

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."¹ 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 assault¹ but neglects the part of the definition of "chaperone" that involves "restraint."² 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 practice¹ and were omitted in Roger Jones's editorial on the subject.² 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.¹ 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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Retinopathy of prematurity

Low iron binding capacity may contribute

EDITOR,—Gerd Holmström¹ does not cite a role for iron in retinopathy of prematurity.^{2,4} 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.^{2,4} 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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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

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Author's reply

EDITOR,—My editorial on retinopathy of prematurity mentioned antioxidants in general, both regarding aetiology and prevention. Several antioxidant mechanisms have certainly been described previously,¹ but owing to restriction of space vitamin E was the only antioxidant specifically mentioned in the editorial. I agree that transferrin also is very interesting. Further research concerning the relation of iron and transferrin concentrations in extremely premature children and development of retinopathy of prematurity, as well as the possible preventive effects of transferrin on retinopathy of prematurity, will be welcomed.

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Urination and fluid intake

EDITOR,—T S O'Brien and colleagues rightly state the need for inquiring about the volume of fluid intake when patients present with urinary frequency,¹ but the composition of that intake is often very important. Owing to diuretic and stimulant effects, tea and, more so, coffee may cause similar symptoms in some patients without polydipsia. For example, a 50 year old man asked for prostatic surgery because of nocturia (five times nightly), daytime frequency, and poor flow. He was drinking only black coffee and after changing to "bland fluids" (water, non-caffeinated beverages, etc) lost his nocturia and other symptoms. Moreover, a less than optimal total volume may result in frequency, possibly owing to lower pH in the bladder. An 82 year old man with "retention with overflow" but a virtually empty bladder had got himself into a vicious circle of frequency and reduction of intake. After adequate hydration he lost his symptoms. Other patients have associated beer drinking at weekends with a reduction in symptoms.

For the past two years I have kept a file of patients benefiting greatly from advice to take only bland fluids. Ten men aged 54 to 84 years and one woman aged 32 had an average reduction of nocturia from 3.4 to 0.4. In none was a reduction in total intake suggested; an increase was recommended in eight. All were advised to reduce tea and coffee, especially in the evening. On the other hand, in only one of around 200 patients seen in the same period with reduced urinary flow due to obstruction of the bladder outlet were symptoms improved sufficiently to avoid surgical treatment. A 62 year old man had his nocturia fall from six to zero, yet his maximum urinary flow was 8-9 ml/s both before and after increasing bland fluids. Even a small reduction in symptoms may, however, make the symptoms tolerable while the patient is awaiting operation, and the modified fluid intake is worth trying before resorting to drug treatment.

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Schistosomiasis in Malawi

EDITOR,—I am responding to the opinion that swimming in Lake Malawi carries the danger of contracting schistosomiasis.^{1,2} Having lived in Malawi for seven years, worked there on the bilharzia problem, and along with a large expatriate community enjoyed the pleasures of "sea" and beach, I know of no community member who claimed the infection from sensible bathing in this vast inland lake. This community included a white Rhodesian population, well known for excellence at water sports, who had moved from neighbouring Zimbabwe.

No doubt we benefited from local knowledge that the cleared, white, palm lined beaches fronting hotels and weekend chalets were a safe ticket for bathing: the very areas that the tourist industry aims to promote. Dangers of the lake we equated with the occasional squall, high waves and strong currents, or night bathing and the risk of meeting hippopotamuses. This specific environment with its lack of suitable vegetation is no habitat for the vector snail species; the wave action is hostile to any fragile cercariae that may be found; and the lake itself presents a massive dilutional factor.

Overland visitors to Africa should be aware that inland pools and streams pose the greatest threat. The nearer they are to endemic village areas the greater the risk and degree of exposure to cercariae. Malawi is not different. The lake is the least likely place to acquire schistosomiasis. However, the unwary tourist should beware the cheaper accommodation that borders fishing communities around vegetated areas of calm bays, lagoons, and river inlets. There is nothing wrong with this type of accommodation, but these parts of the lake may present a risk to the bather. My colleague from those days in Malawi has first hand knowledge of snail distribution along the lakeshore.³

Malawi is a beautiful country with a varied topography. Its tourist trade deserves protection from generalised criticism of one of its prime assets on health grounds. The risk to the informed traveller of contracting schistosomiasis in Lake Malawi may not be as remote as a great white shark attack off an Australian shore, but this risk should be put into perspective.

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Road traffic and respiratory health of children

EDITOR,—In their study of the relation between the density of car traffic and the respiratory health of children Matthias Wjst and colleagues state that "as the total sample of children in the fourth grade was used no calculations of sample size were needed."¹ This implies that the calculation of sample size is an administrative matter, whereas the purpose is to calculate the power of the study. Part of this process should include an estimation of what degree of difference in the outcome measure between the study groups is clinically important.

That this has been ignored is reflected in the study's results, which, although sometimes significant, are not necessarily clinically meaningful. In table II the highest percentage change per 25 000 cars for any of the tests of pulmonary function was a 0.71% decrease. As most of the children lived in

areas where the traffic count was 50 000 cars a day or less this means that even for the test with the worst results the change was less than 1.5%. Is this clinically important? Similarly, the difference between the two groups shown in table III may have been significant, but was it large enough to be clinically relevant? If common colds are excluded the highest adjusted odds ratio that was significant was 1.1—a low figure.

The association that Wjst and colleagues have studied is complicated and multifactorial, and excluding all confounding variables will always be difficult. If the difference between the two groups is small this may well be due to residual confounding. I suspect, however, that the problem underlying these criticisms is not that the conclusions are incorrect but that such studies are extremely difficult to carry out.

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Suspended doctors

EDITOR,—The correspondent who was suspended may be considered fortunate in being reinstated after one month.¹ Our group has a case of a doctor who has been suspended for 11 years without trial. Our records also show that only 20% of the suspensions are proved justified in the ensuing inquiry. The figure for female doctors is 10%. Doctors born overseas are 2½ times more likely to be suspended than doctors born locally and twice as likely to be found guilty, such is the gender and racial intolerance among the administrative hierarchy.

The suspensions cause considerable mortality and morbidity. Out of 83 cases we have collected over the past 10 years there were four associated deaths, including two stress induced myocardial infarcts. There have been three suicide attempts, two of which were fatal, and two would be suicides were prevented by emergency psychiatric action. Reactive depression is common, arising in part from the undermining of confidence in one's professional abilities; in part from the malevolence with which some health authorities pursue their case, particularly when the case is without foundation, when after years of procrastination anything will be dredged up in a vain attempt to justify the suspension; in part from the financial uncertainty that legal expenses will be covered (the Medical Defence Union will not always cover these cases); and in part because the NHS is a monopoly employer of doctors and suspended doctors may therefore be forced into exile.

We can confirm that some authorities are trigger happy and reckless with their suspensions, oblivious to the harm that they do. Two adjacent health districts—out of almost 200 health districts—between them account for nearly 10% of suspensions over the past 10 years.

One thing we have found to be very effective if suspended is to get a court order as fast as possible to order a reinstatement. This is particularly necessary if the suspension has been for a trivial reason such as described by the correspondent. Sometimes the mere threat of a court action is enough to bring a health authority to its senses.

As a last resort the case can be taken to the European Court of Human Rights; we have found that the English courts will not always give the protection needed against a hostile administration. It has been recognised in Europe that to practise as a doctor is a civil right which cannot be taken away except by a body appointed by law (the courts or