Initiative."[1] Baby-friendly is the trademark term to describe the formal recognition bestowed on those hospitals that fully conform with the assessment criteria. It is a global effort to encourage and recognize hospitals that have established and adopted optimal lactation management for mothers and babies.

Many physicians have expressed concerns similar to those of Dr Kents about the terminology, because, if their hospital does not conform to the assessment criteria, it might be implied that they are not friendly to babies. However, the terminology applies to the global program designed to protect, promote, and support breastfeeding, not to the relationship doctors might have with their newborn patients.

This terminology was intentionally adopted in 1997 by the College of Family Physicians of Canada's Task Force on Child Health as a means to encourage and honour *best* breastfeeding practices in family doctors' offices.[2] Baby-friendly is therefore the formal recognition bestowed on an office that met the assessment criteria. Dr Kents should be commended on his obvious dedication and commitment to infants. He and his office staff might be very friendly toward babies, but unfortunately, if Dr Kents' office does not conform with these criteria, it would not be designated as a "baby-friendly office."

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Don't shoot the messenger

In his editorial,[1] Dr Maurice takes direct aim at the messenger. The editorial demonstrates some lack of understanding of the role of the Canadian Medical Protective Association (CMPA). The CMPA does not "make policy." Rather, it has a twofold role: to defend members who face medicolegal allegations and to educate members about ways to avoid medicolegal risks.

In order to fulfil the latter function, the CMPA assesses medicolegal risks based on experience through judgments of courts and findings of disciplinary bodies, such as Provincial/Territorial Colleges of Physicians and Surgeons. The courts and the disciplinary bodies rely on clinical experts, such as Dr Maurice or other practising physicians, and on position statements from medical organizations, such as the College of Family Physicians of Canada, the Canadian Medical Association, and the Society of Obstetricians and Gynaecologists of Canada. Based on these opinions and policies as well as other evidence, and taken in context of the overall evidence presented, a physician's practice is judged as being either within or outside the boundaries of acceptable practice. The CMPA then attempts to alert physicians to the implications of these judicial and disciplinary rulings.

Dr Maurice might also have misinterpreted some of the comments in the CMPA's *Information Letter*.[2] The article clearly states that "the physician must always consider first the well-being of the patient." This does, of course, require the physician to take an *adequate* history, in accordance with accepted medical practice, neither neglecting relevant sexual issues nor dwelling on them inappropriately. The *Information Letter* also indicates some areas that have been considered by patients, courts, and licensing authorities to be sexually abusive. Included in these areas are such things as criticizing a patient's sexual orientation, comments about *potential* sexual performance "except clinical comments where the patient's purpose in seeking the consultation was to discuss sexual issues," requesting sexual history "when not clinically indicated," or discussing a physician's own sexuality. Note that *clinically indicated* questions and comments are always appropriate but must be expressed in a sensitive manner.

A recent review of cases dealt with by the CMPA reveals that, in the 10 years ending December 31, 1999, there were 379 cases in which patients alleged sexual impropriety on the part of their doctors. This is a significant number, considering that it does not include more serious allegations, such as inappropriate touching or sexual intercourse or allegations of lack of privacy in disrobing or draping. In 69 of the 379 cases (both disciplinary and legal), it was clear that communication was a severe problem, because in more than a third of those 69 cases it was alleged that inappropriate sexual questions were asked. In other cases, the nature of the examination was not communicated, and in yet others, inappropriate comments were alleged to have been made by the doctor.

Dr Maurice gives as an example a case where a physician was clearly judged by both the court and the College as having fallen below the required standard by *failing* to make appropriate and clinically indicated inquiries. In fact the specific case was complicated and had many more ramifications, but it was certainly brought to the attention of the members of the CMPA in its annual report for the year 1993.[3] A more recent case reported in Ontario illustrates how a communication problem led to

allegations of sexual impropriety against a doctor.[4] In this case the complainant alleged that the doctor's sexual history and physical examination were inappropriate in the context of her presenting complaint.

Dr Maurice clearly believes that the reasons for conducting a sexual history are much more inclusive than they were a few years ago. Not all clinicians agree that a sexual history is necessary in *every* doctor-patient encounter, and most patients will not likely expect a sexual history to be taken during all visits. The CMPA, therefore, must continue to advise doctors to consider carefully under which circumstances a sexual history is required. It is beyond the scope of the CMPA's medicolegal advice to suggest when such a history would be considered essential or non-essential. That falls more appropriately in the purview of the "medical educators and public health officials" to whom Dr Maurice refers.

In addition, knowing that patients might not be aware that such a history is appropriate in the context of today's medicine, physicians might wish to inform patients that sensitive questions will be asked and tell them the medical relevance of these questions.

The law and its interpretation changes in accordance with new knowledge and new cases. The CMPA will continue to keep its members informed of the implications of new developments and interpretations as they arise.

—John E Gray, MD, CCFP
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by mail

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Tips from a retired family physician

I retired from general practice 2 years ago, and I do not think I have ever had anything published in a medical magazine. However, during my career of 45 years, I believe I picked up (or invented) two little helpers that could be passed on to your readers.

First, looking down the throat of someone who gags can be a simple matter. It is *impossible* to gag *and* hold your breath. Try it! Explain this to your patients, and, if necessary, allow them to put the tongue depressor down their own throats. Then, ask them to take a deep breath and hold it, and you have plenty of time to do a gag-free examination.

Second, I know a foolproof method for making friends with little patients. To examine their throats or ears, approach them with the auriscope turned *off*. Then explain that the light is magic and goes on only if someone blows on it. Then, invite your little patients to give it a puff and simultaneously turn the light on—smiles all around while you peek into the ear or throat. But remember to then get them to blow the light off when the examination is finished. Each time these patients come to see you, they will actually look for the magic light and will be most upset if you do not use it. When your patients get to be 10 or 11, however, forget about it—the magic has gone by then.

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by e-mail

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