

**A CROSS- SECTIONAL SURVEY OF PATIENTS ATTITUDE TO VAGINAL
EXAMINATION AND CHAPERONE AT KING EDWARD VIII HOSPITAL**

By

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DECLARATION

I, Dr Okezie Ubaka AMAECHINA, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it is to be, has been, or is being submitted for another degree at this or any other university.

Signed.....

Date.....

ABSTRACT

Background: In the state regional hospitals, obstetrics and gynaecology units are often overloaded with patients. Most consultations in these units culminate in vaginal examination (VE) and oftentimes, because of the busy nature of the job, VE may be performed hurriedly and leave out the psychosocial aspect that is paramount. Understanding patients' attitudes towards VE in such a challenging environment will help compare what is known as well as guide drafting guidelines on VE.

Objectives: The aim of the study was to survey the attitude of King Edward VIII Hospital's patients towards vaginal examination and chaperoning, as well as understand the effect of doctors' gender on this attitude.

Method: Four hundred women who came to King Edward VIII Hospital for obstetric or gynaecological reasons were purposively sampled via a self-administered semi-structured questionnaire and data was analysed descriptively using SPSS version 19.

Results: Most women (68%) were aged between 20 and 35 years. In terms of educational attainment, 35% did not reach grade 12, 28.7% reached grade 12 while 27.8% had further studies beyond grade 12. Out of 400 women, 377 (94.3%) gave their opinion on what they think is the most intimate examination a woman can undergo, 193(48.3%) were of the opinion that vaginal examination is the most intimate examination; 25.5% regarded abdominal examination as the most intimate examination; 19.0% felt the most intimate examination to be breast examination; and only 1.5% rated rectal examination as the most intimate. Response to a statement that vaginal examination causes discomfort was low (47%); however, of the respondents, 61.7% agreed or strongly agreed that vaginal examination causes discomfort. A conclusion that vaginal examination causes pain cannot be made based on the above findings as most participants (53%) did not respond to the question. Response to a statement "It is better to have a chaperone present if the doctor is a male" was low (40%); 70% of the respondent either agreed or strongly agreed that it is better to have a chaperone during an examination if the doctor is male". Again a conclusion cannot be made based on the 40% that responded, however because 76.8% (307 out of 400 women) responded to a statement "There is no need for a chaperone during vaginal examination" one can probably infer that women are neither in support of nor against the presence of chaperone as 54.5% said yes to the statement while 45.1% said no. 386 (96.7%) women out of 400 responded to the question that sought opinion on preferred type of chaperone, those aged 20 to 35 years, preferred a nurse as their chaperone. Younger women, aged 19 years or less, preferred their mum as a chaperone.

Conclusion: In a state regional hospital, women are more likely to regard vaginal examination as the most intimate examination and the procedure probably causes some discomfort. They are equivocal on the use of a chaperone and where it is necessary; nurses are the preferred choice of chaperone, except teenagers, who may prefer their mum. The gender of the examining doctor is probably irrelevant.

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TABLE OF CONTENTS

Title	1
Declaration	2
Abstract	3
Acknowledgements	5
Table of Contents	6
List of Tables	7
CHAPTER ONE	9
Introduction and Literature review	
CHAPTER TWO	19
Methodology	
CHAPTER THREE	22
Results	
CHAPTER FOUR	33
Discussion	33
Strengths and weaknesses of the study	36
Conclusion	37
Recommendations	38
REFERENCES	39
APPENDIX I (Information given to patients)	42
APPENDIX II (Questionnaire)	44
APPENDIX III (Ethics & post graduate approval letters)	48

LIST OF TABLES

Table 1. Descriptive summary of age groups	22
Table 2. Descriptive summary of other baseline characteristics	22
Table 3. Descriptive summary of opinion on most intimate examination	25
Table 4. Contingency table between age groups and intimate examination	25
Table 5. Chi square test of association between age groups & intimate examination	26
Table 6. Previous VE & most intimate examination	26
Table 7. Chi square test of association between previous VE & most intimate exam	27
Table 8. Response to statement “ VE causes discomfort	28
Table 9. Table of response – “ Better to have a chaperone present during exam”	28
Table 10. Response to statement “ there is no need for a chaperone during vaginal exam”	29
Table 11. Participants preferred type of chaperone	29
Table 12. Age and preferred type of chaperone	30
Table 13. Test of association between age & preferred type of chaperone	30
Table 14. Effect of doctors gender on intimate examination	31
Table 15. Scale of discomfort of vaginal examination	32

LIST OF FIGURES

Figure 1. Bar chart showing opinion on most intimate examination	24
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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

1.1 BACKGROUND

Even at its scientific best, medicine is always a social act.¹ Obstetrics and gynaecology differs from other specialties in a number of ways. Apart from being a combination of medical and surgical specialty, it has a high psychosocial component.² The majority of our patients are fit and well women who by nature are sensitive and emotional.² Secondly, most obstetric and gynaecological consultation culminates in a vaginal examination, which is intrusive and intimate.² Intimate examination, especially when it is carried out by a physician of the opposite sex, can be embarrassing. It is partly for this reason that physicians in many developed countries have long been advised to have a third party (chaperone) present during certain parts of a physical examination. The rate of medical chaperone use varies among countries. Higher utilisation rates are reported from the United States of America (USA) and Canada compared with the United Kingdom (UK).³ In South Africa, the use of a chaperone is not included in the Health Professions Council of South Africa's (HPCSA) guideline on ethics.⁴ What is common is the presence of an interpreter who is mostly a female professional nurse or student nurse. The presence of a third party, be it interpreter or chaperone, may violate the principle of confidentiality and privacy, which are key components of the patients' rights charter in South Africa. This is more so if it occurs without the patient's permission. According to the Royal College of Obstetricians and Gynecologist (RCOG):

“The presence of a chaperone may intrude in a confiding doctor-patient relationship and may lower a doctor's acuity in detecting non-verbal signs of distress from the patient. Some patients' level of embarrassment may increase in proportion to the number of individuals present during an examination. It is acceptable for a doctor to perform an intimate examination without a chaperone if the patient and doctor agree”.⁵

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Sexual Misconduct states, “The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated irrespective of the physician's gender.”⁶ Family members should not be used as chaperones unless specifically

requested by the patient and then only in the presence of an additional chaperone who is not a family member.⁶ There are controversies associated with the above statement. For example some physicians feel that personnel costs and time constraints make the presence of a chaperone impractical for each and every physical that includes a breast and pelvic examination.⁶

1.2 WHAT IS KNOWN SO FAR?

An intimate examination is a physical examination for medical purposes that include the examination of female breasts, the genitalia, or the rectum of a patient.⁷ Such examinations can cause patients stress or embarrassment.⁷ Human concerns against exposure of the private parts is a natural instinct and it is not surprising to note that vaginal examinations can trigger feelings of fear, shame, guilt, exposure and powerlessness.⁸ In the (UK), the General Medical Council (GMC) noted that intimate examinations can be embarrassing or distressing for patients.⁹ Whenever a doctor examines a patient he or she should be sensitive to what the patient may perceive as intimate.⁹ Wherever possible, the doctor should offer the patient the security of having an impartial observer (a chaperone) present during an intimate examination. This applies whether or not the doctor is the same gender as the patient. Women generally prefer female doctors^{10, 8} and this finding is not surprising because they can identify with the doctor and expect empathy for their problem. The tendency to prefer female physician is prevalent in Islamic or Asian society. A survey in a multi-cultural location in USA showed that a female provider was preferred by 56% of Protestants, 58% of Catholics, and 58% of Jews and by 74% of Hindus and 89% of Muslims ($p = 0.02$).¹¹ Paradoxically, the field of obstetrics and gynaecology is still dominated by males. Gender differences can be overcome in a good doctor-patient relationship where excellent principles of good communication care and respect for human dignity are practised. Doctors also have their own anxieties with regard to pelvic examination.¹⁰ In Scotland, not infrequently doctors use the view that “women don’t like pelvic examinations” as a justification for not doing them.¹⁰ There are instances where general practitioners had been treating women with chronic vaginal discharge only to be discovered later that such women had advanced cervical cancer.

1.3 WHAT IS THE IMPORTANCE OF THE STUDY?

Most of the studies on this topic have been carried out in developed countries⁸ and it is important to describe and compare our patients’ attitudes to those of their counterparts abroad. The few available local studies are more of physicians’ attitude to chaperone and it is still not clear what patients’ attitude are. Every nation is peculiar, and in South Africa

more than 80% of medical interactions take place across linguistic and cultural barriers. Many of these interactions are mediated by the presence of a third party (interpreter).¹²

It is currently believed that the number of litigations against doctors especially in obstetrics and gynaecology is increasing in South Africa. At the level of the HPCSA, complaints of sexual impropriety against health care practitioners are escalating. In the context of public hospitals in South Africa, the doctor-patient ratio is very low and this creates serious constraints to the development of an excellent doctor-patient relationship, which may be necessary in overcoming gender difference issues on intimate examination. In a large number of units the number of patients is high and vaginal examinations may be performed hurriedly with a focus on identifying and addressing pathology. However, the psychosocial aspect of the examination, which is paramount, may be neglected. Of note is that during 9 months of antenatal care (ANC) in a public hospital, a patient is often seen by different doctors at each antenatal care visit and this may adversely affect the development of trust in the doctor-patient relationship. Therefore, in the context of the public regional hospital, understanding how patients feel about a vaginal examination and a chaperone may modify how doctors approach patients, with a view to increasing patients' satisfaction.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to survey the attitude of patients attending King Edward VIII Hospital towards vaginal examination, the presence of a chaperone and the examining doctor's gender.

1.5 SCOPE OF THE STUDY

This was a descriptive cross-sectional survey. Chapter Two is an overview of relevant studies, guidelines and events on this topic. Chapter Three outlines materials and methods used for the study. Chapter Four sets out the results of the survey. Chapter Five comprises the discussion, a statement of weaknesses and strengths, a conclusion and recommendations.

LITERATURE REVIEW

A literature search was done online via the website of the University of KwaZulu-Natal. Online library databases like MEDLINE, SCIENCE DIRECT, OVID MD and GOOGLE SCHOLAR were accessed by clicking on electronic resources. Also www.google.com was used as a search engine.

KEY WORDS: Use of chaperone, patient-physician relationship, intimate examinations, vaginal examinations.

DEFINITION, HISTORICAL & ETHICO-LEGAL PERSPECTIVES

From the mid-1990s onward, the UK saw a series of medical scandals that resulted in a number of major official public inquiries and reports that were published over a period of five years beginning in 2000.¹³ For example, Dr Rodney Ledward a consultant gynaecologist was struck off by the GMC in 1998 for professional misconduct involving numerous instances of unprofessional behaviour.¹³ Dr Clifford Ayling was convicted in 2000 of 12 counts of indecent assault on women he had treated as a general practitioner (GP) and gynaecologist.¹³ These led many hospital trusts to develop chaperone policies.¹³ The word “chaperone” derives from the French word *chaperon* meaning “hood” and later a kind of hat. The term was first borrowed into English in the 1700s and came to refer to an “escort,” commonly an older woman who accompanied a young, unmarried woman in public to provide protection. While the use of these social chaperones now seems quaint and has fallen out of practice, the use of medical chaperones has never been more hotly debated owing, of course, to the increasingly consumerist and litigious nature of healthcare in the 21st century.¹⁴ According to the RCOG, vaginal speculum examination and bimanual palpation of the female internal genitalia are among the most intimate and potentially embarrassing examinations carried out in clinical medicine.⁵ In the light of the above, the GMC felt that vaginal examination should not be considered as an automatic and inevitable part of every single gynaecological consultation.⁹ However the management of many gynaecological problems is based on competent pelvic examination proceeded by an explanation of its purpose and followed by effective communication about its finding.⁵ The basic principles of respect, privacy, explanation and consent should be a part of every gynaecological examination.⁵ The GMC recommends that all patients undergoing such an examination be offered a chaperone, which may be a friend or relative.⁵ The American College of Obstetricians and Gynaecologist is against use of relatives as chaperone and

states that If a chaperone is an employee of the practice, the physician must establish clear rules about respect for privacy and confidentiality.⁶ The GMC guideline addresses comfort and protection of patients, whilst also serving a secondary role to protect doctors from false allegations.⁹ Practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. Health care practitioners hold information about patients that is private and sensitive. While it may be argued that provision of chaperones demonstrates an attention to the patients' well-being, a respect for their concerns and an understanding of their vulnerability, there is a concern that patient privacy and confidentiality may be compromised by the presence of a third party.¹⁵ Some physicians contend that the presence of a third party may only serve to heighten the feelings of susceptibility and embarrassment on the part of the patient.¹⁵ A shy patient may feel even more inhibited about revealing personal and medically important information.¹⁵ In a well-established patient-physician alliance grounded in trust, the use of chaperones may be seen by both parties as unnecessary and cumbersome, and may indeed be a moot issue.¹⁵ In the UK, most problems and litigation arise from unnecessary examinations rather than unchaperoned ones.²

PATIENTS ATTITUDE TO CHAPERONE USE – EFFECT OF SEX AND AGE.

In a study of male and female adults and teenagers in a general practice setting in the USA, Penn and Bourguet found that the majority of patients, of either sex and of all ages, did not express a strong opinion on the presence of a chaperone.¹⁶ However, substantial proportions of adult women (29%) and female teenagers (46%) preferred that a chaperone be present during a breast, pelvic or rectal examination by a male physician; 36% of adult women and 63% of female teenagers wanted a chaperone present during a first examination of these regions.¹⁶ Adults of both sex thought that the nurse would be the best chaperone, whereas teenagers ranked a parent first and the nurse second. Patients indicated that they felt comfortable asking for a chaperone.¹⁶ Ong and colleagues surveyed all male patients attending a urology outpatient clinic over a 3-month period and out of 315 evaluable patients, 270 (85.7%) patients did not wish a chaperone present for their own intimate examinations and 45(14.3%) patients preferred a chaperone.¹⁷ Also in that study only 3% of urologists offered a chaperone to all male patients.¹⁷ When attitude of males and females are compared, it appears that males are generally more comfortable without a chaperone and this comfort increases with age, irrespective of sex. In Melbourne Sexual Health Centre, Teague and colleagues studied the attitudes of male and female patients to

the use of chaperones during genital examination within a sexually transmitted disease clinic and the result was that among male patients, only 7.3% and 6.0% expressed a desire for a chaperone when being examined by a male and female practitioner, respectively. Among female patients, 26.8% desired a chaperone if they were going to be examined by a male practitioner, compared with 5.5% for a female practitioner ($P < 0.001$).¹⁸ Views about pelvic examinations and chaperones were sought from 1 000 women attending a family planning clinic in the UK and it was observed that older women and women who had been pregnant were less likely to feel negative towards pelvic examination and both these demographic variables were independently significant.¹⁰ Most women expressed a clear preference for a female doctor and the majority of the women did not want a chaperone present when they were being examined by a female doctor.¹⁰

Yanikkerem and colleagues described women's attitudes and expectations regarding gynaecological examination by surveying 433 women who applied to a gynaecological outpatient clinic in Turkey. More than one-half of the women felt anxious or worried about their health situation during the pelvic examination (54.8%) and 41.8% of women said that they were embarrassed about having to undress. Under 50% (45.5%) of women reported that they would prefer a female doctor; only 4.2% reported that they would prefer a male doctor in their obstetric and gynaecological care; and the remaining women (49.9%) expressed no preference.¹⁹ In another similar study in Poland, the most unpleasant moment during a woman's visit to the gynaecologist is time spent in the gynaecological chair (47%) and preparation for the examination (30%), whereas the least embarrassing moment is the gynaecological examination itself (21%). However, the most embarrassing moment of the examination is vaginal examination (40%), rectal examination (33%), colposcopy (27%), and breast examination (2%). All the women stated that gynaecological examination was necessary; with 40% of them having examinations once every 12 months, 32% once every 6 months, 9% once every 24 months and 19% even more seldom.²⁰ In South eastern Nigeria, Ouj and colleagues studied the perceptions of 486 women who were attending a gynaecological clinic and over 25% of the women felt embarrassed at a vaginal examination and 37.2% found it a bit painful or felt discomfort. In spite of the discomfort, 73.7% believed vaginal examination was necessary and over 95% indicated readiness to undergo such examination in future if necessary.²¹

HEALTH-CARE PROVIDERS' ATTITUDES TO CHAPERONE USE

In the UK, attitudes and behaviour of medical professionals are often at odds with the recommendations of the royal colleges and other bodies regarding the universal use of

chaperones for intimate examinations. Use of chaperones by male doctors since the 1980s and 1990s has substantially increased, but use by female doctors remains low.²² In a cross-sectional survey of internal medicine residents in the USA, Ehrental and colleagues found that, when examining female patients, male residents overall were very likely to use a chaperone during a pelvic exam, but less likely for the breast exam and rectal exam. For the female resident, there was a significantly lower likelihood of using chaperones during the pelvic, breast, or rectal exams. There was a much lower rate of chaperone use during the sensitive portions of the male physical examination compared with the female examination, with somewhat higher use by female residents.²³ Even in strong Islamic culture, Al Gaai and Hammami surveyed physicians in a tertiary care hospital in Saudi Arabia regarding their practice and perception of medical chaperone use and they found that medical chaperoning (MC) is underutilised, especially among female physicians.³ One hundred and twenty-six (67.7%) of the physicians perceived MC as a protection for physicians against allegations of misconduct, and 122 (65.6%) perceived MC as a protection for patients against abuse.³

REGIONAL VARIATIONS ON THE TOPIC OF VAGINAL EXAMINATION, CHAPERONE AND PHYSICIANS GENDER.

Comparative analysis of surveys in various parts of the world shows that culture and religion have effect on women's preferences for female physicians. In a study in United Arab Emirates, 86.4% of participant's preferred female physicians and reasons for female preference was privacy during intimate examination (89.1%) or counselling (68.8%), religious beliefs (74.3%), and cultural traditions (45.3%).²⁴ In a study of 500 women in Syria, Bashour and Abdulsalam showed that most women preferred to be attended by a female doctor during delivery.²⁵ In western societies this huge preference for female physicians is not observed. A survey of 264 patients in 13 obstetrics and gynaecological waiting rooms in Connecticut, USA showed that the majority of patients (66.6%) had no gender bias when selecting an obstetrician-gynaecologist, and an even larger majority (198, 80.8%) felt that physician gender does not influence quality of care.²⁶ In a similar study in Tel Aviv, Israel, Piper and colleagues showed that most women (60.3%) did not consider the gender of gynaecologist or obstetrician when choosing a gynaecologist or an obstetrician rather major determinants in their choice of a gynaecologist or an obstetrician included professionalism (98.9%), courtesy (96.6%) and board certification (92%).²⁷ In another study, four hundred and nine women were asked whether they would prefer a woman gynaecologist, 33.9 per cent

said yes; 19.3 per cent said no while 36.2 per cent were indifferent.²⁸ A survey in a multicultural location in USA showed that a female provider was preferred by 56% of Protestants, 58% of Catholics, and 58% of Jews and by 74% of Hindus and 89% of Muslims ($p = 0.02$).¹¹ Said and Wielandt studied the attitude of Arabic speaking women to gynaecological examinations in Denmark and found that there was a connection between the refusal of gynaecological examination by a male doctor and the length of time the women had lived in Denmark.²⁹ Most women who permitted examination by a male doctor had lived in Denmark longer than those who refused the same gynaecological examination.²⁹ In Japan, pelvic examination requires a curtain that hangs down from the ceiling at waist level and this blocks the woman and physician from seeing each other.³⁰ The U.S. style of examination is characterised by use of private rooms and a sheet to cover the perineum. Fetters et al interviewed 19 Japanese women in Michigan and found that most of the participants did not support using a curtain during pelvic examinations in the U.S., as practiced in Japan, and some were critical of the Japanese practice.³¹ In the UK, Australia, and New Zealand speculum examinations are done without stirrups with the woman in the dorsal or lateral positions, in the United States medical providers are trained to do gynaecological examinations with women in the dorsal lithotomy position in stirrups.³²

FACTORS AFFECTING DISCOMFORT OF VAGINAL EXAMINATION

In a randomised trial, Seehusen et al found that women undergoing examination without stirrups had a reduction in mean sense of vulnerability from 23.6 to 13.1 (95% confidence interval of the difference - 16.6 to - 4.4).³² Mean physical discomfort was reduced from 30.4 to 17.2 (- 19.7 to - 6.8). There was no significant reduction in sense of loss of control.³² In a Swedish study that studied factors associated with strong discomfort during vaginal examinations (SD/VE), Swahnberg et al concluded that women who unexpectedly react with SD/VE are more likely to have a background of abuse, and may even run a risk of feeling re-traumatised during the VE.³³ In a systematic review of 6 trials, Galaal and colleagues found that playing music during colposcopy appears to reduce anxiety.³⁴ Keskin et al via a randomised trial evaluated the effectiveness of lidocaine-prilocaine (EMLA 5%) cream application to genital mucosa for reducing pain or discomfort associated with speculum examination in postmenopausal women and the conclusion was that topical application of EMLA 5% cream on genital mucosa of postmenopausal women before vaginal examination significantly reduces pain associated with speculum application.³⁵

Good patient centred communication has been shown to allay anxiety and improve patient satisfaction. Therefore it may have a discomfort reducing effect on vaginal examination. A systematic review of studies in the last 10 years suggest that preference for a female gynecologist-obstetrician might be explained by a more patient-centered communication style used by female gynecologists-obstetricians.³⁶ Moettus et al studied if the examiner's gender affects women's perceived pain and embarrassment during emergency department pelvic examination, and the conclusion was that emergency department patients perceive pelvic examination by a male examiner as more embarrassing but not more painful than examination by a woman.³⁷ A prospective randomised study suggest that patients who did their first digital rectal examination after an educational clarification on the issue reported significantly less discomfort than those who were not exposed to educational clarification.³⁸

INTIMATE EXAMINATION, CHAPERONE AND SEXUAL MISCONDUCT: THE SOUTH AFRICAN PERSPECTIVE.

In an article in the South African Medical Journal in 2011, Ames Dhai and colleagues noted that the number of sexual misconduct cases reaching formal enquiry at the HPCSA had increased.³⁹ In late 2012, a Gauteng woman laid a complaint with HPCSA after she went to see a doctor about a sore throat and was given a vaginal examination instead. Further investigation revealed that the doctor in question was not a doctor but a Congolese man standing for a fellow Congolese doctor.⁴⁰ Out of several cases in 2012, the HPCSA posted on its website, a case of one Dr DA Merrell who was found guilty of performing a trans-vaginal ultrasound and digital vaginal examination on a patient who was a virgin and who informed him that she was not comfortable with an internal examination.⁴¹ The proponents of the attendance of a MC may believe that this may not have happened had there been a chaperone.³⁹ However; the core issue was neither intimate examination nor absence of a chaperone but a violation of a patients' right of consent. A thorough look at the cases on the HPCSA website clearly demonstrates that most cases relate to issues of fraudulent claims, use of unqualified locum doctors and not about sexual misconduct.⁴² Despite the strong Western influence on South Africa, it is unclear why the HPCSA does not yet have a policy on chaperoning.⁴ It is plausible to reason that unlike opinion of some bioethics experts⁴³, sexual misconduct among doctors is probably not too much at present. In a recent local study to ascertain how a group of medical practitioners, especially gynaecologists, felt about the presence of chaperones during the consultation and intimate examination of patients, Guidoizzi and colleagues established that medical practitioners, or

at least gynaecologists, support the development and production of ethical guidelines on the use of chaperones.⁴⁴ At the moment, there is no South African study that surveyed patients' opinions on both vaginal examination and chaperoning. Considering that South Africa is a rights-based constitutional democracy where people's interest comes first (Bathopele) it is probably premature to call on the HPCSA to recommend the use of chaperones based on opinion of doctors only. There is an adage that says that the customer is always right and the customer in this case is the patient. Therefore, there is a need to know what patients feel about chaperone use during a vaginal examination.

MEDICAL INTERPRETATION IN DOCTOR-PATIENT RELATIONSHIP

Medical interpreting refers specifically to the process of facilitating face-to-face communication between client and practitioner in the clinical setting. According to the University of Arizona's National Centre for Interpretation, medical interpretation is interpreting that takes place in medical / healthcare settings of any sort, including doctor's offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations.⁴⁵ Medical interpretation is inevitable in a situation where a language barrier exist between the doctor and the patient. Confidentiality and privacy are at stake and the clinician must not forget to seek permission from the patient.

In summary, the most important factor for the patient is the attitude of the doctor; the patient views the offer of a chaperone as a sign of respect by the doctor.⁴⁶ The development of shared decision making within a consultation involving an intimate examination should be seen as more important than a rigid approach towards using a chaperone.⁴⁶ If one is to reason which party in the doctor-patient relationship is more important with regard to issues of vaginal examination and chaperone, the patient's views will be considered first in a constitutional democracy like South Africa.

CHAPTER TWO

METHODOLOGY

RESEARCH QUESTION: What is the attitude of patients towards vaginal examination and how is the attitude affected by the presence of a chaperone as well as the doctor's gender?

OBJECTIVE

1. To describe and relate demographic and reproductive characteristics of women to perceptions on vaginal examination.
2. To examine patients' opinions on the presence of a chaperone during vaginal examination.
3. To examine the effect of a doctor's gender on the patient's views on vaginal examination.
4. To examine which aspects of physical examination are the most intimate.

METHODS

STUDY DESIGN

The study design was a descriptive cross-sectional study.

STUDY SETTING

The study setting was the obstetrics and gynaecology unit of King Edward VIII Hospital. King Edward VIII hospital is a teaching hospital for the University of KwaZulu-Natal's Nelson R Mandela School of Medicine and it provides regional and tertiary services to major parts of KwaZulu-Natal and the Eastern Cape.⁴⁷ The hospital is a 922 bed hospital with plus or minus 360,000 out patients.⁴⁷ The obstetrics and gynaecology unit carries out approximately 7000 deliveries per annum and has a total of about 5000 new patient visits to both the ante-natal and the gynaecological clinic per annum. The hospital is located in ward 33 of eThekweni municipality.

PARTICIPANT SELECTION

STUDY POPULATION

The study population was composed of women that were seen at King Edward VIII Hospital, Durban, for either pregnancy-related or gynaecological complaints between June 2012 and October 2012. Questionnaires were made available to every woman in the

various sections of the obstetrics and gynaecological unit (i.e. clinic, wards, and admission rooms). The exclusion criteria were potential participants who refused to give consent for the study, as well as patients who were in painful or respiratory distress – e.g. patients in labour.

SAMPLE SIZE

Purpose sampling was carried out until 400 eligible patients were sampled (giving 5% margin of error). Eligibility was restricted to patients who had not filled the questionnaire before. Therefore, 160 questionnaires were discarded because they were completed by participants who had filled in the questionnaire before.

MEASUREMENTS

METHOD OF DATA COLLECTION

Data was collected on a semi-structured questionnaire that was designed for women visiting King Edward VIII Hospital for obstetrics and gynaecological reasons. In order to design a valid instrument for measurement, firstly well-defined goals of the study were set out and questions that directly addressed these goals were designed through a thorough search for a pre-existing questionnaire from the literature. And in order to ensure face validity of the questionnaire, senior academics and colleagues were asked to review the questions with a view to acquiring the best possible ways of addressing the goals of the study. These senior academics and colleagues gave their opinion about whether the questions were essential, useful or irrelevant to measuring the construct under study. Their inputs were analysed and the questionnaire modified to improve the rational validity. The instrument's reliability was obtained by pilot testing the questionnaires on 10 patients and comparing the result with the study based on findings from the literature review. The final questionnaire included demographic data like age, ethnic group and gravidity, questions relating to feelings towards vaginal examination, preferences about the gender of the examining doctor as well as the presence of a chaperone. Adjustments made by various institutional committees on data collection strategy were adopted.

DATA ANALYSIS

Data collected were analysed with SPSS version 19. The analysis that was undertaken was descriptive, providing summary statistics (frequencies, percentages etc.). Pearson Chi square test was used to determine if there were significant associations between variables.

ETHICAL CONSIDERATION

Permission was obtained from the postgraduate education committee of University of KwaZulu-Natal (UKZN), the Biomedical research ethics committee of UKZN, medical manager of King Edward Hospital, and research participants. All information obtained was held in confidence and no name was requested in the questionnaire.

CHAPTER THREE

RESULTS

After the necessary institutional review-committee approvals had been obtained, 400 patients were targeted. Five-hundred-and-sixty questionnaires were completed; however, 160 questionnaires were excluded because they were filled by participants who had filled the questionnaire before. Participants who had previously filled the questionnaire were detected through a question that asked whether they had filled the questionnaire before. Those who answered 'yes' were excluded to avoid bias. Not all women answered every question. The following tables/figure are a descriptive summary of their responses.

3.1 Characteristics of the study population

Table 1: Age groups

Age groups	Frequency	Percent
less than or equal to 19	60	15.0
20 - 35 years	272	68.0
Above 35 years	68	17.0
Total	400	100.0

Two-hundred-and-seventy-two women (68%) were aged between 20-35 years, representing the most common age group seen at King Edward VIII hospital for gynaecological or pregnancy related reasons. The mean age of the sample was 28.03 years (range of 13 to 75 years) while the 2 most common ages of these women were 24 (28%) and 30 years (28%).

Table 2: Other baseline characteristics

Characteristics	Frequency	Percent = % when n = 400 (valid percent) ^{***}
Reason for visiting KEH.		
• ANC	265	66.3 (80.5)
• Gynae care	64	16.0 (19.5)
• Unspecified	71	17.8
Previous vaginal examination		

• Yes, has had VE	230	57.5(59.9)
• No, never had VE	154	38.5 (40.1)
Educational background		
• Less than grade 12	140	35 (36.1)
• Grade 12	115	28.7 (29.6)
• >grade 12 with further studies	133	33.3 (34.3)
Reproductive characteristics		
• 1 st pregnancy or has had 1 pregnancy	143	35.8 (38.9)
• 2 nd pregnancy or has had 2 pregnancies	110	27.5 (29.9)
• 3 rd preg or has had 3 pregnancies	71	17.8 (19.3)
• 4 th preg or has had 4 pregnancies	38	9.5 (10.3)
• ≥5 th preg or has had 5 pregnancies	6	1.5 (1.6)
Ethnic background		
• Black	339	84.8 (84.8)
• Indian	26	6.5 (6.5)
• White	21	5.3 (5.3)
• Other(coloured)	14	3.5 (3.5)
Marital status		
• Married	86	21.5 (21.6)
• Divorced	9	2.3 (2.3)
• Single	238	59.5 (59.6)
• Unmarried but lives with boyfriend	53	13.3 (13.3)
• Other (specify)	13	3.3 (3.3)

*** Valid percent = percentage after exclusion of missing data.

Of the 400 women that were interviewed, 265 (66.3%) visited King Edward VIII hospital for pregnancy related reasons, 64 (16%) came for gynaecological reasons while 71 (17.8%) did not disclose whether they were there for ANC or gynaecological care. Two-hundred-and-thirty women (59.9%) had had a vaginal examination previously; 154 had never had a vaginal examination; and a few (4%) did not disclose whether they had

had a vaginal examination or not. Those who had not had a vaginal examination were mostly women in their first pregnancies, as well as teenagers.

In terms of educational background, 140 women (35%) had not reached grade 12; 115 (28.7%) had reached grade 12; while 27.8% had studied further than grade 12. What “had studied further” means is not clear.

Reproductive background was as above. Forty-four women (11%) were in their 4th pregnancy or had had ≥ 4 pregnancies previously.

Marriage was unpopular, as only 86 (21.5%) women were married. This is supported by the finding that only very few 2.3% were divorced and this is another category that had previous marriage experience.

As expected, 84% of the women were of African origin and they were followed by Indians (at only 6.5%) and whites (5.3%).

3.2 Opinion on most intimate examination

Figure 1: Most intimate examination

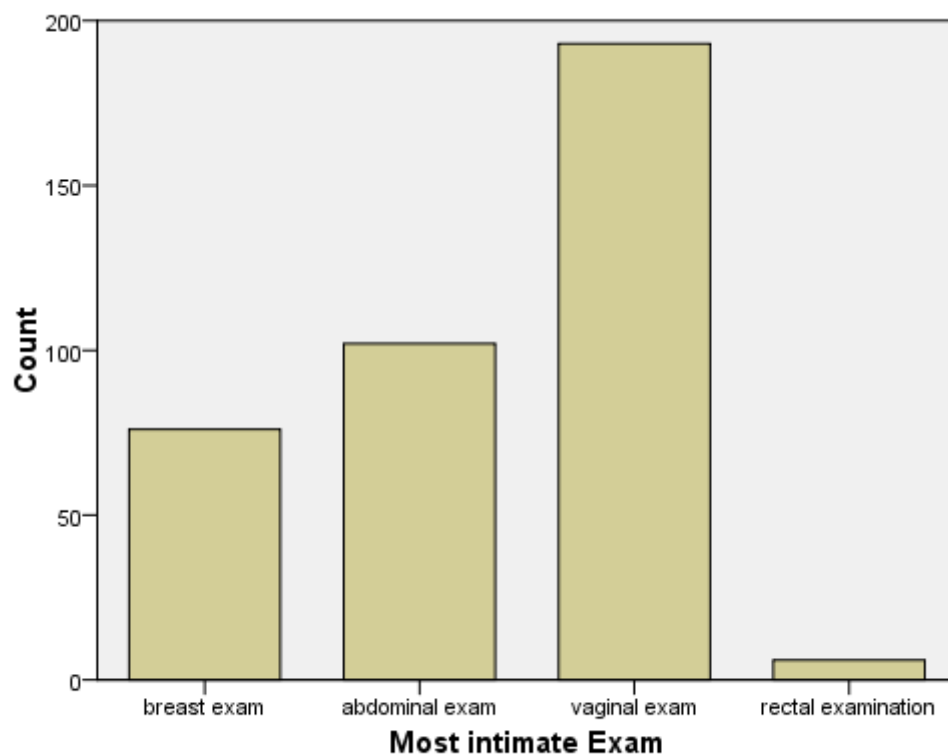


Table 3: Most intimate examination

Type of exam	Frequency	%	Valid %
Breast exam	76	19.0	20.2
Abdominal exam	102	25.5	27.1
Vaginal exam	193	48.3	51.2
Rectal exam	6	1.5	1.6
Unspecified	23	5.8	-
Total	400	100.0	100.0

Out of 400 women, 377 (94.3%) gave their opinion on what they think is the most intimate examination a woman can undergo. One hundred and ninety-three (48.3%) were of the opinion that vaginal examination is the most intimate examination. The next most intimate examination was abdominal examination (25.5%), followed by breast examination (19.0%). A rectal examination was thought of as the least most intimate examination (1.5%). In order to assess if there is any association between variables and opinion on the most intimate examination, two-way (contingency) table was generated as shown in table 4 below.

Table 4: Age groups and most intimate examination

	Most Intimate examination				
	Breast exam	Abdominal exam	Vaginal examination	Rectal examination	Total
≤19 years	19	16	23	0	58
20-35 years	49	72	132	5	258
Above 35 years	8	14	38	1	61
Total	76	102	193	6	377

Table 5: Chi-Square test of association between age & most intimate examination.

	Value	Df	Asymp Sig (2- sided)
Pearson Chi-square	10.794	6	0.095
Likelihood ratio	11.240	6	0.081
Linear by linear association	9.239	1	0.002

All age groups were of the opinion that vaginal examination is the most intimate examination a woman can have. Age groups did not significantly influence opinion on the most intimate examination, as P value is 0.095.

Educational and reproductive background did not significantly influence opinion on the most intimate examination because both had Pearson chi-square test greater than 0.05.

Table 6 is a two way contingency table to assess if there is any association between previous vaginal examination and most intimate examination.

Table 6: Previous vaginal exam and most intimate examination

	Most Intimate Examination				
	Breast exam	Abdominal exam	Vaginal exam	Rectal exam	Total
Previously had VE	34	56	128	3	221
Never had VE before	39	45	55	3	142
Total	73	101	183	6	363

Table 7: Chi-square test of association between previous VE and most intimate exam

	Value	df	Asymp Sig (2-sided)
Pearson Chi-square	14.137	3	0.003
Likelihood ratio	14.158	3	0.003
Linear by linear association	11.594	1	0.002

Just under 58% (57.9%) of those who had been previously examined vaginally were of the opinion that a vaginal examination is the most intimate examination. Just under 39% (38.7%) of women who had never had a vaginal examination also rated a vaginal examination as the most intimate examination. With a Pearson chi-square of 0.003, those who had experience of a vaginal examination were more likely to consider it the most intimate examination than those who were yet to have experience of a vaginal examination.

African women were more likely to say that a vaginal examination was the most intimate examination (p value = 0.005) but this is likely to be due to the fact that 84.3% of women were of African origin, which skewed the statistics in favour of African women.

When asked to respond to the statement that says “vaginal examination causes discomfort”, 188 (47%) out of 400 women responded to the question as follows; 3.0% strongly disagreed, 15.0% disagreed, 23.3% agreed while 5.8% strongly agreed. Because of the low response to this statement, Pearson chi-square test was not used to determine if there is any significant association between variables. However, if one excludes missing data and looks at valid per cent, 61.7% either agree or strongly agree that vaginal examination causes discomfort (see Table 8 below).

Table 8: Response to statement – “VE causes discomfort”

Response	Frequency	Percent	Valid %
Strongly disagree	12	3.0	6.4
Disagree	60	15.0	31.9
Agree	93	23.3	49.5
Strongly agree	23	5.8	12.2
Unspecified(missing data)	212	53	NA
Total	400	100.0	100.0

3.3 Opinion on presence of chaperone as well as doctor’s gender

On the issue of a chaperone, a statement was made as follows; “It is better to have another female (chaperone) during an examination if the doctor is a male”. Below is the response.

Table 9: Table of response –“Better to have a chaperone present during exam”

Response	Frequency	Percent	Valid %
Strongly disagree	7	1.8	4.3
Disagree	42	10.5	25.8
Agree	87	21.8	53.4
Strongly agree	27	6.8	16.6
Unspecified (missing data)	237	59.3	NA
Total	400	100.0	100.0

One-hundred-and-sixty-three (40%) women responded to the statement set out immediately above Table 9. Seventy per cent of respondent either agreed or strongly agreed that it is better to have a chaperone during an examination if the doctor is male. Even though the numbers were low, it appears that the majority of the respondent preferred a chaperone to be present during a vaginal examination. It is unclear why many

people did not respond to the question; however, part of the unspecified or missing data included participants whose response were not recorded in the SPSS software because they ticked more than one response. Of note is that the question was not specific to any kind of examination; therefore, participants were also asked to respond with ‘yes’ or ‘no’ to the statement: “There is no need for a chaperone during vaginal examination”. And here is their response.

Table 10: Response to statement “there is no need for a chaperone during vaginal exam”.

	Frequency	Percent	Valid %
Yes, there is no need.	168	42.0	54.5
No, there is a need.	139	34.8	45.1
Unspecified	93	23.3	-
Total	400	100.0	100

Out of 400 women, three hundred and seven (76.8%) responded and 54.5% of the respondents said there was no need for a chaperone during a vaginal examination while 45.1% said there was a need. Therefore, patients’ opinion on vaginal examination was equivocal.

Table 11: Participants’ preferred type of chaperone

Choice of Chaperone	Frequency	Percent	Valid %
Partner	143	35.8	37.0
Mum	54	13.5	14.0
Friend	3	0.8	0.8
Nurse	168	42.0	43.5
Other (specify)	18	4.5	4.7

Missing data	14	3.5	NA
Total	400	100	100

Participants were informed that a chaperone is a neutral observer during a doctor-patient consultation and it could be a relative, a nurse or a friend. They were then asked to choose their preferred kind of chaperone. As shown in Table 10, 386 women responded. One-hundred and-sixty-eight (42%) of these preferred a nurse; 143 (35.8%) preferred their partners; 54 (13.5%) preferred their mum and three preferred a friend. There was little missing data (3.5%).

Table 12: Age and preferred type of chaperone

	Preferred type of chaperone					
Age	Partner	Mum	Friend	Nurse	Other(specify)	Total
≤19 years – count (% within age group)	19 (31.7%)	21 (35.0%)	1 (1.7%)	18 (30.0%)	1 (1.7%)	60 (100.0%)
20-35 years – count (% within age group)	103 (39.2%)	32 (12.2%)	2 (0.8%)	113 (43.0%)	13 (4.9%)	263 (100.0%)
≥35 years – count (% within age group)	21 (33.3%)	1 (1.6%)	0 (0.0%)	37 (58.7%)	4 (6.3%)	63 (100.0%)
Total	143 (37.0%)	54 (14.0%)	3 (0.8%)	168 (43.5%)	18 (4.7%)	386 (100.0%)

Table 13: Chi-square test of association between age and preferred type of chaperone

	Value	Df	Asymp. Sig. (2 sided)
Pearson Chi-square	36.077 ^a	8	0.000
Likelihood Ratio	35.509	8	0.000
Linear-by-linear association	6.769	1	0.009
N of valid cases	386		

It appears that there is an association between age and choice of type of chaperone. Women who were 19 years or less were more likely to choose their mum while older women (20 years and above) were more likely to choose their partner or nurse as chaperone.

Table 14: Effect of doctor's gender on intimate examination

With respect to most intimate examination, my feeling is the same whether the doctor is a male or female.	Frequency	Percent	Valid %
Yes	253	63.2	73.8
No	90	22.5	26.2
Unspecified	57	14.2	-
Total	400	100.0	100.0

Out of 400 women, 343 (85.8%) responded with either 'yes' or 'no' to a structured statement that assessed whether their feelings about intimate examinations is influenced by the gender of the examining doctor. The majority of the respondents (73.8%) did not think that what they consider to be the most intimate examination is affected by the gender of the doctor. Fifty-seven (14.2%) of the women did not respond to the statement.

Finally, we assessed how the discomfort of a vaginal examination is graded on a scale of 1 to 5 where 1 is mild discomfort, 2 is between mild and moderate discomfort, 3 is moderate discomfort, 4 is between moderate and severe discomfort and 5 is severe discomfort. Table 15 below is the response.

Table 15: Scale of discomfort of vaginal examination

	Frequency	Percent	Valid %
Mild discomfort(1)	87	21.8	27.1
B/w mild & moderate	58	14.5	18.1

discomfort (2)			
Moderate discomfort (3)	78	19.5	24.3%
B/W moderate & severe discomfort (4)	37	9.3	11.5
Severe discomfort (5)	61	15.3	19.0
Unspecified(missing data)	79	19.8	-
Total	400	100.0	100.0

There is no outright majority in the grading of discomfort associated with vaginal examination and this shows that the feeling cannot be quantified.

CHAPTER FOUR

DISCUSSION

In the previous chapter the study results were displayed through a descriptive summary. In this chapter, a discussion of the results of the study will be the focus. Strengths, weaknesses and the meaning of the study will also be discussed. The chapter will end with conclusions and recommendations.

This study showed that the most common age group of women seen at King Edward VIII hospital for obstetric and gynaecological reasons is between 20 and 35 years (68%). This is not surprising because this age group is wide and is the peak of a woman's reproductive life. The majority of the women came to the hospital for pregnancy-related reasons.

It is widely known that women of low socio-economic status are prevalent in a public hospital like King Edward VIII Hospital. Therefore, the majority of respondent (65.7%) were women whose educational level was either below grade 12 or at grade 12. The majority of participants were black (84%), which is another parameter that is associated with low socio-economic status in the study region.

The majority of the women who responded to the survey considered vaginal examination (51.2%) as the most intimate examination; abdominal examination as the next most intimate examination (27.1%); followed by breast examination (20.2%) and rectal examination (1.6%). The findings set out above resemble the outcome of a survey in Utah, USA, which showed that women feel less comfortable during the pelvic examination than they do during the breast examination; physical discomfort of the pelvic examination is the reason most frequently cited.⁴⁸ Of all the examinations, rectal examination is one that is least frequently done in obstetrics and gynaecology and it is possible that the study population were not exposed to it previously and that may explain why it was rated the least intimate.

This study failed to demonstrate any influence of age, educational level, and previous number of pregnancies on perceptions of the most intimate examinations. Previous experience of vaginal examination and being a black woman do appear to have an effect on which examination is rated the most intimate. Women who had been previously been examined vaginally were likely to rate vaginal examination the most intimate examination; 57.9% as opposed to 38.7% of women who never had a vaginal examination before ($p = 0.003$). African women were more likely to say that vaginal examination was the most

intimate examination (p value = 0.005) but this is likely due to the fact that 84.3% of women were of African origin, which fact skewed the statistics in favour of African women. The response rate to the statement: “vaginal examination causes discomfort” was 47%, which is lower finding than that of a study that assessed attitudes towards pelvic examination and chaperoning in Scotland; its response rate was 69%.¹⁰ However, in the context of the population that responded, it is clear that the majority (61.7%) either agreed (49.5%) or strongly agreed (12.2%) with the statement that vaginal examination causes discomfort. This appears to be in agreement with the general belief that vaginal examination causes discomfort.^{5, 9, 10} Secondly, 321 women (80.3%) graded the discomfort of vaginal examination on a scale of 1-5 where one is mild discomfort and five is severe discomfort. From this it appears that there is some form of discomfort associated with vaginal examination. It is difficult to quantify this discomfort, as there is no outright majority in the grading (Table 15).

No local guideline exists regarding the use of a chaperone during any form of physical examination and the finding of this study is not robust enough to call for one. Why? When women were asked to respond to the statement “it is better to have a chaperone during examination”, 237 women (59.3%) did not respond. Opportunity to find out why so many participants did not respond to certain questions was lost because the questions were thought to be sensitive and the researcher was advised not to come too close to the participants during data collection. The participants were addressed in groups and the questionnaires were distributed following verbal consent from the participants. Participants were asked to indicate their language of choice “Zulu or English”. The participants on completion of the questionnaire placed them in opaque brown envelopes. The envelopes were collected in batches weekly by the investigator. When significant missing data was noted, a biostatistician was consulted and he advised that nil further could be done. In those that responded, 70% either agreed or strongly agreed that it is better to have a chaperone during examination. When the examination was specified as vaginal examination there was a good response but there is no clear majority, as 54% were in support of a chaperone while 45.1% were against the presence of a chaperone during vaginal examination. This equivocal finding is in line with several surveys that demonstrate variable preferences. Medical practitioners especially private gynaecologists in South Africa are more likely to support use of chaperone.⁴⁴ In a study that looked at perceptions and the use of a chaperone by a Nigerian gynaecologist, 97.6% believed that

chaperone use is necessary during pelvic examination, while 6 (2.4%) thought it unnecessary.⁴⁹ Despite the majority belief that chaperone use is necessary during pelvic examination, only (35.9%) of the male respondents always or often used chaperones.^{48,49} It is important to note that the opinion of the patient is probably superior to the opinion of the practitioner especially in a right based constitutional democracy like South Africa. The researcher could not see a local study that specifically surveyed the opinion of patients on vaginal examination and chaperone. This study unfortunately is not robust enough to say that patients want chaperone or not because of poor response to the question on chaperone. The lesson that has been learnt as result of the method of data collection is stated in our recommendation. However, there is a study that looked at whether patients want a chaperone during anogenital examination, 32% of women wanted a chaperone if being examined by a male; 29% did not.⁵⁰ Also in Dublin, Ireland, a questionnaire-based study demonstrated that most patients (65%) do not wish to have a chaperone during a VE but a small proportion would still request one regardless of the examiner's gender.⁵¹

Over 40% (43.5%) of women, who responded to the question on the preferred kind of chaperone, preferred a nurse to be their chaperone. This response was above the 37% who chose their partner to be present during examination. This means that the issue of having a chaperone during intimate examination is a sensitive one. It is possible that marital status, which reflects a level of intimacy, indirectly influenced this outcome, as only 21.5% of the sample was married while 72.8% were single. The response also showed that nurses have historically and traditionally occupied a position of patient advocate, especially if one considers their often unofficial role of medical interpreter in South Africa, where a huge proportion of doctor-patient interaction takes place across cultural and linguistic barriers. The study also showed that younger women (19 years or less) were more likely to choose their mum over nurse or partner as chaperone. Thirty-five per cent of women who were 19 years or less chose their mum as chaperone, while 31.7% chose their partner and 30% chose a nurse. The findings set out above on the preferred chaperone were similar to results of a study in USA that showed that adults of both sexes thought that the nurse would be the best chaperone, whereas teenagers ranked a parent first and the nurse second.¹⁶

This study did not demonstrate a preference for a female doctor during an intimate examination. The majority of the participants (73.8%) did not think that the most intimate

examination was affected by gender of the doctor. This result differs from that of a study where most women (76%) expressed a clear preference for a female doctor.¹⁰ However, it can be likened to other studies in western countries where the gender of the examining doctor did not matter.^{26, 27} It is possible that the reason for this poor preference for female physician is a result of western influence on South African culture. Another possible reason for the finding is probably because what is important is the attitude of the doctor and not the gender. This is in keeping with opinion of Whitford and colleagues who were of the view that the most important factor for the patient in an intimate examination is the attitude of the doctor.⁴⁶ The development of shared decision making within a consultation involving an intimate examination should be seen as more important than a rigid approach towards using a chaperone.⁴⁶

STRENGTHS AND WEAKNESSES OF THE STUDY

This study has certain limitations that need to be taken into account when considering the contribution the study can make.

Firstly, data in this study was collected quantitatively, even though opinion or perception cannot be easily quantified. The study was therefore limited in its design by not exploring the reasons behind various opinions, as this would require a qualitative methodology.

Secondly, questionnaires were self-administered because some of the questions were considered sensitive by the post graduate committee and the investigator was advised not to be present whilst the participants filled in the questionnaire. The opportunity to seek clarity on the questions was therefore lost. Response rate to key questions would have been improved if the participants were assisted in completing the questionnaire.

Thirdly, there was no standardised questionnaire available. A pilot study and consultation with senior colleagues within the department of obstetrics and gynaecology helped in designing the questionnaire. However, the Pilot study was done prior to the advice from the post graduate committee and therefore this weakness was not identified.

Finally, the question that attempted to investigate the preference of doctor's gender during an intimate examination was ambiguous and, therefore, the finding that women do not have any preference on the sex of the doctor is unreliable and should be studied further.

CONCLUSION

This study suggests that women in their late 20s are visiting King Edward VIII Hospital to access obstetrical and gynaecological services. The majority of these women are African and are of low socio-economic status.

Out of 400 women, 377 (94.3%) gave their opinion on what they think is the most intimate examination a woman can undergo, 193(48.3%) were of the opinion that vaginal examination is the most intimate examination; 25.5% regarded abdominal examination as the most intimate examination; 19.0% felt the most intimate examination to be breast examination; and only 1.5% rated rectal examination as the most intimate. Most women irrespective of their age, educational level, and previous number of pregnancies consider vaginal examination the most intimate examination. Women who have had vaginal examination are more likely to regard vaginal examination as the most intimate examination. Women who have not had vaginal examination are less likely to regard vaginal examination as the most intimate examination. Response to a statement that vaginal examination causes discomfort was low (47%); however, of the respondents, 61.7% agreed or strongly agreed that vaginal examination causes discomfort. A conclusion that vaginal examination causes discomfort cannot be made based on the above findings as most participants (53%) did not respond to the question. 386 (96.7%) women out of 400 responded to the question that sought opinion on preferred type of chaperone, those aged 20 to 35 years, preferred a nurse as their chaperone. Younger women, aged 19 years or less, preferred their mum as a chaperone.

Response to a statement “It is better to have a chaperone present if the doctor is a male” was low (40%); 70% of respondent either agreed or strongly agreed that it is better to have a chaperone during an examination if the doctor is male”. Again a conclusion cannot be made based on the 40% that responded, however because 76.8% (307 out of 400 women) responded to a statement “There is no need for a chaperone during vaginal examination” one can probably infer that women are neither in support of nor against the presence of chaperone as 54.5% said yes to the statement while 45.1% said no.

There is no clear demonstration of preference for a female doctor during intimate examination. This lack of clear preference for female physician requires further investigation, as it is against the expectation. However, it is in line with several surveys in western countries.^{26,27,28}

RECOMMENDATIONS

1. The researcher is of the opinion that other studies should be done in other centres so as to generate more robust local findings. Some of the studies should be qualitative, as perceptions cannot be easily quantified. It will also afford a methodology that is capable of exploring in detail the reasons behind any perception on this topic. Where the study is quantitative, participants should be assisted with completion of data sheet but the assistance should be in such a way that coercion is avoided. The aim of assisting the participants should be to reduce missing data as well as clear any unforeseen ambiguity that may be present in questionnaire.
2. Obstetricians and gynaecologists need to understand that when examining a teenage woman the presence of her mum may assist in allaying anxiety or discomfort associated with intimate examination and the young woman has a right to decline such a chaperone.
3. Vaginal examinations must be carried out with utmost respect and dignity. They must be preceded with an explanation of the purpose of examination and verbal consent.⁵² Women must be informed that the examination may be uncomfortable but not distressing.⁵² During the procedure, the clinician must remain alert to verbal and non-verbal indications of discomfort and any request to discontinue the examination should be respected and documented in the patient's medical records.⁵²

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APPENDIX 1

INFORMATION GIVEN TO PARTICIPANTS

INFORMATION LEAFLET AND INFORMED CONSENT FOR NON-CLINICAL RESEARCH (e.g. educational, health systems or nonclinical operational research)

TITLE OF STUDY:

ATTITUDES TOWARDS VAGINAL EXAMINATION AND CHAPERONE/INTERPRETER: A CROSS-SECTIONAL SURVEY OF PATIENTS AT KEH VIII hospital

Dear Participant,

1. INTRODUCTION

We invite you to participate in this research study. This information leaflet will help you decide if you want to participate. Before you agree to take part, you should fully understand what is involved. If you have any questions that this Leaflet does not fully explain; please do not hesitate to ask the investigator.

2. THE NATURE AND PURPOSE OF THIS STUDY

This study is a quantitative study that seeks to explore patients' perception towards vaginally examination and the effect of examining doctors' gender as well as effect of chaperone or interpreter on this perception. Some of the questions are sensitive. The objective of the study is primarily academic but will inform a better provider understanding of patients feelings during vaginal examination with a view to improving patient care and satisfaction.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves a semi-structured interview seeking your detailed views about vaginal examination. The Interview will be done one on one through a questionnaire which is simple, and self-administered. However, the investigator or its representative will be available to address any of your questions.

4. RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study except that you may need to sacrifice about 10 minutes of your precious time in participating in the study.

5. POSSIBLE BENEFITS OF THIS STUDY

You will not benefit directly from the study; however the results of the study will enable us to understand our patients better with a view to improve handling of patients. These findings will be available in the dissertation which I will be happy to share with you and others.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason. Your withdrawal will not affect our relationship as doctor -patient.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of KwaZulu-Natal and a copy of the approval letter is available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is myself (Dr O.U. Amaechina). If you have any questions about the study please contact me at 072 858 6265(cell). You may contact the Biomedical Research Ethics Office on 031-260 4769 or 260 1074 or Email BREC@ukzn.ac.za if you have complaints or questions about your rights as a research participant. The Biomedical Research Ethics, Research Office, UKZN postal address is Private Bag X54001, Durban 4000

Administrator is Ms D Ramnarain.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

Your name is not required during the interview. All information that you give will be kept strictly confidential. Once we have analyzed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect our relationship.

I have received a signed copy of this informed consent agreement.

I am aware that I may contact the Biomedical Research Ethics Office on 031-260 4769 or 260 1074 or Email BREC@ukzn.ac.za if I have questions about my rights as a research participant.

APPENDIX 2

QUESTIONNAIRE

Please write, tick or circle the most correct answer

1. Kindly indicate your age.
2. Have you filled this questionnaire before? Yes/No
3. Are you for ante-natal care or for gynecological care?
4. Have you ever had a vaginal examination before in your life? Yes/No
5. Which of the following best describes your academic achievement?
 - 5.1. < grade 12.
 - 5.2. grade 12
 - 5.3. > grade 12 with further studies.
 - 5.4. Other (specify)
6. Which of the following best represents your reproductive experiences?
 - 6.1 This is my first pregnancy or I have had 1 pregnancy.
 - 6.2 This is my 2nd pregnancy or I have had 2 pregnancies.
 - 6.3 This is my 3rd pregnancy or I have had 3 pregnancies.
 - 6.4 This is 4th pregnancy or I have had 4 pregnancies.
 - 6.5 This is \geq 5th pregnancy or has had 5 or more pregnancies.
7. Which of the following best describes your ethnic background?
 - 7.1 Black
 - 7.2 Indian
 - 7.3 White
 - 7.4 Other (specify).....
8. Which of the following indicates your marital status? Tick where applicable
 - 8.1 Married
 - 8.2 Divorced
 - 8.3 Single
 - 8.4 Not married but lives with boyfriend
 - 8.5 Other (specify).....
9. In your opinion which of the following is the most intimate examination a woman can undergo?
 - 9.1. Breast exam.
 - 9.2. Abdominal exam.
 - 9.3. Vaginal examination.
 - 9.4. Rectal examination.
10. If the examining doctor is a female, which of the following best represent your feeling with regard to this most intimate examination?
 - 10.1 I will feel the same way I would have felt if the doctor is a male. Yes/No
 - 10.2 I will feel better than I would have felt if the doctor is a male. Yes/No
11. Kindly indicate your views on the following statements:

Strongly disagree
Disagree
Agree
Strongly agree

11.1 Vaginal examination causes me some discomfort.

11.2 Vaginal examination does not cause discomfort but is embarrassing.

11.3 Having to undress creates anxiety

11.4 It would have been better to have another female (chaperone) in the room if the doctor is a male.

12. A chaperone is a neutral observer during a doctor-patient consultation. It could be a nurse, a relative or a friend. In a situation where you want a chaperone, which of the following is your preferred chaperone.

12.1 Partner

12.2 Mum

12.3 Friend

12.4 Nurse

12.5 Other (specify).....

13. Kindly indicate your views about chaperone on the following examinations:

There is no need for a chaperone during abdominal examination. YES/NO

There is no need for a chaperone during breast examination. YES/NO

There is no need for a chaperone during vaginal examination. YES/NO

There is no need for a chaperone during rectal examination. YES/NO

14. If your view is that vaginal examination causes some discomfort; how do you grade this discomfort on a scale of 1 to 5 where 1 is mild and 5 is severe discomfort?

14.1 1

14.2 2

14.3 3

14.4 4

14.5 5

Uhlu lwemibuzo

Beka uphawu lapho kunempendulo eyiqiniso khona.

1. Isho iminyaka yakho.....

2. Uke waligcwalisa loluhlu lwemibuzo phambilini? Yebo/Cha

3. Kungabe uze lapha ngokuzonakekelwa ngokukhulelwa kwakho noma uzohlolwa isinye?
.....

4. Uke wahlolwa isitho sakho sangasese phambilini? Yebo/Cha

5. Okuphi kulokhu okuchaza kahle impumelelo yakho kwezemfundo?

5.1. Ngaphansi kwa-grade 12.

5.2. U-grade 12

5.3. ngaphezu kwa-grade 12 waqhubeka wafunda.

5.4. Okunye (chaza)

6. Okuphi kulokhu okuchaza kahle umlando wakho ngokukhulelwa kwakho?

6.1 Ukukhulelwa kwami kokuqala lokhu noma ngike ngakhulelwa kanye.

6.2 Ukukhulelwa kwami kwesibili lokhu noma sengikhulelwe kabili.

6.3 Ukukhulelwa kwami kwesithathu lokhu noma sengikhulelwe kathathu.

6.4 Ukukhulelwa kwami kwesine lokhu noma sengikhulelwe kane.

6.5 Ukukhulelwa kwami okungaphezu kokuyisihlanu lokhu noma sengikhulelwe kahlanu noma ngaphezulu.

7. Okuphi kulokhu okuchaza kahle ngobuzwe bakho?

7.1 Omnyama 7.2 UmNdiya 7.3 Omhlophe 7.4 Okunye (chaza).....

8. Okuphi kulokhu okuchaza ngesimo sakho somshado? Beka uphawu endaweni efanele.

8.1 Ngishadile.

8.2 Ngidivosile.

8.3 Angishadile.

8.4 Angsihadile kodwa ngihlala nomaqondana wami.

8.5 Okunye (chaza).....

9. Ngombono wakho, okuphi kulokhu kuhlolwa okwenza owesifazane asondelane kakhulu nodokotela?

9.1. Ukuhlolwa amabele.

9.2. Ukuhlolwa isisu.

9.3. Ukuhlolwa isitho sangasese.

9.4. Ukuhlolwa komdidi.

10. Esimweni lapho uhlolwa wudokotela wesifazane, kuvela kanjani lokhu kusondelana kakhulu kulokhu okulandelayo?

10.1 Iyofana indlela engizizwa ngayo noma ngabe udokotela bekungowesilisa. Yebo/Cha

10.2 Ngiyozizwa kangcono kunokuba udokotela bekungowesilisa. Yebo/Cha

11. Veza imibono yakho ngalokhu okulandelayo:

Angivumi kakhulu
Angivumi
Ngiyavuma
Ngivuma kakhulu

- 11.1 Ukuhlolwa isitho sangasese akungiphathi kahle.
- 11.2 Ukuhlolwa isitho akungenzi ngiphatheke kabi kodwa kuyangihlaza.
- 11.3 Ukukhumula kungenza ngibe nexhala
- 11.4 Bekungaba ngcono uma kukhona omunye umsizi wesifazane (chaperone) uma udokotela kungowesilisa.

12. I-chaperone umuntu ozimele ongachemile ngesikhathi udokotela ebonana nesiguli. Kungaba unesi, isihlobo noma umngane. Uma udinga i-chaperone, eyiphi kulaba ongayikhetha.

- 12.1 Umaqondana wakho.
- 12.2 Umama wakho.
- 12.3 Umngane.
- 12.4 Unesi.
- 12.5 Okunye (chaza).....

13. Sicela uveze imibono yakho nge-chaperone uma uhlolelwa lokhu:

- 13.1 Asikho isidingo se-chaperone uma uhlolwa isisu. YEBO/CHA
- 13.2 Asikho isidingo se-chaperone uma uhlolwa amabele? YEBO/CHA
- 13.3 Asikho isidingo se-chaperone uma uhlolwa isitho sangasese? YEBO/CHA
- 13.4 Asikho isidingo se-chaperone uma uhlolwa umdidi? YEBO/CHA

14. Uma umbono wakho wokuthi ukuhlolwa kwesitho sangasese akukuphathi kahle; Ikuphi kulokhu okuchaza kahle ukungaphatheki kahle kwakho khombisa lokhu ngokusebenzisa isikali kusukela ku 1 - 5 okungahuthi u 1 kungconywa u 5 kunzima?

- 14.1 1
- 14.2 2
- 14.3 3
- 14.4 4
- 14.5 5



03 July 2012

Dr. O Amaechina
Department of Obstetrics and Gynaecology
Nelson R Mandela School of Medicine
University of KwaZulu-Natal

Dear Dr Amaechina

PROTOCOL: A cross-sectional survey of patients attitude towards vaginal examination and chaperone at King Edward Hospital. REF: BE104/12

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 16 April 2012.

The study was provisionally approved pending appropriate responses to queries raised. Your responses dated 21 June 2012 to queries raised on 08 June 2012 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from 03 July 2012.

This approval is valid for one year from **03 July 2012**. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>.

6 June 2012

Dr H Ramnarain
Department of Obstetrics and Gynaecology
School of Clinical Medicine

Dear Dr Ramnarain

PROTOCOL: "A cross-sectional survey of patients' attitude towards vaginal examination and chaperone at King Edward Hospital." Student: O Amaechina, student number: 211559833. (Obstetrics and Gynaecology)

I am pleased to inform you that the abovementioned study has been approved.

Please note:

- The Academic Leader: Research must review any changes made to this study.
- The study may not begin without the approval of the Biomedical Research Ethics Committee.

May I take this opportunity to wish the student every success with the study.

Yours sincerely








pp: Professor JK Burns
Academic Leader School Research
School of Clinical Medicine

CC. Dr O Amaechina

Biomedical Research Ethics Committee
Westville Campus

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