reviews

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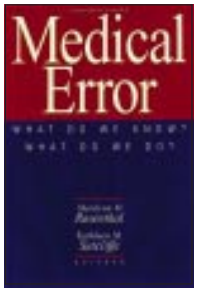
Medical Error: What Do We Know? What Do We Do?

Eds Marilynn M Rosenthal, Kathleen M Sutcliffe



Jossey-Bass, $45, pp 368
For ordering details, see www.josseybass.com
ISBN 0 7879 6395 X

Rating: ★★★

The causes of medical error are well documented: stress, burnout, and loss of autonomy among physicians; nurses' unwillingness to challenge or question doctors' actions; the complexity and interdependence of medical procedures; fear of litigation; and strained resources. More than 80% of medical error, though, according to this book, can be blamed on non-communication or miscommunication. And what we do about all this is, like medicine itself, not entirely an exact science.

This book emerged from a conference at the University of Michigan, where its editors are professors. Their purpose is to present views on the subject of medical error "articulated by the best people we can find." On the whole, they deliver on that promise, although there's inevitably some repetition and not a little "academespeak."

Among the proposals are a non-punitive climate for error reporting; a 14-point strategy for medication errors; improved communication between doctors and patients; a stronger focus on evidence based medicine, best practices, and standardisation of procedures; an emphasis on risk management and particularly its teaching in medical schools; swifter and wider adoption of information technology; and greatly expanded research.

In all of this, some contributors point out, doctors must lead and dominate patient safety initiatives. Primary care, they note, is a particularly fertile area for research and action, and one that is hardly addressed in the 1999 Institute of Medicine report, which claimed that 98 000 US deaths a year could be attributed to medical error. As a result of shorter hospital stays and a consequent increase in the acute care provided in outpatient settings, the authors say, the office practice setting could yield a greater margin for improvement.

It's in the controversial area of applying systems solutions to patient safety—particularly those in the aviation industry—that this book is especially helpful. But the word *system*, according to one contributor, "carries the notion of an entity that is mechanical, orderly, designed, impervious to improvisation, stable, and routinized." All of that may be true for aircraft, where accidents are infrequent, highly visible, and often involve massive loss of life, which, in contrast to medicine, may even include the lives of the professionals themselves. Moreover, patients are more complex than aeroplanes, and a cockpit crew is a clearly defined team with a formal hierarchy of authority that makes decisions during a flight, which has a clear beginning and end. Medicine, by contrast, is open ended and involves many more people. However, it is beginning to adopt aviation's approach by using incident reports, survey data, and direct observation—and especially by paying more attention to normal operations—a data source the authors say is vastly underused in healthcare.

The editors helpfully append 16 pages of definitions—some of which, such as *negligence*, *mistakes*, and *incident*, may seem pretty obvious—and a collection of website information. Overall, this is a timely and useful review of a topic that has assumed major importance in health care.

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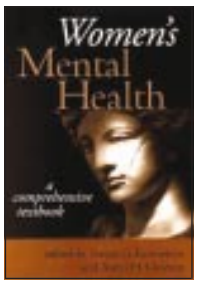
Women's Mental Health: A Comprehensive Textbook

Eds Susan G Kornstein, Anita H Clayton



The Guilford Press, £49.95, pp 638
ISBN 1 57230 699 8

Rating: ★★

Why is it necessary to have a book on women's mental health? Simply, because there are sex differences and gender differences between men and women's health, which mean that women's illness is researched, diagnosed, and treated differently from men's. Sometimes this is justifiable on clinical grounds—for example, gender roles have an impact on the presentation of schizophrenia; sometimes it is not—for example, gender stereotyping has an impact on the diagnosis of cardiovascular disease.

In this book there is an often impressive attempt to chart what we know about mental health and illness in women. Inevitably such an ambitious project, accomplished by so many authors, is not entirely successful, not only because the quality of contributions is variable but also because each of the areas covered would warrant a book in its own right. So, for example, the chapter on pregnancy concentrates on the effects of pregnancy on women with existing mental illness and one is left wanting to know far more about how it affects the mental health of other women.

This is a reference book designed to be consulted on particular areas rather than read from cover to cover. When it is read from cover to cover, one can see inconsistencies in approach, in the tightness of argument, and even in language, which presumably arise from a rather light editorial touch. To talk about, for example, "gender differences … in animals" (p 31) reveals an unacceptable sloppiness. To concentrate on the weaknesses of this book might seem churlish when it offers so much up to date material. However, the book blurs sex, gender, race, ethnic, cultural, social, political, and economic issues, and it is probably at its least coherent on sociocultural issues. "Women of color" is used as a blanket term for those who are of "minority" groups and who are not of "white, European, Christian ethnic groups" (p 570), regardless of their economic, linguistic, religious, or residential status. To lump together African American women born in the United States with women newly arrived from rural Pakistan, for example, clearly does a disservice to both.

This book is firmly centred on the US experience, and this will limit its value to an international readership, particularly on matters of management and health policy. These criticisms aside, this book will provide a valuable resource.

Helen Pattison *senior lecturer in psychology, University of Birmingham*

Items reviewed are rated on a 4 star scale (4=excellent)

Celebrity selling—part two

By admitting he is shy, an American football player has become the latest star to promote disease—and drug—awareness

United States professional football sensation Ricky Williams last week sparked a blaze of publicity when he revealed that he had social anxiety disorder and was benefiting from both therapy and Paxil (Seroxat/paroxetine), the drug that earned GlaxoSmithKline global sales last year of US$2.7bn (£1.7bn; €2.7bn).

Items appeared on the front page of the *New York Times* sports section, in the prestigious *Los Angeles Times*, and a host of other papers, as well as broadcast media including NBC. Stories described a serious psychiatric condition affecting between 5 and 10 million Americans. Some reports revealed that GlaxoSmithKline was paying the sports celebrity, some didn't.

Williams joins a stellar cast of characters now using the mass media to promote awareness of a whole suite of medical conditions and diseases. In May Camilla Parker Bowles spoke out about osteoporosis at an international meeting in Portugal (*BMJ* 2002;324:1342). While Mrs Parker Bowles received no funding from pharmaceutical companies, that meeting, and another key report that she has promoted, were both sponsored in part by a company with a new osteoporosis drug on the market.

At about the same time Hollywood star Kathleen Turner was talking publicly of rheumatoid arthritis, and promoting a website funded by the company selling a new drug for the condition. And another Hollywood actress, Cybill Shepherd, has educated American consumers about the menopause on behalf of a menopause supplement manufacturer, and presidential hopeful Bob Dole has raised awareness about erectile dysfunction, courtesy of a drug maker with a new pill for the condition.

Without in any way questioning the effects these conditions have on these celebrities, their families, or others in the broader community, it is not hard to tell what is wrong with this picture. Celebrity selling is just one more way in which pharmaceutical companies are indirectly shaping public perceptions about conditions and diseases in which they have an interest. Self evidently, the more severe and/or widespread the condition is perceived to be, the bigger the potential market for the latest drug.

In an interview on NBC TV last week, Ricky Williams said, "I've always been a shy person." His comments prompt questions about whether raising awareness of social anxiety disorder may in fact be medicalising shyness. "It's an important point, but I don't think so," said a GlaxoSmithKline spokesperson, who added that there was a big difference between shyness and social anxiety disorder, which he said was underdiagnosed and under-treated. "We're very pleased to be working with Ricky. He's got an important message, he's got an inspirational story, encouraging others who might have the symptoms of social anxiety disorder to seek treatment."

WILFREDO LEE/AP PHOTO

Williams: "I've always been a shy person"

The next day on NBC, in a segment providing tips for shy people, a psychiatrist said that for "social anxiety disorders or even a public speaking problem, medication may be helpful …" Although the GlaxoSmithKline spokesperson said of Williams, "He's not hired to sell product," it seems an increase in drug sales may be an incidental outcome.

Social anxiety disorder is another name for "social phobia." As has been already reported in this journal, some in the pharmaceutical marketing industry have described awareness raising for this condition as a "classic example" where corporate sponsored campaigns help "establish a need" for a new drug by reinforcing "the actual existence of a disease and/or the value of treating it" (*BMJ* 2002;324:886-91).

The other obvious problem with such widespread media coverage is that there is often no genuine attempt to explain the actual benefits or harms of a medication.

A quick check of the prescribing information about paroxetine for social anxiety disorder on the website of the Food and Drug Administration is sobering. Key trials are short term and side effect rates, as for other new antidepressants, are not insignificant. Data suggest sexual side effects are common: 5% of those taking the drug experienced impotence, compared with 1% with placebo, 9% experienced "female genital disorder," compared with 1% with placebo, and 28% experienced abnormal ejaculation, compared with 1% on placebo (all gender adjusted). The prescribing information also recommends a gradual reduction in dose when stopping the drug rather than abrupt discontinuation, and states: "Symptoms associated with discontinuation of Paxil have been reported."

GlaxoSmithKline confirmed that the company was paying Williams, who currently plays with the Miami Dolphins, but the spokesperson would not reveal the size or length of the deal. With publicity like that generated last week, it is unlikely that the contract will be abruptly discontinued.

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WEBSITE OF THE WEEK

Depressed children Probably the last thing on your mind as a parent is that the rosy-cheeked cherub you have so carefully nurtured may actually have depression. It's not widely known but, as the editorial on p 229 of this week's *BMJ* explains, children do actually get depressive illnesses and they often go unnoticed and untreated.

Unsurprisingly, it seems that most websites relating to depression are US based. One of these, Wing of Madness, has excellent links to web pages, online articles, books, and mental health organisations dealing with childhood depression (www.wingofmadness.com/articles/children.htm). Just don't be put off by the site's fanciful name.

For parents worried about their children's mental health www.psycom.net/depression.central.children.html should be a one-stop shop. This site gives extremely comprehensive information on symptoms of children with depression, dysthmia, and bipolar disorder, and answers frequently asked questions. Parents can find information on how to prevent suicide in children and adolescents and also look up information on drugs such as isotretinoin (for severe acne), which has been linked to depression.

A phenomenon of the web is the emergence of chat rooms and discussion groups, where visitors can pick up an identity at the virtual door and enter a room where they can unburden themselves and get advice without fear of exposure. Such forums can be useful in tackling depression. www.geocities.com/HotSprings/Villa/S712/ is a site set up for and by young people who are depressed. Visitors can chat about and read the personal experiences of adolescents who have had depression as well as the experiences of friends and family members of people with mood disorders. The aim of the site is to show young people that they are not alone.

http://communitynetdoktor.com/ccs/uk/depression/facts/index.jsp is a good general UK site on depression, with chat rooms, anecdotes, and excellent information on treatment options.

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PERSONAL VIEW

A leap of faith?

Imagine this: I am standing on a narrow ledge on the side of a suspension bridge. In a moment I am going to jump off, trusting that the elastic rope attached to my ankles will stop me plunging to certain death in the river 43 metres (142 feet) below.

Such bungee jumping derives from the harvest celebrations in Vanuatu in the South Pacific when men leapt from 20 m platforms with vines attached to their ankles. The Oxford dangerous sports club used elastic rope to jump from the Clifton suspension bridge—and were promptly arrested. The "sport" was popularised in New Zealand from the very bridge that I was on.

I am an otherwise rational 52 year old general surgeon, so what possessed me to do such a thing?

Firstly, I have always been scared of heights, not only because of the fear of falling but also partly because of the fatal attraction of actually jumping off. This must be some atavistic impulse since many people experience it. Indeed one of the temptations of Christ was to leap from a high place. For me the enduring image of September 11 was those blurred images of people who had the courage to jump from the twin towers rather than await immolation. A bungee jump under controlled conditions was a way of indulging my inclination with minimal actual risk.

Secondly, all surgeons have to learn to control fear. We all have testing times in theatre when dark venous blood wells up from the pelvis, or the clamp comes off the aorta, or it looks as if the common bile duct is in half. I have always been pretty cool in such crises so I wanted to see if I could be the same on the edge of the jump. Although the rational mind knows that bungee jumping is not fatal, it is still frightening even to watch, so it was a self inflicted test of nerve.

Finally, any patient in their right mind must be scared witless of entrusting their life to us during surgery and I wanted to see how it felt to be at the mercy of others' expertise.

As it turned out, there were many similarities to the "patient journey." I turned up at the bridge expecting to jump immediately (like a patient coming to the outpatient clinic but expecting the operation there and then), but after paying my money I discovered that I was on a waiting list. Admittedly this was only four hours, but it didn't do much for my appetite over lunch.

I then had to complete a consent form. Because of my anxiety the words were just a blur, so like most patients I just signed without reading. I was pretty horrified when I looked at it after the event. The jumps were done in batches, so I was in a list of eight, but luckily was near the beginning; I now have more sympathy for those unfortunates at the end of my all-day lists. But suddenly my number was called and I was in the preparation area.

As a briskly efficient technician attached the rope I had a most odd sense of dislocation. On one level I could hear myself having an apparently calm chat, yet I wasn't really aware of anything except the river so far below. I wonder if patients in theatre feel the same as they are prepared for surgery. And I wonder if the technicians' banter is any help (although I am not volunteering for a randomised trial). I have often been surprised and a little annoyed that many patients cannot remember their surgeon. But try as I might I have no recollection of the name or face of the man who prepared me for the jump; perhaps in stressful situations memory is impaired. Then came the moment when I nearly bottled out; just as I was ready there was a delay while the camera needed more film. I hope I can remember the effect such a last minute delay can have.

> I have learnt a new respect for those who entrust their lives to us in theatre

So, finally, ankles bound, I shuffled to the edge. Rictus grin, quick wave to the audience, then one … two … three … jumpppppppp (just like the anaesthetist asking a victim to count to 10?). I have vague memories of the millisecond between standing and falling, but, as with operations, thankfully the rest is a blur. Climbing up from the bottom of the gorge was an effort on jelly-like legs, so I'm no longer asking patients to get off the table themselves after even minor procedures. My groggy feeling lasted some hours, so I'm going to give patients a bit longer to recover.

Did I learn anything from this deeply unpleasant experience? I hope I have lost any desire to jump from a height; I have learnt it is possible to conquer fear; I have learnt that bungee jumping is best left to the young; and I have learnt a new respect for those who entrust their lives to us in theatre. Would I do it again? Not in a million years, unless I had to make a choice between a jump and an operation!

Alan Cameron *consultant surgeon, Ipswich*

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SOUNDINGS

Graduation for oldies

Happier than funerals, less fraught than christenings, and cheaper than weddings, graduations are the most enjoyable of family milestones. They are also the most exclusive. With only two tickets per graduand and no black market, most of the family has to be content with the official video.

After years of gazing impassively over the audience as one of the gowned academics on the platform, it comes as a mild shock to find yourself in your Sunday best among the mums and dads. You have noticed that all parents somehow act alike on these occasions and, when your turn comes, you effortlessly follow the pattern.

Your basic instinct is to whoop and whistle at the climactic moment and to accost passers by throughout the day and tell them what a smart kid you've got. Your superego tells you this would be a mistake. New graduates are perceptive and tolerant, but there are limits.

Moreover, says your superego sternly, remember this is our kid's day and you are supporting cast. Hence the dad's characteristic air of controlled pride. He carries his smallest camera and tries to snap discreetly. There is also a tinge of anxiety. Will his choice of restaurant impress the new generation?

Graduations are of two types—at the alma mater and elsewhere. At the University of Elsewhere you expect to get lost so you turn up too early and then try to look casual among the bustling Elsewherians.

At the alma mater you think you know your way around. Big mistake. How can so many one way systems and office blocks appear in only 30 years? Once inside the hall the nostalgia is overwhelming. The first time you were here was as a fresher, waiting in a long queue for the mass chest *x* ray. When did they decide that tuberculosis was no longer a problem?

No matter where the ceremony, medical or not, you bump into old friends. Once you have exhausted the main topic of conversation (retirement dates) you fall silent and watch the happy graduates—mainly women now, whatever the profession.

It is an odd feeling, being one of the grey brigade. Passing on the baton, what? As we leave the hall, the organ music ends in a huge crescendo. Nobody seems to notice. We're heading for the Pimms.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*