

Soundings

Mistakes



Last year the newspapers reported that doctors in Florida had amputated the wrong leg of a patient with diabetes and that technicians in the same community hospital had removed the wrong patient from ventilator support. Missed

diagnoses are claimed to be found in 40% of autopsies; 5-10% of hospital admissions are said to result in iatrogenic injury; and 10-20% of these have been classified as serious, a statistic extrapolated to 150 000 Americans dying each year—a “hidden epidemic,” comparable with a jumbo jet aeroplane crashing every few days.

That errors may occur in medicine has long been taken for granted, given the complexity and uncertainties inherent in medical practice and the multitude of interventions that patients are being subjected to. But the public has always taken a dim view of people who make trains crash or bridges collapse, or for that matter of doctors who make mistakes. Prosecutors, juries, and hos-

pital officials also tend to deal harshly with those who have made mistakes. Nurses have been dismissed for giving the wrong drug, house officers have been severely disciplined for making mistakes, and hospitals have had their accreditation revoked in the aftermath of serious errors or accidents.

When a few years ago a New York doctor mistakenly ordered enteral feedings to be administered through a peritoneal dialysis catheter and then delayed transferring the patient from a nursing home to the hospital for 10 hours, he was convicted of manslaughter by an apparently enraged jury and sentenced to spend 52 weekends in prison. He failed to have the case reversed until after four years of legal entanglements the governor of the state of New York commuted his sentence.

A more constructive and less punitive suggested approach has been to reduce the frequency of mistakes by studying them and learning from them. This would necessitate inducing doctors to report their errors themselves, a requirement already embodied in codes of medical ethics but difficult to implement in practice without fundamental changes in the legal system and in the public's expectations. But already the Joint

Commission on Accreditation of Hospitals has revised its procedures to allow hospitals to investigate in house serious mistakes that were reported voluntarily and promptly, and to develop corrective action. Other people have suggested that more mistakes could be avoided by adopting systems already used in industry; making information more readily available by means of modern technology; entering orders directly on to computers to reduce prescribing and dispensing errors; standardising, simplifying, and structuring tasks so that mistakes cannot be made; and designing self correcting systems.

Diagnostic mistakes could further be avoided by recognising the underlying factors that distract attention, such as boredom, frustration, anger, work overload, or environmental factors, such as noise or heat. Errors may be due to poor skills, faulty judgment, flawed data, or doctor bias, to haste, to not seeing the patient as a whole, to not looking rather than not knowing. Unwanted outcomes may also result from leaving major decisions in the hands of inexperienced junior staff; these often also represent system failures and should be corrected by better deployment of medical personnel.

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Personal views

Most patients don't read the *BMJ*

Editorial by Smith and Education and debate pp 1000-11

Colleagues stopped me in the corridor to discuss it. Others wrote of their own similar experiences on Christmas cards that year. The reason for this sudden rush of attention? I had written a personal view in the *BMJ* (17 December 1994, p 1666). No research paper I have written has provoked such a response. It led me to believe that most doctors read the personal view section. But since 1994 there have been changes at the *BMJ*, and if the article had been submitted today it would not have been accepted. The issue is one of patient consent.

The personal view contained details of a father's response to being confronted with the diagnosis of Down's syndrome in his newborn son. I was aware that he might recognise himself from the details but was confident that others would not identify him. So far, no litigation having resulted, it seems I am in the clear, although having drawn attention to it again might prove to have been a risky move. I would not have sought the patient's consent as this would have merely brought the article to the patient's attention and caused an embarrassing situation.

The *BMJ* and other journals have moved from the traditional means of protecting patient confidentiality by anonymity to one of obtaining patient's consent. The problem was highlighted when a patient made a complaint to the General Medical Council after two psychiatrists reported details of her case in a psychiatric journal. A local newspaper reported the case and a friend of the patient recognised her from personal details that included the patient's occupation. The psychiatrists were found not guilty of serious professional misconduct, but

future cases may be viewed differently when the GMC adopts new guidelines shortly. The draft reads: "You must obtain consent from patients before publishing personal information about them as individuals in journals, textbooks, or other media in the public domain, whether or not you believe the patient can be identified. Consent must therefore be sought to the publication of, for example, case histories about, or photographs of, patients."

Psychiatric case reports may contain personal details relevant to the patient's personality and deal with diagnoses for which there remains considerable social stigma. No one would argue that patient consent should not be obtained in these instances; the question is where you should draw the line.

There has been recent debate in the controversies section of the journal of the American Medical Association (*JAMA*) about whether or not the rules on gaining consent for publication should be absolute (27 August 1997, pp 624-6, 628-9, 682-3). The first article by D E Snider describes a manuscript which failed to be published because of the lack of a patient's consent. It concerned an outbreak of drug resistant tuberculosis which had attracted considerable media attention, partly the result of legal action brought by one family who claimed that the outbreak was mishandled by the health department. Despite the fact that the patient's details were

in the public domain, because the patient had been interviewed by a major newspaper, informed consent for publication was required. Because of the impending legal action the authors were prevented from obtaining this consent as legal counsel advised them and other health department staff not to speak with the patient.

■ "I wouldn't even recognise my lungs in a centrefold spread in the *BMJ*"

I too have fallen foul of the new ruling. While not on a par with a full research paper, titled "An inappropriate present for a doctor," it was accepted for publication in the "memorable patient" section of the *BMJ* and considered to be an "excellent and thought provoking story" by the editorial team. It has not appeared in print because of the absence of patient consent which the editorial staff acknowledged would be embarrassing to obtain. Moreover it would have required considerable detective skills on my part to track down a lady who was already very elderly 10 years ago and living hundreds of miles from where I now live. The issue was not that others would recognise her but that she might recognise herself.

There are many situations in which it would be inappropriate to ask a patient for

consent. Implied criticism of a patient's behaviour or a doctor's management and light hearted humorous articles are examples where patient consent might be difficult to obtain without damaging the doctor and patient relationship. Are articles like this to be written only about patients long dead and gone?

The strict application of the ruling inevitably leads to farcical situations. As a radiologist I have several films that might interest the Minerva column in the *BMJ*. One is the computerised tomogram of a patient with a lung tumour that cuts through the aetiological agent giving a perfect cross section of a packet of cigarettes in the patient's pocket. I can describe this film to you but to reproduce the image would require the patient's consent. The underlying assumption is that patients might possibly recognise themselves from a particular section. This is absurd. I wouldn't even recognise my lungs in a centrefold spread in the *BMJ*.

The purpose of this article is not for an aggrieved author to vent spleen on the editorial staff of the *BMJ*. They are doing a difficult job in difficult times, and the fact that you are reading this shows that they are not afraid of a bit of criticism.

For those of you who are wondering what the "inappropriate present for a doctor" was, I will leave you with this cryptic clue: most doctors don't do it.

James J Rankine, *lecturer in diagnostic radiology, Manchester*

Nuchal translucency—screening without consent

It was during a pregnancy four years ago that I became aware of nuchal translucency. As a doctor with postgraduate training in obstetrics, I thought that I would understand quite a lot about my obstetric care.

During a scan I became aware that the ultrasonographer was spending a lot of time viewing round the back of the baby's head. "I'm just measuring fluid around the back of the neck," was the not unreasonable response to my question. It was only after the baby's birth that I learnt what was being measured and studied.

I realised how close I had been to the receipt of non-specific information from a test that I had not consented to. If the baby had had Down's syndrome I could have been told and been troubled for the rest of the pregnancy. If the test was for research where the results were not given to the mother it means that considerable unnecessary scanning was being done without my consent. I have always said that I would not have an abortion in such circumstances and that I would not have antenatal tests unless they were designed to promote the health of me and the child.

I am angry that this happened to me. I thought that ethical committees were supposed to regulate the way in which trials are conducted. Do they approve of multicentre

trials in which patient consent is not considered?

My experience has made me extremely wary of attending for an ultrasound test before the time when the information gained would benefit the baby. I believe that many mothers attend for ultrasound diagnosis, believing that the test is designed to confirm that the baby is well. It is only when they are presented with an abnormal scan result that they start to consider what it means. By that time they have already been offered advice on amniocentesis and are well on the way to an abortion.

In at least one district the first contact that mothers have with hospital antenatal services is a letter inviting them to the 11 week nuchal translucency test. There is no counselling; it is simply called the first trimester scan. While most women attend for a cosy view of their healthy baby, few are well informed of the key purpose of the scan—namely, to detect Down's syndrome and to decrease the live birth rate of children with this condition. I am told that the studies show that detecting and eliminating two babies with Down's syndrome by screening programmes costs one "normal" baby who succumbs as a result of the programme. The loss of one normal baby is thought to be a price worth paying.

My experience of being screened, without my knowledge, and despite my obstetric training, has heightened my awareness of the ethical issues which surround antenatal testing. Although nuchal translucency may have some scientific use, what are the ethical issues? Should society seek to eliminate undesirable members on the basis of health economics? Are mothers who attend for a health check on their baby being propelled towards a termination? There is a real need for screening programmes to be honest about their purpose and for mothers to be sure that they know why tests are performed and what therapeutic outcomes there may be.

A dishonest approach will distance the service providers from many of those who are producing the next generation. They may not be medically trained but are devoted and loving parents. I have seen many people benefit from the richness of life that people with Down's syndrome can bring. Yet we live in a country which finds devious means to eliminate people who might cost more than the average. If this is an acceptable situation we should be honest and tell the parents.

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