ORIGINAL ARTICLE

Patients attitudes to vaginal examination and use of chaperones at a public hospital in South Africa

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Abstract

Background: Obstetrics and gynecology units in public hospitals in South Africa (SA) are often overloaded with patients. Most physical examinations/consultations in these units involve vaginal examination (VE) and often because of the rapid turnover of patients the pelvic examination may be performed hurriedly without due consideration being given to the psychosocial aspects of such procedures.

Objective: This study surveyed the attitudes of patients to VE and the use of chaperones.

Methods: A descriptive cross-sectional survey of patients attending obstetrics and gynecology clinics at a public hospital in SA was carried out. A structured questionnaire was used to collect sociodemographic data such as age, ethnic group, gravidity, feelings toward VE, and preferences about the gender of the examining doctor, as well as the presence of a chaperone.

Results: Most women (68%) were aged between 20 and 35 years. The respondents stated that the most intimate examination was VE in 48.3% and abdominal in 25% of cases; 19.0% and 1.5% of respondents felt that breast and rectal examinations, respectively, was the most intimate. On the response to the statement "there is no need for chaperone during VE;" 54% of the participants were in support of chaperone while 45.1% were against chaperone. Women aged 20–35 years, preferred a nurse as their chaperone; younger women, aged ≤19 years preferred their mother as a chaperone.

Conclusion: In an SA public hospital, women are more likely to regard VE as the most intimate examination. Women are equivocal on the use of a chaperone and if it was necessary; nurses are their preferred choice except for teenagers, who preferred their mothers.

Key words: Intimate examinations, patient-physician relationship, use of chaperone, vaginal examinations

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Introduction

Most obstetric and gynecological consultations involve a vaginal examination (VE) which is intrusive and intimate.[1] It is for this reason that obstetricians and gynecologists have been advised to have a third party (chaperone) present during intimate examinations. The rate of use of medical chaperones, however, varies among countries. Higher utilization rates are reported from the United States of America (USA) and Canada compared with the United Kingdom (UK).[2] In South Africa (SA), the use of a chaperone is not specifically included in the Health Professions Council of SAs (HPCSA) guideline

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on ethics.[3] It is, however, generally accepted that women should be informed about the intimate nature of the genital examination and asked whether they would prefer a third person to be present. In the public sector in SA, the third person is usually a professional nurse. The presence of a third party, irrespective of his/her profession, may violate the principle of confidentiality and privacy.

Good patient centered communication has been shown to allay anxiety and improve patient satisfaction.[4] Gynecological examination guideline in the UK states that most women will accept VE if the necessity of the procedure is explained.[2] In SA, especially in the context of public regional hospitals where the doctor-patient ratio is low and patient load high, allocation of sufficient time for quality communication is usually challenging. In such constrained circumstances, VE may be performed with a focus to identify and address pathology as quickly as possible, and the psychosocial aspects which are paramount may be neglected. Furthermore, during the period of antenatal care in a public regional hospital, a patient is often seen by different doctors at individual antenatal care visits and this may adversely affect the development of trust in the doctor-patient relationship.

A literature survey (PubMed and EMBASE) revealed a limited number of SA studies that have investigated patient's attitude to VE and chaperone. Guidozzi *et al.* surveyed gynecologists' opinions on chaperone use in SA and 72% of practitioners were in favor of using a chaperone during an intimate examination.[5] Based on their findings, these authors recommended that HPCSA should officially implement a policy of chaperone use. Our view is that patient's view on this matter should be obtained to strengthen any recommendation or policy that will be made. Therefore, in the context of a challenging clinical environment (a regional public hospital), we surveyed the attitudes of patients toward VEs and chaperones.

Methods

Following Institutional Ethical Clearance (Reference: BE 104/12) and hospital permission, the study used a self-administered questionnaire that was piloted on 10 patients. A sample size of 400 was deemed adequate following a determination that there are about 6000 new patients that visit the antenatal clinics per annum at the study site. The questionnaire included demographic data such as age, ethnic group, and gravidity, questions relating to feelings toward VE, 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.

Prospective participants were recruited daily at combined ante-natal/gynecology clinic after group information sessions. Patients who were interested in participating were informed individually, consent obtained, and a questionnaire issued. On completion, the questionnaires were kept in a large brown envelope and were later collected in batches by the investigator. Sampling continued until 400 valid questionnaires were collected. Eligibility was restricted to volunteers who had not filled the questionnaire previously and were not in any form of distress (physical or mental). Data were analyzed with SPSS version 19 (IBM corporation released 2010). 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.

Results

The sociodemographic profile and other baseline characteristics are shown in Table 1. Not all women

Table 1: Demographic characteristics of all study participants

Characteristics	Number	Percent=% when *n*=400 (valid percent)***
Age groups		
≤19 years	60	15.0
20-35 years	272	68.0
>35 years	68	17.0
Reason for attending health facility		
Ante natal care	265	66.3 (80.5)
Gynaecology clinic	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)
Race group		
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

Table 2: Response to statement "there is no need for a chaperone during vaginal exam"

	Number	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

Table 3: Age and preferred type of chaperone

Age	Preferred type of chaperone (%)					
	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 4: 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

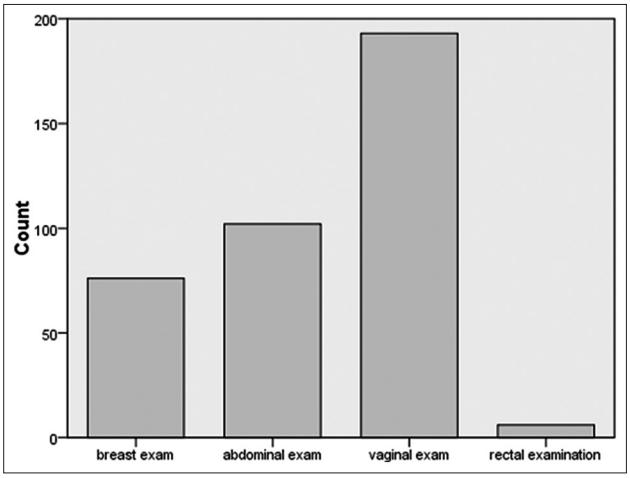

Figure 1: Most intimate examination

answered every question. Of 400 women, 272 (68%) were aged between 20 and 35 years. The mean age was 28 years (range 13–75) (28%). Of those who indicated the reason for visiting hospital 80.5% and 19.5% were for antenatal care and gynecology clinic respectively. Three hundred and seventy-seven women (94.3%) gave their opinions on the most intimate physical examination a woman underwent; the majority (48.3%) rated VE as the most intimate examination [Figure 1]; 25.5% regarded abdominal examination as the most intimate, 19.0% felt it was breast examination, and 1.5% rated rectal examination as the most intimate. Those who had undergone a VE previously were more likely to consider it the most intimate examination than those who were yet to have experienced a VE (Pearson $\chi^2 = 0.005$).

Age, educational level, and a previous number of pregnancies had no demonstrable influence on participant's perceptions on the most intimate examinations. Response to a statement that VE causes discomfort was slightly fewer than 50% (47%) (188 out of 400 women); however, of these respondents, 61.7% agreed or strongly agreed that VE causes discomfort.

Three hundred and seven women (76.8%) responded to the statement, "there is no need for a chaperone during VE;" 54.5% of the respondents said there was no need for a chaperone during a VE examination while 45.1% said there was a need [Table 2]. 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 preference. As shown in Table 3, 386 responded; 168 (42%) preferred a nurse; 143 (35.8%) preferred their partners; 54 (13.5%) preferred their mother; and three preferred a friend. Women who were ≤19 years were more likely to choose their mother.

Of the 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 physician [Table 4]. The majority (73.8%) did not think that what they consider to be the most intimate examination is affected by the gender of the doctor.

Discussion

It is widely known that women of low socioeconomic status form the prevalent social group who attend public referral hospitals in SA. Therefore, the majority of respondents (65.7%) were women whose educational level was either below grade 12 (senior secondary school level) or at grade 12 [Table 1]. Furthermore, the majority of participants were Black SA (84%), which is another parameter that is associated with the low socioeconomic status at the study site.

The finding that VE is the most intimate examination is expected as the procedure is intrusive in nature. Rectal examination is similarly intrusive and was expected to rank far much higher than 1.5%. This might have been due to the fact that the study population was mainly an obstetric population (80.5%) who are in the reproductive phase of life; this might have skewed this finding in favor of VE. Rectal examinations rarely have a place in obstetric practice,

and rectal examinations tend to be carried out mostly in gynecological patients with malignancies.

In general, the outcomes of our study were similar to the findings of a survey in USA which showed that women feel less comfortable during VE than they do during a breast examination; physical discomfort of the pelvic examination was the reason most frequently cited.[6] Black African women were more likely to opine that VE was the most intimate examination (Pearson $\chi^2 = 0.005$), but this may likely be due to the fact that 84.3% of women were of African origin, which skewed the statistics in favor of Black African women.

The response to a question that assessed whether VE causes discomfort was slightly fewer than 50% (47%) (188 of 400). In the context of this slightly fewer participants, the majority (61.7%) either agreed or strongly agreed that VE causes discomfort. This finding was unexpected and may have been due to the fact that the questionnaire was self-administered and therefore misunderstood. Some of the items in the questionnaire were considered sensitive, and therefore questionnaire were self-administered and that may be the reason why this particular question had fewer responses. The response rate to the question may have been improved if the participants were assisted in completing the questionnaire; however, this may cause "influence bias." In a study carried out in South-Eastern Nigeria, 42% of 193 women did not feel uncomfortable during a pelvic examination while 35% felt pain, 10.9% felt embarrassed, and 3.1% felt humiliated.[7] If one is to believe our findings, the South-Eastern Nigeria study is similar to our finding when all negative remarks of pain, embarrassment, and humiliation are interpreted as discomfort. It also appears to be in agreement with the general belief that VE is painful.[8,9]

The response to the statement "there is no need for chaperone during VE" produced just a slight majority as 54% of the participants were in support of chaperone while 45.1% were against chaperone. This finding is in line with several surveys, which demonstrate variable preferences. For example in a study from Australia, Baber *et al.* found that 32% of women wanted a chaperone if being examined by a male, 29% did not.[10] Another questionnaire study performed in Ireland demonstrated that most patients (65%) do not wish to have a chaperone during a VE, but a small proportion would request one regardless of the examiner's gender.[11] In the South-Eastern Nigeria study, 54% of respondents would like to have a chaperone during a pelvic examination when the examining physician is a male while 46% would not like to have a chaperone.[7]

The response to preferred type of chaperone 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 SA, where a huge proportion of doctor-patient interaction takes place across cultural, religious, and linguistic barriers. This is in line with a recent finding in SA where Guidozzi *et al.* in a survey of gynecologists showed that 65% of respondents used medical staff (e.g., nurses), 21% used family or partners and the rest used a combination of both.[5] The American College of Obstetricians and Gynecologists Committee Opinion on Sexual Misconduct, was that 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.[12] This American position was supported by the opinion of South-Eastern Nigerian women where the majority (83%) preferred nurses while 8.1% preferred their husbands.[7] In our study, there was a tendency for teenagers to prefer their mother (35% for the mother vs. 31.7% for partner). This is not surprising because at that age we expect teenagers to be closer to their mother.

Women generally prefer female doctors,[8] therefore, the finding that 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 is unexpected especially in the context of medium-low socioeconomic Black African population who we thought are conservative. Comparative analysis of surveys in various parts of the world shows that culture and religion have an effect on women's preferences for female physicians. In Asia and Islamic societies, there is a huge preference for female physicians.[13] In Western societies, this huge preference for female physicians is not observed. For example, a survey of 264 patients in 13 obstetrics and gynecological waiting rooms in Connecticut, USA showed that the majority of patients (66.6%) had no gender bias when selecting an obstetrician-gynecologist, and an even larger majority (198, 80.8%) felt that physician gender does not influence quality of care.[14]

Conclusion

This study suggests that most women (mainly Black SA) accessing women's health services in a public hospital in SA, irrespective of their age, educational level and previous number of pregnancies consider VE the most intimate examination. Most women responded that VE causes discomfort. Based on our study, 54% of the women preferred to have a chaperone in attendance during a VE. We, therefore, think it is prudent to offer women the presence of a chaperone particularly in societies in which litigation is increasing. Women's choices should then be observed, and the decision documented.

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Conflicts of interest
There are no conflicts of interest.

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