We now invite the submission of manuscript papers to be considered for inclusion in this theme issue. The issue will appear in March 2000, and the closing date for submissions is 30 November 1999. Examples of topics of special interest include (but are by no means limited to) the following:

- Error-reporting systems, especially non-punitive reporting
- The safety of medical equipment and devices
- Approaches to team training and improving interactions in medical care
- Innovative systems and procedures to improve safety and to decrease or mitigate the effects of errors—for example, medication administration, operating room management, and emergency care
- The use of simulation for training and system improvement
- Approaches to safety in non-health-care sectors that may hold promise for adapting to medical care
- Epidemiological studies of the distribution and patterns of medical error and threats to patient safety
- Workplace safety for healthcare employees and professionals.

We are especially interested in innovative approaches to improving patient safety, in empirical evaluations and experiments, and in multidisciplinary efforts involving not just clinicians but also human factors specialists, engineers, and others who may not normally think of their work as relevant to health care. As always in selecting papers, we will have very much in mind the *BMJ* reader-practitioners and how best to help them understand and participate in improving patient safety.

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The Institute for Healthcare Improvement, which DMB works for, is a non-profit organisation which offers training and opportunities to take part in demonstration projects for the improvement of health care, including the reduction of errors. LLL lectures internationally on error prevention and sometimes receives honorariums for this.

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Chaperones for genital examination

Provide comfort and support for the patient and protection for the doctor

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Never, sometimes, or always characterise the wide variation in individual doctors' practice of using chaperones during genital and rectal examination. This variation is not confined to general practice.[1] In this week's issue Torrance et al report a survey of chaperone policy in genitourinary medicine clinics (p 159).[2] Some clinics would appear to allow male doctors to examine female patients without the presence or offer of a chaperone. Such practice is surely beyond justification.

Some may argue that the use of chaperones is an area where physician discretion is more relevant than policy. Certainly not all patients choose to have a chaperone present during intimate examinations, and it may be difficult to provide chaperones in some settings. However, in this area of quality and clinical risk guidelines rather than discretion need to dictate practice.

What considerations should direct the use of chaperones? Several studies have sought patient preferences in primary and secondary healthcare settings,[3–7] although not in genitourinary medicine. The findings show remarkable consistency. Male and female patients differ markedly in their desire for a chaperone. Most women want the offer of a chaperone and feel uncomfortable asking for one if it is not offered. Most teenagers want a chaperone during intimate examinations, and a family member may be the preferred choice. Many women prefer having a third party present when the examining doctor is male, fewer if the examining doctor is female. For women a female nurse is generally the preferred choice as chaperone, would be accepted as a routine part of the clinical examination, and is generally viewed as having a positive supporting role during the examination. Men, however, particularly teenagers, find the presence of a female nurse as observer during genital examination unwelcome. Interestingly, a substantial proportion of patients in primary care didn't mind if a chaperone was present or not,[7] although this finding may reflect an older patient sample and familiar doctors.

These findings suggest some strong imperatives. Every woman having a genital or rectal examination should be offered a chaperone. Failure to offer one deprives patients of support they may want, and non-availability is an unacceptable excuse. It is unacceptable for a teenage woman to be alone with an unfamiliar male physician for genital examination. Moreover, it shouldn't be assumed that a female nurse will be an acceptable chaperone for a man.

Genital examination is one area of medical practice where the sex of the patient and sex of the doctor have a significant influence on patient preferences. Clear differences exist in the preferences of male and female patients, and these can and should be accommodated. In genitourinary medicine it is difficult to argue against a female nurse routinely being present during the

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examination of women to support the patient and provide assistance to the examining doctor, regardless of the sex of the doctor. Assistance is rarely required in examination of male patients, who generally do not express a need for the support of a chaperone and are likely to feel embarrassed if one is present. Teenagers, however, are probably more apprehensive about genital examination than older patients. They are a major patient group in genitourinary medicine clinics, and their concerns need to be handled sensitively.

What other factors bear on chaperone use? Doctors have been accused of unprofessional conduct and sexual assault after unchaperoned examinations. Eight per cent of the women sampled by Webb and Opdahl reported experiences where doctors had conducted a gynaecological examination in a "less than professional manner."[4] Unprofessional behaviour involved overexposure of the woman's body; inappropriate comments, gestures, or facial expressions; and being examined in an unusual position. Eight per cent of the lead physicians in genitourinary medicine clinics surveyed by Torrance et al were aware of allegations of unprofessional behaviour in their departments in the preceding five years.[2] For medicolegal protection therefore a third party should always be present during genital examination. It is, however, difficult not to proceed with a clinically indicated examination if the patient declines a chaperone, providing the physician feels comfortable in this situation. It would be prudent to document the patient's decision for an unchaperoned examination. It should also be recognised that in a few consultations—for example, the assessment of sexual dysfunction—the introduction of a third party for the examination might negatively affect the doctor-patient relationship.

Variations and inconsistencies in doctors' attitudes and practice in the use of chaperones have again been demonstrated. Examinations need to be conducted in an atmosphere characterised by sensitivity to patients' feelings, care, support, and respect for privacy, dignity, and patient choice. Such qualities are not discretionary. Most female patients in genitourinary medicine expect, welcome, and receive support from the presence of a female nurse. Policy should acknowledge this as best practice. Whether chaperoning should be more frequent during male genital examination is less clear and needs further study. Action is needed where practice is suboptimal and clear policies need to be formulated. Patient preference, the need for assistance, and medicolegal considerations would seem to be the major determining factors.

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Treating behavioural and psychological signs in Alzheimer's disease

The evidence for current pharmacological treatments is not strong

Dementia is a prominent healthcare issue for primary care physicians and specialist services. Over 90% of patients with dementia experience a "behaviour disturbance,"[1] often referred to as behavioural or psychological signs in dementia in accordance with the recommendation of the International Psychogeriatric Association. These symptoms are distressing to patients and troublesome to carers and often precipitate admission to residential facilities.[1] What is the evidence that any of the several drugs that are currently used to treat these symptoms are effective?

Managing the behavioural and psychological signs of dementia is a major problem for healthcare professionals. Neuroleptic drugs are the mainstay of pharmacological treatment, although their use is justified largely on the basis of clinical anecdote, and they have many harmful side effects. These include parkinsonism, drowsiness, tardive dyskinesia, falls, accelerated cognitive decline,[2] and severe neuroleptic sensitivity reactions.[3] It is therefore not surprising that the chief medical officer has recommended judicious use of these agents in patients with dementia.[4]

In 1990 Schneider published a landmark study showing the paucity of large, placebo controlled, double blind trials of neuroleptic agents in treating behavioural and psychological signs in dementia.[5] Since then research in the subject has increased, but most treatment studies have used an open or active comparison design, a major methodological flaw given the high placebo response rates (40%).[5] Two large multicentre studies with risperidone have recently been completed,[6] showing a significant advantage over placebo for overall reduction of behaviour disturbances, although in one of the studies psychotic symptoms did not improve significantly. In addition, psychosis and aggression responded preferentially to different doses. The studies of neuroleptic agents are summarised in the table on the *BMJ*'s website (www.bmj.com).

There is a tendency in clinical trials to group together different behavioural and psychological signs, although they are likely to have separate neurochemical or neurophysiological bases. For example, there is evidence linking visual hallucinations to cholinergic

website *e*xtra

A table showing the results of randomised trials of neuroleptics is available on the BMJ's website

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