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CORRESPONDENCE

Correspondents are asked to be brief

Chaperones

SIR,—Dr. J. A. Henderson (30 January, p. 273) seems to argue that "modesty and prudishness" are the only reasons for the presence of a chaperone when a male general practitioner makes a gynaecological examination in his surgery; he considers these reasons to be inadequate in most cases, and prefers to rely on trust. The true reason for having a chaperone should be frankly acknowledged. For each occasion on which a doctor really behaves improperly towards a patient—and they are rare indeed—there is a host of false accusations and this should be fully appreciated, especially by new graduates.

One of the functions of the chaperone is to vouch for the doctor's conduct when his behaviour is attacked. Baseless allegations of improper conduct are common. Allegations of unprofessional conduct occur not once in a decade, as some appear to think, but several times every year. Quite often practitioners who have to appear in a magistrates' court, or before the Disciplinary Committee of the General Medical Council, to answer a charge of sexual assault made by a patient, are unable to call any supporting evidence because there was no-one else present at the time of the examination.

The Medical Defence Union was founded in 1885 largely as the result of a case in which a doctor was sentenced to two years' imprisonment with hard labour on the unsupported evidence of a woman who had attended his surgery during her pregnancy. He served eight months before belated evidence of the woman's previous psychiatric disorders led the Home Secretary of the day to arrange a free pardon.

In his book *Law for the Medical Practitioner*[1] Harcourt Kitchin, barrister at law, wrote: "The Medical Defence Union finds that practitioners are rather apt, through daily association with members of the other sex in somewhat intimate circumstances, to be lulled into a false sense of security and to believe that they are above accusation. That they are not so is shown by many instances in which, for various obscure reasons, women have falsely accused their medical men of seducing them." The views of the Union were accurately reported by Harcourt Kitchin in 1941 and the Union holds the same views now even more firmly.—I am, etc.,

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[1] D. H. Kitchin, *Law for the Medical Practitioner*, p. 102, London, Eyre and Spottiswoode, 1941.

Safety of Combined Antidepressant Drugs

SIR,—On several occasions in your correspondence column[1 2] you have allowed me to express the opinion that it is not dangerous to combine the tricyclic antidepressant drugs, such as trimipramine and amitriptyline, with the monoamine oxidase inhibitor drugs, provided certain precautions are taken. In general a sufficient dosage (25-150 mg) of the tricyclic drug should be given only at night to produce deep sleep and combat early morning waking, reducing it if the sleep is too deep or prolonged. The monoamine oxidase inhibitor drugs should be given during the day; the dosage again should be reduced if there are any postural hypotensive symptoms.

In this department we have used combined antidepressant drugs for nearly ten years now on some thousands of patients. We still wait to see any of the rare dangerous complications reported. But we have collected quite a lot of information as to why the combination was originally thought to be dangerous. For instance, I have reported a supposed death from combined drugs,[2] which turned out at post mortem to be due to undiagnosed cheese reaction. The stomach still contained cheese and it was found that the patient had taken a large amount an hour before the symptoms started.

Just recently two other cases have been seen which should be reported as throwing further light on this matter. One patient, who had sudden cardiovascular collapse after having been on combined antidepressants for six months, was admitted to an intensive care unit and died. The case was reported to the coroner as a possible combined drug death. But at post mortem a volvulus of the small intestine was found. Possibly too quick a diagnosis of a supposed combined drug reaction led to the abdominal lesion being overlooked.

A few weeks ago I was told that a patient I had put on combined drugs a week or two previously was now in hospital very seriously ill. He had clouding of consciousness, was continually plucking at the bedclothes, and was obviously hallucinated. He was twitching in all his limbs. His temperature was raised. There was tachycardia and profuse sweating. His physical condition was deteriorating rapidly. Some of these symptoms were described in the rare cases who have supposedly died with combined drugs. At first he seemed to me to be suffering from delirium tremens. But the general practitioner said that the patient had only had sodium amytal in ordinary doses before being put on the combined antidepressants. The mother was also quite insistent that no other drugs had been taken in excess, and he had become ill only after starting the combined antidepressants which I had prescribed.

After getting the patient into a better physical condition with fluid replacement, he was transferred to the intensive care unit at St. Thomas's Hospital. With further administration of fluids he quickly recovered consciousness. Then one was able to find out exactly what had happened. He had, in fact, been taking sedatives in very large doses and getting them from varied sources. At one time he was taking up to ten carbromal with pentobarbitone tablets a day and, before stopping them to start the combined antidepressants, was still taking up to four at night. He had actually taken very few of the tranylcypromine and trimipramine prescribed, but it was the stopping of all the sedatives which had produced a typical delirium tremens around the fourth day of sedative withdrawal.

All these cases naturally give one considerable anxiety. But so many patients in the past ten years have been helped by combining the antidepressants that one feels one must go on using them until proved to be unsafe for this purpose. What is so impor-