

## The need for chaperones

### Is greatest during intimate examination

EDITOR,—Arie Speelman and colleagues are inaccurate in stating that "the defence organisations strongly advise both female and male doctors always to use a chaperone."<sup>1</sup> The Medical Protection Society has long advised that a chaperone should ideally be present when intimate examinations are performed. Each year a small number (perhaps 10 or 20) practitioners in Britain receive visits from police officers who are investigating allegations of indecent assault. Most such allegations could have been avoided had a chaperone been present at the examination in question.

The Medical Protection Society recognises, however, that the ideal may not be achievable in practice. Thus it advises members that they should recognise the risks they run and take sensible steps to minimise those risks. Awareness and sensitivity are important, as is the need to provide adequate explanations to patients.

An example of someone who may make a complaint is a teenager who attends with a trivial problem, such as a sore throat. A careful and thorough practitioner may palpate for swollen glands and examine the chest. Some practitioners may additionally palpate the breasts for lumps. Unless care is taken to explain the reason for this thorough examination the teenager may report to her parents, and thereafter to the police, that she was indecently assaulted, having attended for a sore throat but having (as she perceives it) had her breasts fondled for no apparent reason.

Comments and innuendo during an intimate examination also give rise to complaints of indecency, and allegations of homosexual indecent assault have also been made.

The investigation of allegations of indecent assault is invariably distressing for the practitioners concerned, even though many cases will not proceed further for lack of corroborative evidence. Practitioners must decide whether they wish to face these risks and, if so, take elementary precautions to minimise the likelihood of complaints of indecent assault after examinations of patients.

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1 Speelman A, Savage J, Verburgh M. Use of chaperones by general practitioners. *BMJ* 1993;307:986-7. (16 October.)

### Doctors need protection from assault

EDITOR,—Roger Jones discusses how using chaperones may protect doctors against complaints of indecent assault<sup>1</sup> but neglects the part of the definition of "chaperone" that involves "restraint."<sup>2</sup> I have had to request the presence of

chaperones—either staff or police officers—on many occasions in hospital and general practice owing to a well founded fear of assault by a patient or relative. Medical staff have the worry both of being unjustifiably accused of indecent assault and of being assaulted. I have not seen a patient's charter that addresses the responsibility of patients to doctors on either issue.

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1 Jones R. The need for chaperones. *BMJ* 1993;307:951-2. (16 October.)

2 *Chambers English dictionary*. Cambridge: Chambers, 1989.

### Chaperones are expensive and time consuming

EDITOR,—Three important issues were only hinted at by Arie Speelman and colleagues in their paper on the use of chaperones in general practice<sup>1</sup> and were omitted in Roger Jones's editorial on the subject.<sup>2</sup> They are, however, important when the use of chaperones in general practice is being considered.

Firstly, there are the feelings and thoughts of the chaperone herself (or himself in certain circumstances). Surely chaperones have a right to a say about their role?

Secondly, there is the cost: time means money. Every potential chaperone, whether a receptionist, practice nurse, practice manager, trainee general practitioner, or partner in a practice, has his or her own work to do. Can neglecting this be justified?

Thirdly, it takes time to use a chaperone. Usually a patient is examined at a point that arises naturally during the consultation, but this cannot be the case if a chaperone is required: the chaperone has to be found and called away from whatever work he or she is doing.

Because of these restraints the use of chaperones will never be established as a routine part of general practice, whatever medicolegal reasons there are for having them. Should their use not be regarded as a relic of a past style of practice? New methods are needed to protect the doctor or the patient, or both.

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1 Speelman A, Savage J, Verburgh M. Use of chaperones by general practitioners. *BMJ* 1993;307:986-7. (16 October.)

2 Jones R. The need for chaperones. *BMJ* 1993;307:951-2. (16 October.)

### Chaperones valuable in difficult psychiatric interviews

EDITOR,—Roger Jones gives us sound advice in his critical evaluation of the use of chaperones in general practice.<sup>1</sup> He concentrates on the presence of a chaperone when a physical examination—vaginal examination in particular—is performed.

The experience of assessing acutely disturbed patients suffering from symptoms of mania while practising as a psychiatrist has led me to insist, during the initial assessment at least, on the presence of a chaperone. The thoughts of such

patients commonly have a considerable sexual content and it is not unknown for patients, their recollection clouded by flight of ideas and psychotropic drugs, to assume, later on, that some sexual impropriety by the assessing doctor has taken place.

The benefit of a chaperone's presence during these characteristically tricky interviews may extend beyond medicolegal protection. Disinhibited patients may sometimes be quite persistent in their attempts to remove clothing (theirs or the doctor's) or even kiss and molest the doctor. A stoical chaperone of the same sex as the patient may be invaluable in separating an ill patient from an embarrassed male or female doctor.

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1 Jones R. The need for chaperones. *BMJ* 1993;307:951-2. (16 October.)

## Retinopathy of prematurity

### Low iron binding capacity may contribute

EDITOR,—Gerd Holmström<sup>1</sup> does not cite a role for iron in retinopathy of prematurity.<sup>2,4</sup> His suggestion that it is a multifactorial condition distracts from the possibility that there is one main, avoidable cause.

Premature infants may be prone to injury of the retina by oxygen radicals and other tissues because of a deficiency of iron binding capacity.<sup>2,4</sup> In premature infants, serum ferritin values greater than 10 times the upper limit of normal for adults and transferrin saturations of 100% can be seen during the first few days of life. Similar changes, though generally less extreme, occur shortly after birth in infants born at term. Premature infants are born before full rates of transferrin synthesis are achieved. Low concentrations of transferrin make premature infants especially vulnerable to increased transferrin saturation, even in the absence of iron supplementation or transfusions. High concentrations of ferritin and transferrin saturation may not be benign phenomena. Peak values of serum ferritin and transferrin saturation are large even by adult standards.

These changes clearly increase the potential for catalytically active iron occurring *in vivo*. They are seen in the first few days of life, during the time of increased vulnerability to injury from oxygen radicals. The magnitude, direction, and timing of these changes suggest that deficiency in available iron binding capacity has an important role in promoting oxygen radical injury in premature infants.

A definitive test of this hypothesis should be given high priority because it identifies a potentially correctable cause of retinopathy of prematurity. Parenteral human apotransferrin, either a purified preparation or in the form of adult plasma selected for low transferrin saturation, may be an effective preventive treatment. The hypothesis also suggests that measurements of transferrin saturation in premature infants can be used to identify infants at risk.

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