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Hippocrates

For heaven's sake, be clear

A recurrent theme in this Journal's correspondence is that communication in health care is often simply not good enough. That seems to apply between the authorities and professionals; it is very clearly the case between doctors and patients. If one party does not know or understand what is going on (or, worse, is full of misconceptions about it) it will take effort and insight by the other to put it right; and dealing with risk-taking is clearly one of the things where clarity is essential. Courses in communication have for too long between largely a preserve of industrial managers learning to keep the peace with one another; medical students seem to have regarded optional courses as expendable embroidery in their training. Mary-Lou Nesbitt has profiled the consequences [1]: "In any month about a thousand new complaints and claims are notified to the MDU by members. A survey of a recent month's complaints showed that 59 mentioned alleged failures of communication. Forty-three of these contained references to varying degrees of rudeness, intimidation and aggressive behaviour by doctors and dentists of all ranks and their staff. Most of these allegations were made by or on behalf of the patient concerned, but it is interesting to note that a couple were also made by colleagues in the same or similar professions ...". The Medical Defence Union has put much common sense into a booklet simply called *Talking to patients* [2]. Recommended, even to people who believe that they know it all.

References

1 Nesbitt M-L (1990): Failing to communicate. J Med Def Union, Winter 1990/1991, 49.
2 Talking to Patients. Medical Defence Union, London.

Hospital characteristics and mortality rates

Mortality rates are never the ideal way of measuring the quality of care, but at least they provide a clear black-and-white measure. The public health statistics are commonly far too weak on morbidity data for that to provide an alternative; usable figures on the occurrence of medical accidents in particular situations are emerging as another possibility.

In the meantime, particularly with the increasing swing in western countries towards privatization of hospitals, every inspectorate (to say nothing of every patient) needs to know how one type of hospital compares with another in terms of

caring and safety; it is an extension of the old concern – am I safer off in a teaching hospital or precisely the reverse? Again, the mortality figures can be a help.

Hartz et al. [1] found sufficient U.S. figures in the reports of the Health Care Financing Administration and the American Hospital Association's annual surveys to make an analysis covering 3100 hospitals. The mortality rate for all hospitalizations in 1986 was 116 per 1000 patients. Adjusted mortality rates were significantly higher for for-profit hospitals (121 per 1000) and public hospitals (120 per 1000) than for private not-for-profit hospitals (114 per 1000). Osteopathic hospitals also had an adjusted mortality rate that was significantly higher than average (129 per 1000). Private teaching hospitals had a significantly lower adjusted mortality rate than private nonteaching hospitals.

The figures quite clearly cannot be extrapolated to any other country, but the methods are worth following. Who will have the courage to find out whether one country's hospitals are safer than another's?

Reference

1 Hartz AJ, Krakauer H, Kuhn EM et al. Hospital characteristics and mortality rate. N Engl J Med 321: 1720–1725.

The Good Samaritan

Litigation against doctors who have done their best under difficult conditions seems to be taking increasing account of the Good Samaritan principle. It has sometimes been embodied in statute law, and the Courts seem willing to interpret it broadly, so as not to discourage the giving of emergency help.

In the 1988 case of *Johnson vs Matviuw*, which has now been reviewed in the legal literature [1], the Appellate Court of Illinois held that a good samaritan statute shields a hospital consultant who, while on duty, had responded to an emergency call not involving one of his own patients.

In that case, a widower brought a malpractice action against the staff physician who had responded to his pregnant wife's cardiac arrest. In spite of the physician's best efforts, the woman had died and the infant was stillborn. The plaintiff claimed immunity under the Illinois good samaritan law, which provides that a "person licensed to practice the treatment of human ailments ... who in good faith and without prior notice of the illness or injury, provides emergency care without fee ... shall not, as a result of his acts or omissions, except wilful or wanton misconduct on the part of such person, in providing such care, be liable for civil damages ...".

The argument in this case centred around the physician's status; the statute was worded to protect full staff members, and the court considered that it could validly

be applied as well to consultants having staff privileges. The decision has not gone undisputed but it seems to be a step in the right direction.

Reference

1 Johnson v. Matviuw. 176 Ill. App. 3d 907, 531 N.E. 2d 970 (1988)

Lasers in health care

On March 11th 1991, the Canadian Standards Association of Toronto issued its newest draft standard on laser safety in health care facilities; it is now open for public comment – and comments from outside Canada are welcome. The draft provides a good overview of clinical laser hazards, proposes the appointment in each hospital of a Laser Safety Committee (and Officer) and proposes a series of technical control measures as well as procedures to protect patients. Training in the proper use of equipment is not forgotten. Recommended reading indeed, from Mrs Jackie Halge, Canadian Standards Association, 178 Rexdale Blvd., Rexdale (Toronto), Ontario.

Preventing anaphylaxis

Another piece of good sense from Canada, where at least ten people are estimated to die each year because of anaphylactic reactions. The Allergy Information Association in Ontario claims that the deaths could be prevented by improved education; in September 1990 the Association launched an awareness campaign employing posters, the media and medical professions to alert those at risks about the dangers of anaphylaxis and sources of effective treatment. Doctors can request kits containing a review of anaphylaxis and its treatment, information on educational materials and a sample handout for patients at risk from the AIA, 65 Tromley Drive., Ste 10, Etobicoke, ON M9B 5Y7, Canada.
