Second Person in the Room

There have been a number of questions from members on whether a second person in the room is required during pelvic floor muscle exams. APTA and the Section on Women's Health do not have a policy regarding second person in the room during pelvic floor muscle exams and treatment. I would like to share information on this question/issue that I have received from our colleagues that practice in a variety of settings, APTA's Departments of Reimbursement, Practice, and Risk Management and Member Services as well as statements/guidelines from the AMA and the American College of Obstetricians and Gynecologists (ACOG).

Around this question and any risk management issue, in order to make the most informed decision you need to consider/check the following sources:

Check your state practice act to see if it provides any guidance.
Check with your employer or the agency/organization they contract with to see if there is any policy or guidelines regarding second person in the room.
Check with payer sources to see if there are any policies/guidelines or requirements regarding this question.
Check with professional organizations.
Check with other appropriate organizations (i.e. ACOG).
Consult with colleagues in similar settings to assess what they are doing.

Depending on your practice setting, some of these sources won't need to be checked, i.e. self-employed no employer to check with, or cash only business will obviously not need to check payer sources. Be aware that when checking sources you may find 1) Helpful guidance; 2) Unclear/gray information; 3) Source is silent on the question at hand.

Information is key in order to make the best decisions for you and your practice. Practice considerations around second person in the room:

Treatment of minors/children – practitioners have shared that they ask mother to attend

Opposite gender issues – some practices will have a second person in the room when female therapists are treating male patients or when male therapists are treating female patients.

Need to have documented, signed informed consent for physical therapy evaluation and treatment. Risk Management has indicated that a generic/general consent form for PT evaluation and treatment is appropriate and that pelvic floor muscle exam is part of our evaluation and within the practice of physical therapy. A separate consent form for pelvic floor muscle exam raises questions that it is not within physical therapy practice.

Thorough communication and explanation regarding the pelvic floor muscle exam and treatment, Including the reason for the examination and what is involved. This information should be included in the provider's documentation as well.

Solo practices have shared that they send a letter to patients before the first visit that states they may have an internal assessment of the pelvic floor musculature and that they are welcome to bring someone with them. This approach addresses the practices that do not have an employee available to provide a second person in the room.

Need for good documentation throughout – evaluation, treatment plan and treatment session.

<u>Recommendation -</u> Give the patient the option - Ask the patient if they would like a second person in the room – document that the question was asked and always provide a second person if a patient desires. Document if the patient refuses a second person in the room.

A therapist shared that with the Stanley Paris program, it is always recommended to have another person in the room, who is the same gender as the patient, during internal coccyx manipulations.

AMA's Statement is as follows:

E-8.21 Use of Chaperones During Physical Exams.

From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended. Physicians aim to respect the patient's dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient--such actions include the provision of appropriate gowns, private facilities for undressing, sensitive use of draping, and clear explanations on various components of the physical examination. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored. An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. (I, IV) Issued December 1998 based on the report, "Use of Chaperones During Physical Exams," adopted June 1998.

ACOG's statement is as follows:
The request by either a patient or a physician to have a chaperon present during a physical examination should be accommodated irrespective of the physician's gender. Local practices and expectations differ with regard to the use of chaperons, but the presence of a third person in the examination room can confer benefits for both patient and physician, regardless of the gender of the chaperon. Chaperons can provide reassurance to the patient about the professional context and content of the exam and the intention of the physician and offer witness to the actual events taking place should there be any misunderstanding. The presence of a third party in the room may, however, cause some embarrassment to the patient and limit her willingness to talk openly with the physician because of concerns about confidentiality. If a chaperon is present, the physician should provide a separate opportunity for private conversation. If the chaperon is an employee of the practice, the physician must establish clear rules about respect for privacy and confidentiality. In addition, some patients (especially, but not limited to, adolescents) may consider the presence of a family member as an intrusion. Family members should not be used as chaperons unless specifically requested by the patient.

Per APTA Risk Management, good communication and documentation is of great importance and something that should always be highlighted and encouraged in conjunction with any risk management question. Good documentation is an important output for all practitioners; however, it is doubly so for those working with patient/client populations who can be perceived as "vulnerable" (e.g. women, children, the elderly). Clear and open communication is very important as well and can go a long way towards minimizing a practitioner's risk. The risk management page on APTA's Web site has information that you may find helpful. You may access this page at http://www.apta.org/member_benefits/mb3/risk_management From this page you can link to readings on a wide range of risk management topics including documentation and communication.

You and your practice/facility need to make a decision on how you will handle these practice issues based on all the available evidence/information and your own risk tolerance. You may decide that you don't need to do anything differently or you may decide that you do need to start practicing differently and/or establish or update policies/procedures. All facilities/practices should have policies and procedures on how they will address evaluation and treatment of minors, second person in the room and opposite gender issues.

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