

Numbers (percentages) of respondents whose departmental policies never, sometimes, or always provided for chaperones during performance of genital tests on female and male patients

Clinical scenario (No of respondents to question)	Policy provided for chaperones		
	Never	Sometimes	Always
Female patient being examined by:			
Male doctor (n=165)	1 (1)	5 (3)	159 (96)
Male nurse (n=47)	14 (30)	5 (10)	28 (60)
Female doctor (n=159)	19 (12)	47 (30)	93 (59)
Female nurse (n=145)	81 (56)	52 (36)	12 (8)
Male patient being examined by:			
Male doctor (n=163)	74 (45)	44 (27)	45 (28)
Male nurse (n=95)	63 (66)	26 (27)	6 (6)
Female doctor (n=158)	38 (24)	55 (35)	65 (41)
Female nurse (n=128)	62 (48)	44 (34)	22 (17)

departments while female patients were being examined by male doctors.

Thirty seven departments were more likely to offer chaperones during examinations of patients aged under 16. Only 20 respondents said that their hospital had a policy on chaperoning. Fourteen knew of allegations of impropriety concerning medical or nursing staff in their department during the preceding five years. In the opinion of half of these respondents, allegations could have been prevented had a chaperone been present.

Comment

To our knowledge this is the first survey on chaperoning policies in genitourinary practice. Use varies widely among the respondents, and only one tenth of hospitals have a policy on chaperones. Doctors are more likely than nurses to be chaperoned while performing genital tests. The working party of the Royal College of Obstetricians and Gynaecologists concluded that a chaperone should be offered to all

patients having intimate examinations in gynaecology and obstetrics, irrespective of the sex of the gynaecologist, and that if the patient declines one the response to the request should be honoured and recorded in the notes. Surveys in primary care show that many women decline chaperones.² On the other hand, our survey identified allegations of impropriety, half of which might have been prevented by the presence of a chaperone. On this basis we believe that chaperones should be offered more widely during genitourinary examinations. Perhaps clinicians in other specialties should encourage their patients to accept chaperones during vaginal or rectal examinations.

Who should act as chaperone in genitourinary medicine clinics? Some patients (particularly adolescent females) prefer a relative to be present during pelvic examinations in general practice.⁴ A nurse seems better suited to the role of chaperone in genitourinary practice because he or she can help the examiner, reassure patients if they are anxious, and safeguard both parties against abuse or subsequent allegations. Many would argue that the sex of the chaperone should match that of the patient. Small clinics may face difficulty in funding nurses to fulfil this role, but costs have to be balanced against time taken to deal with complaints. Perhaps wider use should be made of auxiliary nursing staff as chaperones.

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Competing interests: None declared.

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Review of randomised controlled trials of traditional Chinese medicine

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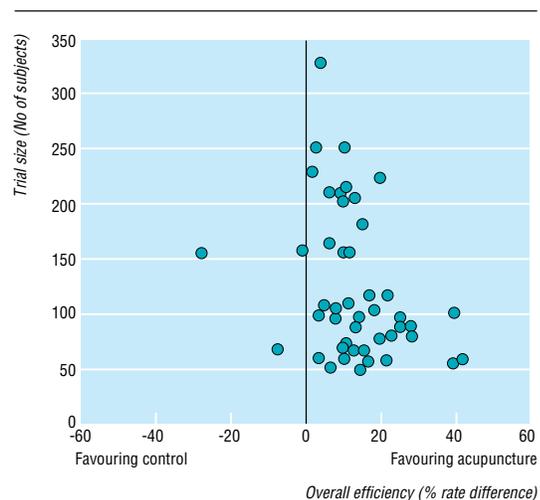
BMJ 1999;319:160-1

Many randomised controlled trials have been conducted in China to evaluate the effectiveness of traditional Chinese medicine, but much of the information is inaccessible to Western doctors. We estimated the total number of randomised controlled trials published in China and identified problems in applying such methodology to the evaluation of traditional Chinese medicine, which would serve as preparatory work for systematic review and dissemination of the randomised evidence for such medicine.

Methods and results

We randomly selected 28 journals using stratified sampling from a total of 100 Chinese journals of

traditional Chinese medicine (4 national, 10 university, 10 provincial or regional, and 4 specialist journals). After special training, eight fifth year medical students (working in pairs) hand searched all the issues of the journals published before 1 January 1997 to identify randomised controlled trials. Discrepancies were settled by one of the principal investigators (S-YZ). Data on methodological quality of randomised controlled trials were extracted from 414 full length articles in the *Chinese Journal of Integrated Traditional and Western Medicine*. Ten times as many randomised controlled trials appeared in that journal as in the other journals, and those published in that journal were of a higher quality.^{1 2}



Funnel plot of overall efficacy of acupuncture in treatment of stroke (49 trials), according to trial size

Altogether, 2938 randomised controlled trials were identified in the 28 selected journals. The first trials were published in the early 1980s. The number of trials had doubled every two to three years over the past 15 years. The number of randomised controlled trials published in all 100 journals by the end of 1996 was estimated to be around 7500 (95% confidence interval 6000 to 9000). Comparison of hand searched trials with trials of traditional Chinese medicine found in electronic databases (which hold journals of conventional medicine too) shows that journals of conventional medicine in China published about a quarter of the number randomised controlled trials published in journals of traditional Chinese medicine. Thus, almost 10 000 randomised controlled trials were published in China before 1997.

In most of the trials, disease was defined and diagnosed according to conventional medicine; trial outcomes were assessed with objective or subjective (or both) methods of conventional medicine, often complemented by traditional Chinese methods. Over 90% of the trials in non-specialist journals evaluated herbal treatments that were mostly proprietary Chinese medicines. The 10 most common diseases in the trials were ischaemic heart disease, stroke, chronic viral hepatitis, peptic ulcer, childhood diarrhoea, hyperlipidaemia, primary hypertension, upper digestive tract bleeding, diabetes mellitus, and pneumonia. They accounted for a fifth of the trials.

Although methodological quality has been improving over the years, many problems remain.^{1 2} The method of randomisation was often inappropriately described. Blinding was used in only 15% of trials. Only a few studies had sample sizes of 300 subjects or more. Many trials used as a control another Chinese medicine treatment whose effectiveness had often not been evaluated by randomised controlled trials. Most trials focused on short term or intermediate rather than long term outcomes. Most trials did not report data on compliance and completeness of follow up. Effectiveness was rarely quantitatively

expressed and reported. Intention to treat analysis was never mentioned. Over half did not report data on baseline characteristics or on side effects. Many trials were published as short reports. Most trials claimed that the tested treatments were effective, indicating that publication bias may be common; a funnel plot of the 49 trials of acupuncture in the treatment of stroke confirmed selective publication of positive trials in the area, suggesting that acupuncture may not be more effective than the control treatments (figure).³

Comment

The quality of trials of traditional Chinese medicine must be improved urgently. Large and well designed randomised controlled trials on long term major outcomes should be funded.⁴ Subsequently, such studies may serve as models for future trials in the area. Treatments to be tested should be selected so that potentially effective and important treatments are evaluated first. The best evidence should be systematically reviewed, summarised, and disseminated, which in turn would lead to evidence based decision making in traditional Chinese medicine.⁵

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Endpiece The ideal

Give me a doctor, partridge-plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands,
Who'll never make absurd demands
That I abandon all my vices,
Nor pull a long face in a crisis,
But with a twinkle in his eye
Will tell me that I have to die.

W H Auden, *Collected Poems* (1991)

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