Professional probity post-Fernando:

A terrible beauty is born

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'Operating in the unwitnessed privacy of the examining room and with the presumed authority of their exclusive knowledge, physicians have always been in a virtually unique position to exploit routine encounters to extract private gain.'[1]

During my practising life there have been a number of sentinel events that have irrevocably changed the way we practise medicine.

The morning sickness drug thalidomide caused terrible birth defects and (post-thalidomide) challenged our trust in medicines as magic bullets, and in drug manufacturers as altruistic organisations.

'All changed, changed utterly' is how *BMJ* editor Richard Smith assessed the future for British medical practice after the tragic events in Bristol.[2] The next line of Yeats's poem (*Easter, 1916*) is *'A terrible beauty is born'*: if we can learn from a shocking event, there is the promise of a clearer future, but it will be frighteningly difficult for many of us. (*'I am become death, the destroyer of worlds,'* thought Robert J Oppenheimer as he observed the first atomic test at Los Alamos).

The investigation into the arrogant disregard for women's rights by some doctors at National Women's Hospital in Auckland coined a new word and a new age in New Zealand medicine: 'post-Cartwright'. There can hardly be a doctor in the country who doesn't know exactly what post-Cartwright means. Informed consent and the Health and Disability Commission were born of it. 'Trust me, I'm a doctor' departed forever.

UK general practitioner Harold Shipman showed us that a good communicator can also be a mass murderer (*'He was a marvellous GP apart from the fact that he killed my father,'* said the son of one of his victims) and, if the post-Shipman reforms suggested in England eventuate, practice will never be the same.

NZ general practitioners Morgan Fahey and Hiran Fernando have shown us that doctors who are highly respected community leaders can also be sexual predators. Post-Fernando general practice has to change too.

I think some of the doctors accused of grubby groping are innocent. I'm not talking about consenting sex with patients – that is an entirely different issue. I'm talking about doctors taking advantage of the power of their position to pervert intimate clinical examinations of vulnerable young women into opportunities for prurient self-gratification. Feeling them up, not to put too fine a point on it: sexual assault in society's view. I may be wrong: perhaps all accused doctors actually are guilty. But I suspect there are at least some who are innocent. Careless, silly, naïve, but innocent. The victims of a tragic misapprehension of what intimate examinations are about. That's a shame, because I think such misunderstanding can easily be avoided, and post-Fernando it has to be avoided.

Agreed, you can't entirely eradicate the possibility of an angry disappointed drug seeker falsely accusing you of demanding sex in exchange for drugs, but you can avoid the impression gained by some honest women that what you are doing during intimate examinations is for your pleasure and not for their benefit.

Let me be plain: I am writing about man doctors and woman patients here – that is the relationship out of which almost all accusations of such impropriety arise. It is a relationship already sexualised by popular mythology – find a Mills & Boon with a darkly handsome bloke in a white coat on the cover and thumb through the pages if you don't believe me. Or visit the Erotic Doctor website ('Naked doctors and nurses!') if you seek a more revealing picture.

Even the avuncular Balint image of the GP as a kind of honorary uncle to the patient may be inept, for uncles notoriously interfere with nieces.

The intimate examination

When you do a breast or vaginal examination the fact is you touch a woman where only her lover does, and you must leave her quite sure you are not seeking to be that. Put simply, if you want to avoid the possibility of an accusation of sexual assault, your whole demeanour should transmit one clear message: *'Let's, both of us, make no mistake: what we are engaged in here is not foreplay, but professional clinical data gathering.'*

What can you do to avoid misinterpretation? Quite a lot actually, and

I think it's blindingly obvious, but I am repeatedly astonished by the number of respectable doctors who don't bother. Perhaps they have skills I lack, an ability to transmit that message safely in other ways, but here are a few personal observations, for what they're worth.

A woman relation of mine, after going to her GP for a smear, told me, *'He said to "Get your beautiful body up on the couch". Then he said "Now let's see what it is your husband likes so much about you".'* Aaarrgghhh! That is verbal foreplay. Maintain professional propriety at this sensitive time. Don't talk dirty.

My nurse once said to an anxious woman about to have a bimanual, *'Lie back and think of England.'* Yecchhh! That was Queen Victoria's advice to women whose husbands wanted sex: quite inappropriate for a clinical examination.

Keep talking: ask permission; explain simply and factually what you are doing and why: i.e. obtain informal informed consent.

Think about what you wear. Professionals have traditionally used formal vestments to preserve distance – the barrister's gown and wig, the doctor's suit and white coat, the priest's raiments. Those days are gone, and nowadays casual dress is regarded as less of a barrier to communication. Sadly it lowers the barrier to misinterpretation too.

Provide privacy (a separate examination room, a full curtain) for undressing; provide a modesty drape; allow the woman to dress her lower body before you examine her breasts or vice versa (she should never be naked); examine one breast at a time. Of course wear gloves for vaginals – it shouldn't have to be said. Be respectful, formal: this is not the time for easy familiarity.

'The time to talk about sex is with one finger in the vagina,' a visiting American sexologist told a gaping audience of New Zealand GPs 20 years ago. Oh no it isn't. That is perilously unwise for male doctors. Use your brains. *'One finger in the throat and one in the rectum makes a good diagnostician,'* said Osler; but one finger in the vagina and a question about sex makes the wrong association entirely.

Don't do unthinking ritual traditional vaginal or breast examinations. Teaching breast self-examination has long been discredited: why continue it in an age of evidence-based medicine? Routine antenatal breast and vaginal examinations may have been advised when you were at medical school, but they provide no useful information (see UK National Institute for Clinical Excellence – NICE – guidelines[3]). What have you ever learned from a breast examination in a young woman about to start the pill (what is the incidence of breast cancer found at such routine examinations of teenagers)? There is no evidence that the bimanual adds useful screening information at the time of a routine cervical smear. Does it add to the information gained from an ultrasound in dysfunctional uterine bleeding? Stop the rituals. Challenge the dogma – why conduct such rites? Adopt a minimalist, evidence-based approach to intimate examinations.

That brings me to the question of chaperones. 'Providing' a chaperone, or 'offering' a chaperone. Inaccurate verbs those, deriving from the patients' rights literature, but we have been slow to question the concept. Let there be no doubt: the chaperone is for my protection too. I don't just offer a chaperone, I require one. I graduated in 1965, and I could count on the (gloved) fingers of one hand the number of vaginal examinations I have conducted without a chaperone – all of them emergencies at home.

'But,' a colleague rationalised to me once, *'a chaperone interferes with my relationship with my patient.'* Errrr, what sort of relationship is that exactly?

'But I'd have to pay for an extra staff member.' Umm, how many vaginals do you do? How long do they take?

'But when I ask my patients if they want a chaperone, they almost always say no.' Yes, but when they say no they are really saying no to the implied question, *'Do you mistrust me?'* The chaperone is for your protection as much as the patient's. (Equally, if you were to ask, *'Do you mind if I have a chaperone?'* your patient might think you don't trust her). Get over it: just provide a chaperone and patients will accept her.

A third person, preferably another health professional (I have a nagging anxiety about the woman's 'support person' filling that role), beside the couch removes any lingering doubts about prurient motivation. Of course the chaperone may assist, comfort, and reassure the patient too, even help her relax so tense abdominal muscles don't make the bimanual more difficult – but primarily she is there to protect the doctor from misunderstanding.

Issues raised by the Fernando case

- The need for clearly understood standards for intimate examinations;
- The training of doctors in intimate examinations;
- The ways in which people concerned about patients' safety can make their concerns known;
- The need for doctors to take prompt action at an early stage when a colleague is suspected, in order to offer the best chance of avoiding further damage to patients;
- The way the Courts and the Medical Council should act when a doctor has been accused of sexual assault.

Not insisting on a chaperone for vaginal examinations is naïve and reckless.

Public protection

There was public concern when the Court did not allow Dr Fernando's name to be published, and the outcry became strident when the Medical Council (whose principal purpose is the protection of the public) allowed him to continue practising until the outcome of the criminal trial.

Should 'innocent until proven guilty' continue to apply to doctors accused of sexual crimes? Any other approach could unfairly destroy not only an innocent doctor's income, but also his reputation. A salaried doctor might be suspended on full pay, but public suspension would be hugely damaging, especially unfairly so for an innocent self-employed doctor. The outrage of New Plymouth people about how their young women were treated is understandable, but rushing to remove from practice all doctors as soon as they are accused of sexual impropriety would be draconian indeed.

Nonetheless, these discussions must now take place among the profession, the public, and its protector, the Medical Council.

'Post-Fernando' may come to mean much more than simply providing a chaperone. It may signify the birth of a new relationship between the profession and the people. Some of us will find that terrible.

Competing interests

None declared.

References

1. Cohen J. Foreword. In Stern D (Ed.) Measuring medical professionalism. OUP, New York, 2006, vii.
2. Smith R. (editorial). All changed, changed utterly. BMJ 1998; 316: 1917-1918.
3. National Institute for Clinical Excellence (NICE). Antenatal care: Routine care for the normal healthy woman; www.nice.org.uk/pdf/CG6_ANC_NICEguideline.pdf.

Meningococcal vaccination for adolescents

'The Advisory Committee on Immunization Practices (ACIP) of the US Centers for Disease Control and Prevention (CDC) has issued new recommendations calling for meningococcal immunization with conjugate vaccine of all adolescents 11 to 18 years of age. The quadrivalent meningococcal polysaccharide diphtheria toxoid conjugate vaccine (MCV4; Menactra, Sanofi Pasteur) is recommended for all adolescents and additional age groups, and vaccination against meningococcus is now recommended for everyone aged 11 to 18 years. The newer conjugate vaccine may be given up to age 55 years (the polysaccharide vaccine may be given to children two to 10 years of age).'

Barclay L. CDC issues new guidelines for meningococcal vaccination. http://www.medscape.com/viewarticle/559807?src=mpnews Accessed 21 July 2007.

Mandating HPV vaccine

'Public health officials may have legitimate questions about the merits of HPV vaccine mandates, in light of the financial and logistic burdens these may impose on families and schools, and also may be uncertain about adverse-event rates in mass-scale programs. But given that the moral objections to requiring HPV vaccination are largely emotional, this source of resistance to mandates is difficult to justify. Since, without exception, the proposed laws permit parents to refuse to have their daughters vaccinated, the only valid objection is that parents must actively manifest such refusal. Such a slight burden on parents can hardly justify backing away from the most effective means of protecting a generation of women, and in particular, poor and disadvantaged women, from the scourge of cervical cancer. To lighten that burden even further, the governor of Virginia has proposed that refusals need not even be put in writing. Perhaps it is time for parents who object to HPV vaccinations to take a lesson from their children and heed the words of Nancy Reagan: Just say no.'

Charo RA. Politics, parents, and prophylaxis – Mandating HPV vaccination in the United States. N Eng J Med 2007; 356:1905–1908.

Head lice

'The timing of head lice maturation most favorable to their survival in the presence of anti-lice agents is the maximum time as an ovum (12 days) and the shortest possible time of maturing from newly hatched nymph to egg-laying adult (8.5 days). Pediculicides that are not reliably ovicidal (pyrethroids and lindane) require two to three treatment cycles to eradicate lice. Ovicidal therapies (malathion) require one to two treatments. Treatment with an agent to which there is genetic resistance is unproductive. In the United States, lice have become increasingly resistant to pyrethroids and lindane but not to malathion. Treatment with malathion has favorable efficacy and safety profiles and enables the immediate, safe return to school. Nit combing can be performed adjunctively. No-nit policies should be rendered obsolete.'

Lebwohl M, Clark L, Levitt J. Therapy for head lice based on life cycle, resistance, and safety considerations. Pediatrics 2007; 119:965-974 (doi:10.1542/peds.2006-3087).

[There is no information on the resistance patterns of lice in New Zealand. Dermnet Updated 26 Dec 2006, Ed.]