



Swansea University  
Prifysgol Abertawe



## Cronfa - Swansea University Open Access Repository

---

This is an author produced version of a paper published in:  
*Nursing Times*

Cronfa URL for this paper:  
<http://cronfa.swan.ac.uk/Record/cronfa45283>

---

### **Paper:**

Marinaccio-Joseph, P. (2019). Nurses as chaperones: legal obligations and implications. *Nursing Times*, 115(7), 18-21.

---

This item is brought to you by Swansea University. Any person downloading material is agreeing to abide by the terms of the repository licence. Copies of full text items may be used or reproduced in any format or medium, without prior permission for personal research or study, educational or non-commercial purposes only. The copyright for any work remains with the original author unless otherwise specified. The full-text must not be sold in any format or medium without the formal permission of the copyright holder.

Permission for multiple reproductions should be obtained from the original author.

Authors are personally responsible for adhering to copyright and publisher restrictions when uploading content to the repository.

<http://www.swansea.ac.uk/library/researchsupport/ris-support/>

### In this article...

- Changes in the patient-doctor relationship in legal terms
- Case law affecting the legal requirements of the role of a chaperone in healthcare
- Needs of nurses who act as chaperones during intimate examinations

# Nurses as chaperones: legal obligations and implications



Nursing Times  
Journal Club

## Key points

**When undertaking intimate examinations, doctors often ask a nurse chaperone to be present**

**Currently there is a lack of definition and guidance regarding the role of chaperones**

**A nurse chaperone must be impartial and is ultimately responsible for the doctor's actions**

**Nurse chaperones need to ensure the patient has consented to the intervention**

**Nurse chaperones need training and policies to adhere to so they can fulfil the role adequately**

**Author** Paul Marinaccio-Joseph is solicitor and lecturer in healthcare law and ethics, Swansea University.

**Abstract** When a doctor undertakes intimate examinations on a patient, it is not unusual for a nurse to be asked to attend as a chaperone. What exactly does this entail? There are several legal requirements attached to the role, for which a nurse may end up being involved in litigation and court proceedings. Nurses need to be aware of what can be expected of a chaperone in the eyes of the law, so they know not only how to protect patients, but also how to protect themselves. However, one thing is clear, in case of litigation, a chaperone cannot 'side' with the health professional against whom allegations of misconduct are being made.

**Citation** Marinaccio-Joseph P (2019) Nurses as chaperones: legal obligations and implications. *Nursing Times*; 115: 7, 18-21.

It is not unusual for a male doctor to ask a female nurse to act as a chaperone when they need to carry out intimate examinations on patients – their rationale being that this may protect them from future false allegations of improper conduct made by patients. This might seem fair at first glance but, on consideration, it is unfair to patients. Chaperones must be impartial and have no obligation to the doctor. However, in the hierarchical structure of the NHS, a junior nurse may feel daunted to speak up about the misconduct of a senior doctor or a consultant. This article discusses the role and responsibilities of nurse chaperones and, crucially, highlights what they need to do to protect themselves if they are involved in litigation.

### Intimate examinations

Some healthcare interventions require examinations that are intimate in nature, often embarrassing and potentially distressing for patients. This is the case, for example, with the examination of breasts, genitalia or the rectum, but such situations also include examinations for which

it is necessary to touch or even be close to the patient – this could include taking a pulse or listening to the patient's chest with a stethoscope.

The General Medical Council (2013) has recommended that patients – both male and female – are offered the possibility of being seen in the presence of a chaperone. In some cases, it will be the doctor who asks for a nurse chaperone to be present while undertaking intimate examinations.

The role of chaperones is not limited to being present in the room during an examination. It may also involve explaining to patients what they can expect beforehand and supporting them afterwards. This requires chaperones to be adequately trained, so they have both clinical knowledge of the procedure undertaken and good communication skills.

### Lack of definition

Defining the role of chaperones is not without problems. In 2004, an independent investigation into how the NHS had handled the actions of Clifford Ayling (a doctor who, in 2000, was convicted of indecently

assaulting patients while chaperones had been sent out of the treatment room) found there was no common definition (Department of Health, 2004). At least four different definitions of the role of chaperones had been given to the investigation committee:

- “A chaperone provides a safeguard against humiliation, pain or distress during an examination and protects against verbal, physical, sexual or other abuse”;
- “A chaperone provides physical and emotional comfort and reassurance to a patient during sensitive and intimate examinations or treatment”;
- “An experienced chaperone will identify unusual or unacceptable behaviour on the part of the other healthcare professional”;
- “A chaperone may also provide protection for the healthcare professional from potentially abusive patients”.

It is clear from these definitions that the role goes much further than that of a passive onlooker but needs to be clarified. Who is the chaperone intended to protect: the patient or doctor? The first three definitions imply chaperones are there to protect patients from harm or violation, whereas the fourth implies that they are also there to protect clinicians.

This uncertainty is unacceptable for all involved, including nurse chaperones. There needs to be one accepted definition accompanied by central guidelines and, at present, this is not the case.

### Lack of policies

The report of the investigation into the Clifford Ayling case recommended that:

- Trusts put in place a chaperoning policy, make patients aware of it and ensure it is properly resourced;
- The chaperoning policy includes accredited training and a manager is appointed to oversee its implementation;
- The policy is rigorously enforced;
- Relatives or friends are not called upon to undertake the chaperoning role;
- Patients have the ultimate choice about whether to have a chaperone present, as well as the right to refuse the chaperone offered by the organisation;
- Only trained chaperones are used, even when patients are examined in their own home (DH, 2004).

Some 15 years after the publication of the Ayling inquiry, NHS trusts are responsible for writing their own policies on chaperoning. It would be preferable to have an agreed national policy in place, which is

### Box 1. The Montgomery case: a legal turning point

Mrs Montgomery, who had type 1 diabetes, was expecting her first baby; a prenatal assessment indicated that the baby would be large. During the later stages of Mrs Montgomery's pregnancy, she told her obstetrician about her concerns that the baby's size would make delivery difficult.

The obstetrician recognised there was a 9-10% risk of shoulder dystocia that would complicate the delivery, but decided not to share that information with Mrs Montgomery. The obstetrician felt the risk to Mrs Montgomery and her baby was relatively small, and did not warrant the elective caesarean section that she would be likely to request if she was told of the risk. She would have been given this information only if she had asked “specifically about exact risks” (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11).

Mrs Montgomery went into labour. Shoulder dystocia occurred and made vaginal delivery impossible, so an emergency caesarean section had to be performed. Oxygen deprivation during birth resulted in severe and permanent disability for Mrs Montgomery's son. She sued the NHS trust, arguing that she should have been advised of the risks of vaginal delivery and that, if she had been aware of those risks, she would have opted for an elective caesarean section.

When this case was first heard, the Court of Session (Scotland's supreme civil court) followed the approach taken in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 and concluded there was insufficient risk of significant harm to Mrs Montgomery to warrant a warning. The Supreme Court disagreed and upheld Mrs Montgomery's appeal. It recognised that there had been a shift in the relationship between patients and health professionals, and patients are “now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services” (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11).

Source: Taylor (2018)

applied uniformly across all trusts – otherwise patients may still be at risk.

### Examples of abuse

Examples of the harm caused by the lack of proper chaperoning have spanned the decades, yet little has been done to formalise training and policies.

In 2005, a GP was suspended from the medical register for four months after a fitness-to-practise panel found him guilty of serious professional misconduct – he had abused a female patient who did not have a chaperone (Wai et al, 2008). In 2014, Dr Myles Bradbury was jailed for abusing young children, which resulted in Scott-Moncrieff and Morris' report of the resulting investigation at the relevant trust ([Bit.ly/MylesBradburyInquiry](http://bit.ly/MylesBradburyInquiry)).

Between 2014 and 2017, the GMC struck off 18 doctors for sexual assault or rape (Rimmer, 2018). The data, which the GMC provided in response to a freedom of information request, did not specify whether the victims were patients or health professionals. In addition to the 18 doctors who were struck off, five were suspended after hearings for alleged sexual assault and another was issued with a warning (Rimmer, 2018).

Unfortunately, there are also examples of abuse carried out by unchaperoned nurses. Senior nurse David Britten abused patients with anorexia over two decades and continued to do so for years after the alarm had been raised. He was struck off the Nursing and Midwifery Council (NMC) register in 2004; the subsequent inquiry report ([Bit.ly/DavidBrittenInquiry](http://bit.ly/DavidBrittenInquiry)) was published four years later. In September 2017, Stephen Board, a male nurse who had groped the breasts of female patients while they were under an anaesthetic, was jailed for 12 years; the following year the NMC struck him off its register (NMC, 2018a).

These examples of abuse demonstrate that chaperoning policies also need to cover intimate examinations that are performed by nurses.

### A shifting legal landscape

The case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (Box 1) brought about a significant change in how courts view the doctor-patient relationship. The position adopted by the Supreme Court in the Montgomery case differed significantly from that expressed in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the*

*Maudsley Hospital* [1985] AC 871, in which Lord Templeman had said that “the provision of too much information might prejudice the attainment of the objective of restoring the patient’s health”.

In 2015, the legal position shifted towards the view that, instead of being passive recipients of care, patients are people with rights who should be allowed to exercise them, much like “consumers exercising choices” (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11). It has now clearly been accepted by the courts that, as times have moved on, patients should be treated as partners in the decision-making process regarding their treatment and care.

In the *Montgomery* case, the Supreme Court concluded that the paradigm of the doctor-patient relationship implicit in previous case law had ceased to reflect reality. In essence, it said the law needed, as far as possible, to treat patients as adults capable of:

- Understanding that the success of a medical intervention is not a given and that medical treatment involves risks;
- Accepting responsibility for decisions affecting their lives;
- Living with the consequences of their choices.

This shift in the legal landscape has occurred in parallel with new legislation and guidance regarding mental capacity and informed consent, two concepts that, today, are at the heart of the relationship between health professionals and patients.

### Chaperoning and consent

Informed consent has become paramount for seeking and obtaining patients’ permission to undertake a treatment or perform an intervention. Standard 4.2 of the

NMC code states that nurses must ensure that they obtain “properly informed consent and document it before carrying out any action” (NMC, 2018b).

For consent to be valid, it must be voluntary and informed, and the patient giving consent must have the mental capacity to make that decision. To be adequately informed, the patient needs to have received full information about the treatment or intervention. A patient deemed to have mental capacity will be able to:

- Understand and retain that information;
- Weigh up the risks and benefits involved;
- Decide what is best for them.

The principles ruling mental capacity are outlined in the Mental Capacity Act (2005) ([Bit.ly/MCAGCode](http://bit.ly/MCAGCode)); it also covers how to deal with situations when people do not have mental capacity to make a decision.

Before carrying out any treatment, procedure or care intervention, nurses need to involve patients in a dialogue and gain their consent (Taylor, 2018). The onus is on nurses to provide patients with sufficient information to enable them to make an informed decision. This has implications for nurse chaperones.

Although the doctor is responsible for obtaining the patient’s consent for the examination, the chaperone is ultimately responsible for the doctor’s actions. Furthermore, it may well be the case that the chaperone needs to gain the patient’s consent for their involvement. Since the *Montgomery* case, simply stepping behind the curtain to witness an examination cannot be seen as good practice. The patient needs to:

- Be told why the chaperone has been asked to be involved;
- Be informed about the exact role of the chaperone;
- Consent to the chaperone’s presence.

The chaperone’s role needs to be fully explained so the patient can give informed consent. Anything less would potentially leave nurses vulnerable to allegations of having acted without consent.

### Current legal position

Currently, the role of chaperone is not formally regulated, either by the NMC or the GMC, so if it came to litigation each case would be judged individually. This leaves nurses in a precarious position. In effect, they are a little like ‘good Samaritans’, who feel a duty to help by acting as chaperones but risk exposing themselves to criticism from the patient, the NMC and the courts.

If patient consent is absent, any action carried out by nurses may be deemed unlawful. This was made clear in the case of *Airedale NHS Trust v Bland* [1993] AC 789, and, more recently, in *Border v Lewisham and Greenwich NHS Trust* [2015] EWCA Civ 8, in which the court highlighted the importance of obtaining consent before starting treatment. However, it was in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 that the courts put forward new guidance for dealing with consent and patients’ own opinions about their care.

### Implications of the Montgomery case

In the *Montgomery* case, Lord Kerr and Lord Reed reasoned that an adult of sound mind is entitled to decide which, if any, of the available treatments to undergo, and that the patient’s consent must be obtained before treatment interfering with bodily integrity is undertaken. Doctors are, therefore, under a duty to take reasonable care to ensure the patient is aware of any material risks involved in the proposed treatment and of reasonable alternatives. A risk is ‘material’ if:

- A reasonable person in the patient’s position would be likely to attach significance to it;
- The doctor is, or should reasonably be, aware that their patient would be likely to attach significance to it (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11). Further points emerged from the case:
- Assessing the significance of a risk is fact-sensitive and cannot be reduced to percentages;
- To advise, the doctor must engage in dialogue with the patient;
- The therapeutic exception – in which giving the patient this information would be seriously detrimental to their health – is limited and should not be abused.

Box 2 lists information patients should be given when invited to have a chaperone.

### Accountability and training

The ruling in the case of *R v Tabassum* [2000] 2 Cr App R 328 (Box 3) makes it clear that informed consent implies that the procedure carried out must match the procedure consented to, not just in its practicalities but also in its intention and spirit.

It also makes it clear that health professionals need to be adequately trained. On the basis of *R v Tabassum* [2000] 2 Cr App R 328, the courts could require chaperones to have been properly trained, as the case



**Nursing Times**  
Journal Club  
online

To use this article for a journal club discussion with colleagues, go to [nursingtimes.net/NTJCchaperones](http://nursingtimes.net/NTJCchaperones) and download the discussion handout. Your journal club activity counts as participatory CPD hours or can be used as the basis for reflective accounts in your revalidation activities.

For more Nursing Times Journal Club articles and tips on how to set up and run your own group, go to: [nursingtimes.net/NTJournalClub](http://nursingtimes.net/NTJournalClub)



## Box 2. Information for patients invited to have a chaperone

Chaperones should ensure patients are fully informed about:

- Why a chaperone is involved in the first instance
- What the chaperone's role will be before, during and after the examination
- What training the chaperone has received to be able to perform that role

Patients should also be informed that they have the right to:

- Decline the presence of a chaperone altogether
- Decline the chaperone proposed by the organisation and choose someone else to act as their chaperone

clearly shows that any patient consenting to a chaperone being involved does so on the basis that they believe the chaperone is properly trained.

Under Standard 6.2 of the NMC code, nurses are required to maintain the knowledge and skills they “need for safe and effective practice” (NMC, 2018b). Therefore, if they are not properly trained to act as chaperones, they may be putting themselves at risk professionally.

Nurses involved as chaperones during a patient's examination by a doctor are accountable for their actions. If the doctor is later accused of having acted inappropriately, chaperones will become involved in litigation and may be called to give evidence

in court. Their documentation and record keeping may be scrutinised, and, if these are deemed to be lacking sufficient detail, nurses may be found to be in breach of their duty to the patient – as well as in breach of Standard 10 of the code, which relates to record keeping. It is worth remembering that, following the Montgomery case, courts are far more prepared to look at how patient consent was obtained, so it is crucial to keep detailed records of this.

If the doctor is alleged to have acted improperly towards the patient, the role of the chaperone will come under scrutiny. The doctor may wish to rely on the chaperone's account of the events. If the nurse lacks formal training and/or relevant experience, their credibility and involvement as a chaperone will be criticised by the patient's advocates. This may well be a cause of concern for the court, whose duty it is to decide whether the patient's complaint against the doctor is valid.

### Equality of arms

Section 6 of the Human Rights Act (1998) ([Bit.ly/1998HumanRightsAct](http://Bit.ly/1998HumanRightsAct)) ensures the right to a fair trial. The jurisprudential principle of equality of arms, which emanates from the European Court of Human Rights, has the right to a fair trial at its heart (Toma, 2018). In simple terms, it means that both sides in a dispute should have the same opportunities to either prosecute or defend their positions. The concept was tested in cases such as *Kaufman v Belgium* [1986], where the court confirmed that equality of arms is violated if a party is not given a reasonable opportunity to present their case in conditions that place it at a substantial disadvantage vis-à-vis its opponent (Rondon, 2012).

Equality of arms means chaperones must be objective in their reporting. They cannot be involved simply to safeguard the doctor. If a doctor asks a nurse to act as a chaperone with the intention that the nurse will give evidence in their favour in case of a patient complaint, the chaperone's involvement goes against the principle of equality of arms, because it creates a ‘two against one’ situation, giving an unfair advantage to the doctor and an unfair disadvantage to the patient.

### Conclusion

Chaperones should not be involved solely to protect doctors, nor should they be passive onlookers. They need to be impartial, have objective reasons to be present, have expertise in the area of clinical practice they are observing, be able to purposefully observe the examination and have the authority to halt it if they suspect malpractice or witness wrongdoing. Until the issue of inadequate chaperoning has been fully addressed, patients will be put at risk of harm during intimate examinations.

Furthermore, nurse chaperones need to be fully trained for the role, and be given clear policies and procedures that will protect both patients and themselves. Every organisation needs to have such policies in place and ensure these are strictly implemented. Until proper policies and training are provided, nurses will be putting their registration at risk. **NT**

### References

- Department of Health (2004) *Independent Investigation into how the NHS Handled Allegations about the Conduct of Clifford Ayling*. [Bit.ly/DHAYling2004](http://Bit.ly/DHAYling2004)
- General Medical Council (2013) *Intimate Examinations and Chaperones*. [Bit.ly/GMCCChaperones](http://Bit.ly/GMCCChaperones)
- Nursing and Midwifery Council (2018a) *Fitness to Practise Committee Meeting 2 July 2018*. [Bit.ly/NMCStephenBoard](http://Bit.ly/NMCStephenBoard)
- Nursing and Midwifery Council (2018b) *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates*. [Bit.ly/NMCCCode2018](http://Bit.ly/NMCCCode2018)
- Rimmer A (2018) Eighteen doctors were struck off for sexual assault or rape in past four years. *British Medical Journal*; 360: k913.
- Rondon YC (2012) *Unmasking Equality of Arms*. [Bit.ly/RondonUnmasking](http://Bit.ly/RondonUnmasking)
- Taylor H (2018) Informed consent 1: legal basis and implications for practice. *Nursing Times*; 114: 6, 25-28.
- Toma E (2018) The principle of equality of arms: part of the right to a fair trial. *Law Review*; VIII: 2.
- Wai D et al (2008) Chaperones: are we protecting patients? *British Journal of General Practice*; 58: 546, 54-57.

## Box 3. *R v Tabassum*: clarifying consent

The case of *R v Tabassum* [2000] 2 Cr App R 328 involved deception by a lecturer in information and communications technology, who induced women to allow him to demonstrate how to carry out a self-examination of the breasts, having told them he was working for the Christie Hospital and was compiling a database on breast cancer. He carried out physical examinations on the women's breasts, demonstrating how they should self-examine to detect signs of breast cancer. In each case, the complainants had consented to the examination, but they were adamant that their consent was predicated on the belief that the appellant possessed the qualifications he claimed to hold.

The complainants' main contention was that consent cannot exist if the person who has consented has been deceived as to the nature or quality of the act performed. The appellant claimed that, as he had done no more than what had ostensibly been consented to by the complainants, their consent remained operative and his conviction for indecent assault should be quashed.

The court of appeal held there could be no true consent, as the women consented only to acts of a medical nature when, in fact, the appellant's actions were without any medical significance. The appellant was convicted on three counts of indecent assault.



For more on this topic online

- Informed consent 1: legal basis and implications for practice  
[Bit.ly/NTConsent1](http://Bit.ly/NTConsent1)