the influence of alcohol. (Patients were considered to be uncooperative if they would not remain relatively still during the procedure or if physical restraint was needed.)

All 30 pairs of unused gloves were intact. Thirty eight (11%) of the 338 pairs of used gloves had a total of 45 perforations (six gloves had more than one perforation). Fifteen of these perforations were not suspected by the doctor. For procedures in patients who were uncooperative owing to the influence of alcohol the rate of perforation increased from 8% (25/295, 95% confidence interval 3.2 to 11.7) to 23% (7/31, 14.7 to 37.3) ($p<0.01$), and for those in patients who were noted to be confused or uncooperative the rate was increased to 50% (6/12, 29.7 to 78.3) ($p<0.05$). Thirty three (73%) perforations were to the left glove, 17 (38%) to the left index finger, and 13 (29%) to the left thumb (fig). Further analysis showed that senior doctors performed no better than senior house officers and that patients who were children did not represent an increased risk.

Comment

The perforation rate of gloves in general and orthopaedic surgery has been reported as ranging from 2.8%-50%.¹⁻⁵ A rate of 11% in this accident and emergency department is surprisingly high in view of the relatively simple procedures that are performed. In total, 37% of perforations had not been suspected and this compares with 61.1% of unsuspected perforations in surgeons and 57.9% in first assistants reported by Brough *et al.*³

Sufficient staff should be available to restrain confused patients, and postponing the suturing of lacerations in patients who are uncooperative because of the influence of alcohol should be considered. Greater use of alternative wound closure methods, such as Histoacryl glue or plastic adhesive tapes and double gloving may help to reduce the risk of perforation.⁴

Thirty three (73%) perforations were found in the non-dominant index finger and thumb; this would suggest poor technique, with the left hand being used to steady the wound and control the needle. Improved training and supervision may be necessary and greater time set aside to suture, although we found that senior medical staff also sustained perforated gloves. Immunisation against hepatitis B should be provided for all staff. Our results have implications for general practitioners, who are now encouraged to perform suturing of wounds and minor surgery.

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Sex bias in the *BMJ*: an audit

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In 1987 an editorial in the *BMJ* stated the journal's policy of neutralising sex biased language in papers accepted for publication.¹ The article listed several examples of sexist writing and particularly criticised the use of "man" and of masculine pronouns to refer to people of either sex. It went on to offer suggestions about how such language might be avoided. The study described here seeks to establish how successful the policy has been in eliminating sex biased writing in the journal.

Method and results

With the exception of the advertisements, obituaries, Memoir Club extracts, and extracts from One Hundred Years Ago, I read the six issues of the *BMJ* from 5 October to 9 November 1991 from cover to cover. Using the examples given in the 1987 editorial as a guide, I noted all instances of sex biased writing. In all, 35 articles contained one or more sexist words or phrases. The table gives the total number of articles read and the numbers containing sexist language, classified by the sections of the journal in which they appeared. A relatively high proportion of articles in the General Practice, Audit in Practice, Education and Debate, News, and Medicopolitical Digest sections contained examples of sexist writing while none of the original articles in the Papers section did so. This seemed to reflect the different topics of the articles in the various sections.

All but one of the instances detected were examples of androcentric writing, implying that the norm of humanity is male.² Thus medical staffing issues were

BMJ articles containing sex biased language, classified by section in which article appeared

Section of <i>BMJ</i>	No of articles read	No (%) of articles containing sex biased language
Editorials	34	2 (6)
News and Medicopolitical Digest	83	12 (14)
Papers	40	0
General Practice and Audit in Practice	10	2 (20)
Middles, Education and Debate	32	7 (22)
Correspondence	205	7 (3)
Medicine and Books	26	2 (8)
Other	39	3 (8)
Total	469	35 (7)

described as issues of medical "manpower." The chairs of many committees were described as "chairmen," even when women; and train drivers, doctors, surgeons, gastroenterologists, inventors, children, and chief executives were all alluded to with masculine pronouns. The average person was "the man in the street," and women were presumably immune to environmental factors "harmful to man." The one exception to an androcentric bias was when nurses were referred to as if all female, thus excluding the many men in the profession.

Comment

Sexist language can be deeply offensive.³ More often it makes a distinction between the sexes that is simply irrelevant to the subject under consideration.⁴ At best this is imprecise, at worst it may confuse. For example, if an employer is seeking "the best man for the job" then is a woman wasting her time to apply? There is also a strongly argued view that the use of sexist language, which excludes women more often than men

and tends to ascribe power to men more often than women, may contribute to inequalities of opportunity between the sexes. "It is through language that we [women] come to know our subordinate place in the world."²

Sexism is deeply embedded in the English language, and various ways of avoiding sex biased writing have been suggested.¹ These have ranged from the use of plural pronouns in the singular and the avoidance of words containing "man" to the creation and use of neologisms such as "himorher." None of the solutions is perfect; which is optimal depends on the context.⁵ By

choosing not to use any of the options we merely perpetuate an imprecise and potentially offensive usage.

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Hospital admission and the start of benzodiazepine use

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Despite awareness of the adverse effects of benzodiazepines and their potential for dependence,¹ 23.2 million NHS prescriptions for them were issued in 1988.² Although most prescriptions are issued from general practice,³ the contribution of hospital prescribing to the initiation of benzodiazepine use should be acknowledged.⁴ We examined whether admission to hospital continues to be a factor in patients starting on these drugs.

Methods and results

Pharmacists at three general hospitals recorded patients supplied with benzodiazepines on discharge from hospital for a two week period in September 1990. Psychiatric cases were excluded. With the consultant's permission 58 sets of notes from the 65 cases notified were scrutinised.

The mean (SD) age of the patients was 74 (11) years. Thirty five (60%) were male. In 38 (65%) cases the consultant was a physician, in 16 (28%) a surgeon, and in four (7%) a cancer therapist. The benzodiazepines used were temazepam (44), nitrazepam (4), diazepam (3), triazolam (3), lorazepam (2), clonazepam (1), and chlordiazepoxide (1).

Before admission to hospital 17 patients, 14 of whom had been under physicians and three under surgeons, had not used benzodiazepines, 12 patients had started taking benzodiazepines during previous hospital admissions, so in all 29—half the group—had started in hospital. Seventeen had started in the community; in 12 cases this was not possible to ascertain.

The rationale for benzodiazepine use was not documented in 22 cases. In eight the drug had been prescribed at the time of the admission clerking. In 26 cases it was to aid sleeping, in eight for anxiety, in three to assist in the management of intractable pain. In 10 of the 17 new users it was to aid sleep, in one for anxiety, and one for pain.

Excluding the 17 new users, five had been taking these drugs for up to two months, seven up to a year, and 20 for more than one year. In the 10 patients who had taken benzodiazepines long term (more than two years) evidence of dependence was found in eight. Attempts to stop the drugs had been made in five patients, and withdrawal symptoms had occurred in two.

Three patients were supplied with benzodiazepines

despite evidence in the notes that the patients had not actually taken them during the admission. One of these patients had been diagnosed as having Alzheimer's disease.

One patient had been given temazepam every night from the time of admission with a cerebrovascular accident throughout the course of a five month stay in hospital. He had not previously used the drug.

An 89 year old woman had been given temazepam for anxiety, lightheadedness, and giddiness. She was subsequently admitted with an accidental overdose.

Comment

The identification of 17 potential new users of benzodiazepines after admission to the general beds in one district in two weeks was higher than expected and is unacceptable. If the study is representative it implies a considerable potential risk for subsequent dependence.

These findings contrast with those of a survey during one week at St Bartholomew's Hospital,⁴ which found that no patient had benzodiazepine treatment initiated at the time of discharge. Trewin *et al*, however, found that 2% of admissions of elderly patients resulted in a discharge prescription for benzodiazepines.⁵ In Newcastle a six week study that included community follow up found 13 new users after hospital admission, but only three had been supplied at the time of discharge.² Our study suggests that hospital prescribing continues to contribute to benzodiazepine use in the community as half the group had first been prescribed the drugs in hospital.

In addition to the inappropriate supply of drugs at the end of a hospital stay, poor prescribing was evident by the drug's apparently unwarranted use in an elderly demented patient and continuous use in a stroke victim. There was also clear evidence that benzodiazepine hypnotics were being prescribed at the time of admission, before an assessment of the need could have been made.

There is no room for complacency in hospitals regarding benzodiazepine prescribing. This study highlights the need for prescribing policies to be formulated and instituted.

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