrespective of the gender of the examining doctor. UK medical practitioners are provided with clear professional guidance on appropriate use of chaperones. The GMC, the Royal College of Nursing, the NHS Clinical Governance Support Teams and the medical defence organisations have all generated guidance around chaperoning.

The ACOG states that irrespective of the physicians gender, should a patient or practitioner request a chaperone, their request should be honoured.[170] The American Medical Association[171] also recommends medically trained chaperones. The UK's GMC on the other hand, states that the chaperone does not need to be medically trained[172] but maintains that a chaperone should be offered for all intimate examinations. The Australian Medical

167 Ibid 166.
168 Note 77 above.
169 NHS Governance support team: 'Guidance on the role and effective use of chaperones in primary and community care settings: Model Chaperone Framework' (June 2005).
170 American College of Obstetricians and Gynaecologists. Committee on Ethics: ACOG committee opinion. Washington DC (1994) 144: 1-3.
171 Council on Ethical and Judicial Affairs, American Medical Association. 'Sexual misconduct in the practice of medicine' *JAMA* (1991) 266: 2741-45.
172 Note 165 above.

Practitioners Board of Victoria is less prescriptive and states that a doctor can offer a chaperone if he or she feels that the patient is uncomfortable.[173]

The Singapore Medical Council recommends that a female chaperone be present when a male doctor examines a female patient.[174] The Malaysian Medical Council's good practice guidelines go further to state that irrespective of the gender of the doctor, patient or if a child is being examined, the chaperone must be 'physically' present and have visual and auditory contact throughout the examination.[175]

Chaperones are also seen as a source of comfort by the American Academy of Paediatrics who recommends that if any part of the physical examination be physically or emotionally uncomfortable, the paediatrician should offer the patient a chaperone.[176] If the child or parents decline this offer, it should be documented. The patient's choice to decline a chaperone is further emphasized in the Hong Kong Code and Conduct guidelines.[177]

In the 2013 update of Good Medical Practice, 'Intimate Examinations and Chaperones' formed a key part of the Maintaining Boundaries section.[178] These guidelines set out the role of a chaperone as the patient's advocate as well as serving as the doctor's protection. It further emphasized that chaperones should be considered when any kind of intimate examination is deemed necessary; "This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient".[179] Considering, amongst others, the abovementioned international councils guidelines, it is timeous to make similarly applicable recommendations for chaperone use in South Africa.

173 Medical practitioners Board of Victoria. 'Professional Boundaries: a guide for patients and doctors' Melbourne: Medical Practitioners Board of Victoria. Medical Protection Society Recommendations (2009).
174 Singapore Medical Council, Ethical Code and Ethical Guidelines (2002)
175 Malaysian Medical Council, Duties of a Doctor: Good Medical Practice (2001)
176 American Academy of Paediatrics. Committee on Practice and Ambulatory medicine 'The use of chaperones during the physical examination of the paediatric patient' *Paediatrics* (1996) 98: 1202.
177 Medical Council of Hong Kong, Professional Code and Conduct for the Guidance of Registered Medical Practitioners (2009).
178 General Medical Council 'Intimate examinations and chaperones' (2013)http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp (Accessed December 2015).
179 Ibid 178.

2) Recommendations for local application:[180,181,182,183]

Recommendations should be in keeping with international trends and guidelines published by professional associations as well as formal regulatory councils administering the registration of all healthcare providers. It would do well to emulate best-practice approaches adopted in jurisdictions where the contemplation of patient protection mechanisms have advanced and developed. South African general oversight professional associations such as SAMA, as well as the numerous different specialist associations, need to develop policies and guidelines on the use of medical chaperones during clinical examinations. The HPCSA is required to further develop Ethical Guidelines in keeping with those of the professional associations but with which sanctions against practitioners may be effected when proven either non-compliant or who are in violation of these.

The following recommendations are made by the author on the use of medical chaperones:

1. Every facility that conducts intimate examinations should have a written, visible policy on the use of a chaperone for intimate examinations.
2. Every healthcare provider should familiarise themselves with the necessary ethical guidelines in place in the facility as well as in his/ her professional field on intimate examinations.
3. A chaperone should be offered to every patient undergoing an intimate examination, irrespective of the gender of the patient or the healthcare provider.
4. The healthcare provider needs to ensure that the intimate examination is necessary and indicated and that it will assist in the patient's care; that the patient understands the need for the examination and has provided full informed consent.
5. The presence and identity of the chaperone needs to be documented. If a medically-trained chaperone is not available, it may be necessary to use the services of a non-medically trained person, and their role and responsibilities should be explained to the chaperone.

[180] Working Party Report 'Intimate examinations' London. Royal College of Obstetricians and Gynaecologists RCOG Press: 1997.
[181] N Croft & J Morrow, et al. 'Chaperones for genital examinations' *BMJ* (1999) 319: 1266.
[182] Note 169 above.
[183] General Medical Council 'Maintaining a professional boundary between you and your patient' (2013) http://www.gmc-uk.org/guidance/ethical_guidance/21170.asp (Accessed December 2015).

6. If a chaperone is unavailable, the patient should give consent to the intimate examination being performed without one, or the examination should be rescheduled. Refusal by the patient towards the presence of a chaperone should be dealt with in accordance to the professional and ethical guidelines in place and should be recorded in the appropriate medical record. If the healthcare provider feels it warranted that a chaperone be present and the patient refuses to consent, the patient should be referred to another healthcare provider.

The author thought it useful to create a practical checklist for intimate examinations which should go together with guidelines on intimate examinations, and should include the following:

1. Treat every patient with respect, dignity and maintain confidentiality.
2. Allow the patient privacy to undress and maintain the dignity of the patient by covering them if possible. Only expose that part of the body being inspected or examined.
3. Only authorised persons such as the practitioner and the chaperone should be present during the examination. Police officers should not be present in the consulting room during the entire consultation and examination.
4. Avoid unnecessary conversation and particularly any comments of a personal nature.
5. During the examination, explain what you are doing and stop if asked to.
6. Do not allow or take disturbances like telephone calls during the examination.
7. The chaperone should hear the explanation of the examination and the patient's consent.
8. The chaperone should be familiar with the procedure and be positioned where they can see the patient and how the examination is being conducted.
9. The chaperone should be prepared to raise any concern if deviations from the norm are witnessed.
10. Do not continue the examination if the chaperone leaves the room unless the patient agrees.

3) <u>Monitoring and Reporting:</u>

All facilities should have policies in place for the optimal care and wellbeing of the patient. As such, every facility providing services that require intimate examinations should have a clear, easy to understand, visible policy with regard to chaperone use. There also needs to be

an ‘open door’ policy in place whereby reporters of misconduct can confidentially report suspicious behaviour. Patients as well as chaperones need to be willing to act timeously on their perceptions.

As pointed out in The Lancet,[184] the inquiry into the actions of Dr Rodney Ledward revealed that although he was accompanied by nurses over numerous years, they did not report or act on his unprofessional behaviour.[185] The author of that article goes further to state that nurses are not equipped to “supervise or control doctors” and may feel inferior in their role in the consulting room. Furthermore, chaperones would be expected to object at the time of the examination if they feel the doctor is behaving in an unprofessional or undignified manner, by embarrassing or causing harm to the patient.

Numerous bodies such as the GMC,[186] the HPCSA, as well as MPS impose a duty on other medical personnel to report colleagues who may be involved in unethical practices. This imposed responsibility caused a colleague of the world renowned gynaecologist, Dr Nikita Levy to report his suspicion of medical malpractice.[187] Management was alerted to the fact that the now infamous, deceased gynaecologist, Dr Levy wore a recording device (masked as a pen) around his neck while performing intimate examinations on patients. More than 8000 of his patients came forward concerned that he had violated their trust and his position spanning more than a decade. A week after police seized photographs and video recordings, he committed suicide. Unfortunately, he did not stand trial for this violation of boundaries and the John Hopkins Hospital has vicariously settled in what is one of the largest class settlement acts for 190 million US dollars. Of concern is that it is reported that Dr Levy performed pelvic examinations unnecessarily and unaccompanied by a nurse which is against the hospitals policy.[188] It is expected that having a policy in place would result in its implementation however it is evident that no monitoring or enforcement of the chaperone policy was performed.

184 V Stern ‘Gynaecological examinations post-Ledward – a private matter’ *The Lancet* (2001) 358: 1896-99.
185 ‘The Report of the Inquiry into Quality and Practice Within the National Health Service Arising from the Actions of Rodney Ledward’ London: Stationary Office, 2000.
186 General Medical Council ‘Raising and acting on concerns about patient safety’ (2012) http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (Accessed December 2015).
187 S Dance & J Fenton, et al. ‘Suspicious colleague reported Levy, Hopkins dean says’ (2013) http://articles.baltimoresun.com/2013-02-27/health/bs-md-hopkins-levy-cameras-20130227_1_hopkins-dean-johns-hopkins-gynecologist-dr-levy (Accessed October 2015).
188 *Jane Doe No1, et al vs Johns Hopkins Hospital, et al*. Case no 24-C-13-001041. Circuit court for Baltimore City. (http://www.insurancejournal.com/news/east/2014/07/22/335393.htm) (Accessed October 2015).

4) Conclusion

In *Doe vs Louisiana State Board of medical Examiners*, the court ruling set a precedent to clarify the physician's role. "The public depends on and trusts that doctors will conduct their medical practice in a professional manner. Special privileges are granted to doctors in the area of personal privacy that are not accorded to anyone else."[189] Values such as altruism, compassion, selflessness and trustworthiness are a few of the foundational principles on which the doctor-patient relationship thrives upon. These principles go beyond policies and duties and should be at the core of every healthcare providers being.[190]

The previously trusted doctor-patient relationship has been tarnished by the steady increase in medical malpractice claims. Chaperones have been endorsed as a risk reduction mechanism by numerous international bodies. Numerous studies have looked at the reasons for and against chaperone use for intimate examinations.[191,192] Possible listed drawbacks for the use of chaperones include limited human resources, patient refusal as they may not want to disclose information due to a fear of a breach of confidentiality occurring, it may be seen as an 'intrusion in the doctor-patient relationship' and the healthcare practitioner refusing another person in the examination room. Ethical codes and practice guidelines aim to remind the doctor of their responsibilities, and to protect the vulnerable patient.

Although there are numerous world renowned bodies with clear policies and guidelines for chaperone use,[193] to date, the HPCSA has not yet set out clear guidelines for their use in clinical practice. It is recommended that the HPCSA acts upon previous recommendations[194] and sets out clear guidelines for the use of chaperones for intimate examinations. Instead of more discussions about the advantages and disadvantages of chaperone use, the author feels that efforts should be made to rather implement, monitor and document chaperone use. Suggested tools to assist documentation include the use of a stamp, electronic pop-ups and a proforma approach.

---

[189] D Gorgos 'Should a chaperone be present during an examination' *Dermatology Nursing* (2004) 16 (5): 459.
[190] The College of Physicians and Surgeons of Ontario. 'The Practice guide. Medical professionalism and college policies' (2007) (http://www.cpso.on.ca/policies-publications/the-practice-guide-medical-professionalism-and-col) (Accessed October 2015).
[191] Note 91 above.
[192] S Loizides & A Kallis, et al. 'Chaperone policy in accident and emergency departments: a national survey' *J Eval Clin Pract (2010)* 16*: 107–10.*
[193] P Hine & H Smith 'Attitudes of UK doctors to intimate examinations' *Cult Health Sex (2014)* 16*: 944–59.*
[194] Note 93 above.

In this present litigious climate, implementing and practicing preventative measures are preferable to damage-control measures applied after an incident has occurred. The author concludes by urging the powers that be, to not only encourage the use of chaperones but to devise clear policies, guidelines and monitoring mechanisms in an attempt to decrease the harm facing patients and doctors.

CHAPTER 5: CONSUMMATION

5.1) Declaration of no conflict of interests

The author declares that there has been no conflict of interest on the part of the candidate nor the supervisor.

5.2) Bibliography

- International Guidelines and Policies

- American Academy of Paediatrics. Committee on Practice and Ambulatory medicine. The use of chaperones during the physical examination of the paediatric patient. *Paediatrics* 1996; 98: 1202.
- American Academy of Paediatrics. Committee on Practice and Ambulatory Medicine. Use of chaperones during the physical examination of the pediatric patient - revised. *Pediatrics* 2011; 127: 9.
- American College of Obstetricians and Gynaecologists. Committee on Ethics: ACOG committee opinion. 1994; 144: 1-3.
- American Medical Association. Council on Ethical and Judicial Affairs. Sexual misconduct in the practice of medicine. *JAMA* 1991; 266: 2741-2745.
- American Medical Association. Sexual misconduct in the practice of medicine. In: Code of medical ethics of the American Medical Association: current opinions with annotations. 2006-2007 ed. Chicago (IL): JAMA; 2006. p. 255-8.
- General Medical Council. Intimate examinations and chaperones. March 2013.
- General Medical Council. Maintaining boundaries. 2006.
- Malaysian Medical Council, Duties of a Doctor: Good Medical Practice (2001).
- Medical Council of Hong Kong, Professional Code and Conduct for the Guidance of Registered Medical Practitioners (2009).
- Medical Practitioners Board of Victoria. Professional Boundaries: a guide for patients and doctors. Melbourne: Medical Practitioners Board of Victoria. Medical Protection Society Recommendations (2009).
- Medical Protection Society Fact Sheet. Chaperones. May 2015.

- National Health Service. Clinical Governance Support Team. Guidance on the role and effective use of chaperones in primary and community care settings. Model Chaperone Framework. June 2005.
- Royal College of Obstetricians and Gynaecologists. Working Party Report, Intimate examinations. London. September 1997.
- Singapore Medical Council, Ethical Code and Ethical Guidelines (2002).
- The African Charter on the Rights and Welfare of the Child (1990).
- The College of Physicians and Surgeons of Ontario. The Practice guide. Medical professionalism and college policies. September 2007.
- The Faculty of Forensic and Legal Medicine of The Royal College of Physicians
- The Medical Board of Australia, sexual Boundaries guidelines, October 2011.
- The Society of Obstetricians and Gynaecologists of Canada. Sexual abuse by physicians. SOGC Policy Statement No. 134. *J Obstet Gynaecol Can* 2003; 25: 862.
- The Universal Declaration of Human Rights (1948).
- United Nations Convention on the Rights of Persons with Disabilities (2006).
- World Health Organization and World Bank. World Report on Disability. Geneva: WHO, 2011.

- Local Legislation:

- Protection of Personal Information Act, 2013 (No. 4 of 2013).
- The Childrens Act, 2005 (No. 38 0f 2005).
- The Constitution of the Republic of South Africa, 1996 (No. 108 of 1996).
- The Criminal Law (Sexual Offenses and Related Matters) Amendment Act 32 of 2007.
- The Health Professions Act, 1974 (Act 56 of 1974).
- The Mental Health Act, 2002 (Act No 17 of 2002).
- The National Health Act 63, 2003 (No. 61 of 2003).

- Case Law:

- *Basner v Trigger* 1946 AD 83.
- *Bradley v. State*, Del. Supr, No. 467, 2011.

- *Castell v De Greef* 1994 (4) SA 408 (C).
- *Delange v Costa* 1989 (2) SA 857 (A) at 860I-861A.
- *Dendy v University of the Witwatersrand* [2007] SCA 30 (RSA) 6
- *Jackson v SA National Institute for Crime Prevention and Rehabilitation of Offenders* [1976 (3) SA 1 (A) 12].
- *Jane Doe No1, et al vs Johns Hopkins Hospital*, et al. Case no 24-C-13-001041.
- *Joubert v Venter* 1985 (1) SA 654 (A).
- *Lillicrap, Wassenaar & Partners v Pilkington Brothers* (SA) (Pty) Ltd 1985 (1) SA 475.
- *Teddy Bear Clinic for the Abused Children and Another v Minister of Justice and Constitutional Development and Another* (73300/10) [2013] ZAGPPHC 1 (4 January 2013).
- *Walker v Van Wezel* 1940 WLD (66) 71.

- Local Guidelines and Policies:

- Health Professions Council Of South Africa: Guidelines for good clinical practice in the health care professions, 2008.
- Ethical and Professional Rules of the Health Professions Council of South Africa. GN R717 in Government Gazette 29079 of 4 August 2006, as amended by GN R68 in Government Gazette 31825 of 2 February 2009.
- National Core Standards for Health Establishments in South Africa, Department of Health, 2011.
- National Patients' Rights Charter, May 2008.
- South African Medical Association Guidelines and Policies.
- The National Strategic Plan on HIV, STI's and TB, 2012-2016.
- Department of Health (2007) Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People.

- Books

  - Hawthorne, Linda, *Constitution and Contract: Human Dignity, the Theory of Capabilities and Existenzgrundlage in South Africa*, 2011 SUBB Jurisprudentia 27.
  - J Neethling, JM Potgieter, PJ Visser. *Law of Delict*. 4th ed. Durban: Butterworths (2001) 338-350.
  - Oosthuizen, Shapiro and Strauss, *Professional Secrecy in South Africa* (1983) 98.
  - TA Mapper, D Degrazia. *The Hippocratic Oath in Biomedical Ethics*, 5th ed. Boston: McGraw-Hill (2001) 66.
  - TL Beauchamp, JF Childress. *Principles of biomedical ethics.* 5th ed. New York: Oxford University Press (2001).

- Journal articles

  - Afaneh I, V Sharma, R McVey, C Murphy, M Geary. The use of a chaperone in obstetrical and gynaecological practice. *Irish Medical Journal* 2010 May; 103 (5): 137-39.
  - Alam A, Klemensberg J, et.al. The characteristics of Physicians disciplined by professional colleges in Canada. *Open Medicine* 2011; 5 (4)E 166.
  - Baber JA, Davies SC, Dayan LS. An extra pair of eyes: Do patients want a chaperone when having an anogenital examination? *Sexual Health* 2007; 4: 89-93.
  - Baker R, Mulka O, Camosso-Stefinovic J, et al. Patients' view on professionals' use of chaperones during intimate examinations in primary health care: a review. *Quality in Primary Care* 2007; 15: 337-44.
  - Bateman C. Medical negligence pay-outs soar by 132% - subs follow. *South African Medical Journal* 2011; 101(4): 216-17.
  - Beckman HB, Markakis KM, Suchman AL, Frankel RM, The doctor–patient relationship and malpractice: lessons from plaintiff depositions, *Archives Internal Medicine* 1994; 154: 1365-70.
  - Bhagwan S. A time for reform in health care litigation. *American Journal of Surgery* 2004; 187: 319-22.
  - Bignell C. Chaperones for genital examinations. *British Medical Journal* 1999; 319: 137-39.

- Buchta R. Adolescent females' preferences regarding the use of a chaperone during a pelvic examination. *Journal of Adolescent Health Care* 1986; 7: 409-411.
- Campbell ML. The Oath: an investigation of the injunction prohibiting physician-patient sexual relations. *Perspectives in Biology and Medicine* 1989; 32: 300-8.
- Clarke L, Bann S, Edwards E, et al. Black box. *Student British Medical Journal* 2003; 11: 43-86.
- Croft N, Morrow, Randall S, Kishen KM. Chaperones for genital examinations. *British Medical Journal* 1999; 319:1266.
- Dhai A 'Why do I need a chaperone'. *Health Professions Council of South Africa: The Bulletin* 2011; 28-29.
- Dhai A, Gardner Y, Guidozzi Y. Professionalism and the intimate examination – are chaperones the answer? *South African Medical Journal* 2011; 110: 814-16.
- Dhai A, Mkhize B. The Health Professions Council of South Africa and the medical practitioner. *Continuing Medical Education* January 2006; 24 (1): 8-11.
- Dhai A. Editorial. *South African Journal of Bioethics and the Law* December 2010; 3 (2): 54.
- Dyer C. Former paediatrician thought he was 'bomb proof' against sex charges, court hears. *British Medical Journal* 2015; 350: 103.
- Guidozzi Y, Gardiner J, Dhai A. Professionalism in the intimate examination: How healthcare practitioners feel about having chaperones present during an intimate consultation and examination. *South African Medical Journal* 2013; 103 (1): 25-27.
- Hall KH. Sexualization of the doctor-patient relationship: is it ever ethically permissible? *Journal of Family Practice* 2001; 18: 511-15.
- Hine P, Smith H. Attitudes of UK doctors to intimate examinations. *Culture Health and Sexuality* 2014; 16: 944–59.
- Howarth G. Keeping out of trouble – the 12 Cs. *Obstetrics and Gynaecology Forum* 2014 (4): 15-20.
- Howarth G, Backer F. Chaperone use in obstetrics and gynaecology. *Obstetrics and gynaecology forum.* May 2002: 14-17.
- Jones R, Barton S, Mclean K, Madalia S, Pickett J, Cohen C. Is it time for the virtual chaperone in genitourinary medicine clinics? *International Journal of STD & AIDS* 2007; 18: 458-60.

- Elkin K, Spittal M. Doctors disciplined for professional misconduct in Australia and New Zealand, 2000-2009. *Medical Journal of Australia* 2011; 194: 452-56.
- Klaud Miller G. The benefits of using medical scribes. American *Academy of Orthopaedic Surgeons* June 2012.
- Loizides S, Kallis A, Oswal A. Chaperone policy in accident and emergency departments: a national survey. *Journal of Evaluation in Clinical Practice* 2010*;* 16*:* 107–10.
- Mall S, Swartz L. Sexuality, disability and human rights: Strengthening healthcare for disabled people. *South African Medical Journal* 2012; 102 (10): 792-93.
- Malherbe J. Counting the cost: The consequence of increased medical malpractice litigation in South Africa. *South African Medical Journal* 2013; 103 (2): 83-84.
- Mayosi B, Solomon R. Benatar Health and Health Care in South Africa – 20 years after Mandela. *New England Journal of Medicine* October 2014; 371 (14): 1344-53.
- McQuoid-Mason. Is it ever justified for doctors to sue their patients whose allegations against them have been dismissed by the courts or The Health Professions Council of South Africa? *South African Medical Journal* 2015; 105 (12): 1010-11.
- Meyer ME, Swanepoel DW. Newborn hearing screening in the private health care sector – a national survey. *South African Medical Journal* 2011; 101 (9): 665-67.
- Mecalfe N, Moores K, Murphey N, Pring D. The extent to which chaperone policies are used in acute trusts in England. *Postgraduate Medical Journal* 2010; 86: 636-40.
- Molajo A, Vaiude P, Graham K. Are we documenting chaperone use? *British Association of Plastic, Reconstructive and Aesthetic Surgeons.* 2012; 65: 275-76.
- Morales Ramirez JJ, Sauceda Gonzalez LF. Most of the complaints in gynaecology and obstetrics care are generated by perceptions stemming from unavoidable results. *Ginecologia y Obstetricia de' Mexico*. 2001; 69: 108-17.
- Newton D, Chen M. Recommendations for chaperoning in sexual health settings. *Sexual Health* 2007; 4: 207.
- Nkwo P, Chigbu C. The perceptions and use of chaperones by Nigerian gynaecologists. *International Journal of Gynaecology and Obstetrics* 2013; 120: 46-48.
- Pepper MS, Slabbert MN. Is South Africa on the verge of a medical malpractice litigation storm? *South African Journal of Bioethics and Law* 2011; 4 (1): 29-35.

- Philips S, Seidenberg M, Friedman S. Teenagers preferences regarding the presence of family members, peers and chaperones during physical examination of the genitalia. *Paediatrics* 1981; 68: 665-69.
- Price D, Tracy C, Upshur R. Chaperone use during intimate examinations in primary care: postal survey of family practitioners. *BioMed Centre Family Practice* 2005; 6:52.
- Prideaux A. Male nurses and the protection of female patient dignity. *Nursing Standard.* 2010; 25 (13): 42-49.
- Pydah K, Howard J. The awareness and use of chaperones by patients in an English general practice. *Journal of Medical Ethics* 2010; 36 (8): 512-13.
- Rachagan SS, Sharon K. The Patient's view. *Medical Journal of Malaysia*. 2003 Mar; 58 Supplimentary A: 86-101.
- Rogstad K. Chaperones: Protecting the patient or protecting the doctor. *Sexual Health* 2007; 4: 85-87.
- Rose K, Eshelby S, Thiruchelvam P, Khoo A, Hogben K. The importance of a medical chaperone: a quality improvement study exploring the use of a note stamp in a tertiary breast surgery unit. *British Medical Journal Open* 2015;5.
- Rymer J, Durbaba S, Resenthal J, Jones RH. Use of chaperones by obstetricians and gynaecologists: A cross-sectional survey. *Journal of Obstetrics and Gynaecology*. January 2007; 27(1): 8-11.
- Salvador-Carulla L, Saxena S. Intellectual disability: between disability and clinical nosology. *Lancet* 2009; 374: 1798-99.
- Segal J. When doctors sue patients – defamation is devastating – but a lawsuit could make it worse. *Medical Justice* 2015.
- Shewn TC. Upseh R. The medical chaperone: outdated anachronism or modern necessity. *Southern Medical Journal.* 2008; 101 (1): 9-10.
- Simon RI. The natural history of therapist sexual misconduct: Identification and prevention. *Psychiatric Annals* 1995; 25: 90-93.
- Simon RI. Therapist-patient sex. From boundary violations to sexual misconduct. *Psychiatric Clinics of North America* 1999; 22: 31-47.
- Sinha S. Patients' attitudes towards the use of a chaperone in breast examination. *Annals of the Royal College of Surgeons of England* 2009; 91: 46-49.

- Stern V. Gynaecological examinations post-Ledward – a private matter. *The Lancet* 2001; 358: 1896-99.
- Toulany A, Goldberg D, Matlow E, Kaufman A. Chaperoning adolescents: A bygone era or modern medical necessity? *Paediatrics and Child Health*. 2012; 17 (6): 305-06.
- Wamisho BL, Abeji M, Feleke Y, Hiruy A, Getachew Y. Analysis of medical malpractice claims and measures proposed by the Health Professionals Ethics Federal Committee of Ethiopia: review of the three years preceding. *Ethiopian Medical Journal* 2015; 53 Supplementary 1: 1-6.
- Webb R, Opdahl M. Breast and pelvic examinations. Easing Women's discomfort. *Canadian Family Physician* 1996; 42: 54-58.

- Web links

- http://www.beta2.statsa.gov.za
- http://www.bipsolutions.com/docstore/pdf/8221.pdf
- http://www.dailymail.co.uk/news/article-389911/Former-male-nurse-wins-chaperone-case.html
- http://www.duhaime.org/LegalDictionary/H/HumanDignity.aspx
- http://www.ibtimes.co.uk/south-africa-progressive-lgbt-rights-gays-still
- http://www.iol.co.za/news/south-africa/sa-s-dodgy-doctors
- http://www.justice.gov.za/sca/judgments%5Csca_2007/sca07-030.pdf
- http://www.justice.gov.za/legislation/acts/2005-038%20childrensact.pdf
- https://www.k4health.org/toolkits/hrh/human-resources-health-south-africa-2030-draft-hr-stratergy-health-sector-201213-201617
- http//www.kingsfund.org.uk/publications/making-shared-decision-making-reality
- http://www.kssdeanery.ac.uk/sites/kssdeanery/files/Intimate_examinations_and_chaperones%20pdf_51449880_0.pdf
- http://www.medicalchronicle.co.za/motsoaledi-wages-war-against-lawyers
- http://www.medicalprotection.org/southafrica/casebook-and-resources/factsheets/Chaperones
- http://www.merriam-webster.com/dictionary/intrusive
- http://www.mps.org.uk
- http://www.oxforddictionaries.com/definition/english/intrusive
- http://www.saflii.org/za/cases/ZASCA/1993/145.html

- http://www.sanc.co.za/stats/stat_ts/Growth/Growth%202004-2013_files/frame.htm)
- http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2015/crime_ http://www.stats.php http://www.statssa.gov.za/publications/P0305/P03052014.pdf
- http://www.themdu.com/about-mdu/annual-report-and-accounts
- http://www.un.org/en/documents/udhr/
- http://www.vocabulary.com/dictionary/intrusive
- http://www.who.int/gho/health_workforce/physicians_density_gender/en/

➢ Other resources

- Johns R. Step by Step: A Sexuality and HIV/AIDS Education Programme for Young Adults with Intellectual Disability: A Facilitator's Manual. Cape Town: 2005:1-157
- Personal communication (confidential) with clinical forensic examiner, Durban, SA, January 2016.
- The Report of the Inquiry into Quality and Practice Within the National Health Service Arising from the Actions of Rodney Ledward. London: Stationary Office, 2000.
- Thomas R. Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure. PhD candidate. UCT. 191.