

BMJ bans “accidents”

Accidents are not unpredictable

For many years safety officials and public health authorities have discouraged use of the word “accident” when it refers to injuries or the events that produce them. An accident is often understood to be unpredictable—a chance occurrence or an “act of God”—and therefore unavoidable. However, most injuries and their precipitating events are predictable and preventable.^{1–3} That is why the *BMJ* has decided to ban the word accident.

In an editorial in the *BMJ* in 1993 Evans explained why “motor vehicle crash” is an appropriate expression but “motor vehicle accident” is not: “The word crash indicates in a simple factual way what is observed, while accident seems to suggest in addition a general explanation of why it occurred without any evidence to support such an explanation.”⁴ Evans also argued that “accident” is inappropriate in reference to medical errors (as in medical accidents) and that “its use in medical settings continues to mislead.”⁴

Eight years later “accident” continues to be misused in medical circles—and on the pages of the *BMJ*. An online search for “accident” in the *BMJ* for the period January 1996 to December 2000 indicated that it has been used in the title or abstract of 101 articles and anywhere within 1559 articles. Some uses of the word may be appropriate or unavoidable—for example, in reference to accident and emergency departments (which should be renamed). On the other hand, many of these uses contravene the terminology recommended by safety officials, public health authorities, and Evans in his *BMJ* editorial. The following are examples from the titles of papers published in the *BMJ* during the past few years: road traffic accidents,⁵ playground accidents,⁶ home accidents,⁷ aviation accidents,⁸ accidental drug overdoses,⁹ accidental carbon monoxide poisoning,¹⁰ and medical accidents.¹¹

As a leading communicator in medicine, the *BMJ* needs to establish or follow standards in language. Therefore we are banning the inappropriate use of “accident” in our pages. The *BMJ* may be the first major medical journal to do so, but we hope we are not the last. The BMJ Publishing Group will encourage all its journals to follow suit. We are pleased that the *Journal of Accident and Emergency Medicine*, which is co-owned by the BMJ Publishing Group and the British Association for Accident and Emergency Medicine, has just changed its name to *Emergency Medicine Journal*. Perhaps the rest of the emergency medicine establishment in the United Kingdom will jettison “accidents,” as have its counterparts in the United States, Canada, and many other countries.¹²

Implementation of the ban will not be draconian, and editors will have the discretion to decide whether use of the term is inappropriate or misleading. “Accident” is used in the Ninth Revision of the International Classification of Diseases (ICD-9), so we will allow it to be used when referring to specific ICD-9 terminology. In addition, we acknowledge that some injury producing events may seem to be attributable to

bad luck or acts of God and thus not preventable. These include earthquakes, being struck by lightning, avalanches, storms at sea, and other natural disasters. Even in these instances, however, there is some disagreement. To the extent that these events are predictable, preventive steps can be taken by avoiding dangerous places at times of risk. With modern technology it is often possible to predict where or when these events will occur.

As Evans noted, some may see this as nothing more than a “pedantic quibble.”⁴ Girasek worries that statements like “injuries aren’t accidents” may actually cause harm by engendering victim blaming and decreasing the support afforded “accident survivors.”¹³ Nevertheless, we believe that correct and consistent terminology will help improve understanding that injuries of all kinds—in homes, schools and workplaces, vehicles, and medical settings—are usually preventable. Such awareness, coupled with efforts to implement prevention strategies, will help reduce the incidence and severity of injuries.

Which words will serve us in place of accidents? The *BMJ*’s linguistic transgressions cited above can be replaced by motor vehicle crashes or collisions, playground injuries, home injuries, aviation crashes, unintentional drug overdoses and carbon monoxide poisoning, and medical errors. Further guidance on how to speak clearly about injuries comes from the US Centers for Disease Control and Prevention (CDC), which has developed a framework for categorising the circumstances of an injury or poisoning along two dimensions. One dimension is the intent of injury or manner of death: unintentional, intentionally self inflicted (suicide if fatal), intentionally inflicted by another (assault or homicide), or intent undetermined. The other dimension—the mechanism of injury or cause of death—characterises the external agent or particular activity that caused the injury (for example, motor vehicle, fall, fire/burn, firearm, poisoning, and suffocation). The framework has been presented in the form of a matrix, depicted as mechanism by intent of injury—for example, poisoning related (mechanism) suicide (intent).^{14 15} Although the framework and matrix were developed primarily to standardise the grouping of ICD-9 E codes (external causes of injury codes) for tabulating injury data, they can help guide the use of terminology in the *BMJ* and other publications.

We are struggling to find a generic term that covers the range of events in which people may be injured, killed, or “lucky” to escape. For example, what do we use in place of “accident survivors”? Mishaps, misadventures, calamities, events, and incidents have their own shortcomings, and the English language may simply fail us here. Perhaps we should coin a word to refer collectively to the incidents that may produce injury (injidents?). We invite suggestions from readers.

Purging a common term from our lexicon will not be easy. “Accident” remains entrenched in lay and

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medical discourse and will no doubt continue to appear in manuscripts submitted to the *BMJ*. We are asking our editors to be vigilant in detecting and rejecting inappropriate use of the “A” word, and we trust that our readers will keep us on our toes by alerting us to instances when “accidents” slip through.

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- 1 Doege TC. An injury is no accident. *N Engl J Med* 1978;298:509-10.
- 2 Loimer H, Driur M, Guarnieri M. Accidents and acts of God: a history of the terms. *Am J Public Health* 1996;86:101-7.
- 3 Doege TC. Eschewing accidents. *JAMA* 1999;282:427.
- 4 Evans L. Medical accidents: no such thing? *BMJ* 1993;307:1438-9.

- 5 Stallard P, Velleman R, Baldwin S. Prospective study of post-traumatic stress disorder in children involved in road traffic accidents. *BMJ* 1998;317:1619-23.
- 6 This week in the *BMJ*: Surveillance of playground accidents can lead to their reduction. *BMJ* 1999;318 (12 June). <http://bmj.com/content/vol318/issue7198/twib.shtml>
- 7 Waldon G. Accidents at home are no more likely in deprived areas. *BMJ* 2000;320:1276.
- 8 Cullen SA, Drysdale HC, Mayes RW. Role of medical factors in 1000 fatal aviation accidents: case note study. *BMJ* 1997;314:1592.
- 9 Satchithananda DK, Stone DL, Chauhan A, Richie AJ. Unrecognised accidental overdose with diltiazem. *BMJ* 2000;321:160-1.
- 10 Pullinger R. Lesson of the week: Something in the air: survival after dramatic, unsuspected case of accidental carbon monoxide poisoning. *BMJ* 1996;312:897-8.
- 11 Dyer C. No fault compensation for medical accidents under consideration. *BMJ* 1997;315:1111-6.
- 12 Reid C, Chan L. Emergency medicine terminology in the United Kingdom—time to follow the trend? *Emerg Med J* 2001;18:79-80.
- 13 Girasek DC. How members of the public interpret the word *accident*. *Injury Prevention* 1999;5:19-25.
- 14 US Centers for Disease Control and Prevention. Recommended framework for presenting injury mortality data. *MMWR* 1997;46(No RR-14):1-30. <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4614.pdf>
- 15 US Centers for Disease Control and Prevention. *Revised framework of external cause of injury (E code) groupings for presenting injury mortality and morbidity data*. on www.cdc.gov/ncipc/whatsnew/matrix1.htm and on www.cdc.gov/ncipc/whatsnew/matrix2.htm (accessed 17 January 2001)

New global health fund

Must be well managed if it is to narrow the gap between rich and poor countries

But then nothing came to us for free. Not even water. It had to be carried a mile and a half, and boiled. “Boiled,” a small word, meant twenty minutes over a roaring fire on a stove that resembled the rusted carcass of an Oldsmobile. “Fire” meant gathering up a pile of sticks in a village that had already been gathering firewood for all the years since God was child, picking its grounds clean of combustibles as efficiently as an animal combing itself for lice. So “fire” meant longer and longer forays into the forest, stealing fallen branches from under the blunt eyed gaze of snakes for just one single bucket of drinkable water.¹

The gap between the rich and poor has widened steadily. Estimates based on World Bank data suggest that over 40% of the 614 million people in less developed countries live in absolute poverty and that average life expectancy is now 25 years less than it is in developed countries.² Ten years ago the countries of the Organisation for Economic Cooperation and Development (OECD) promised to scale up their development assistance. Since then the flow of aid has actually decreased to its lowest level (in relation to members' combined gross national product) for 20 years.³ Oxfam describes the rich country record on aid as “derisory” and their trade policies akin to “highway robbery.”⁴ The recent announcement at the World Health Assembly of a massive new global health fund to combat infectious disease in poor countries has therefore attracted much attention.⁵

Poor countries have the odds stacked against them. Climatic, political, and geographical factors matter. Professor Jeffrey Sachs, a Harvard economist and chair of the World Health Organization's commission on macroeconomics and health, believes that it is no coincidence that most of the world's poorest countries are in tropical climate zones. At a meeting last month organised by the Office of Health Economics in

London he emphasised that these zones experience much higher rates of infectious disease than temperate zones. He believes that malaria has been the single most important factor in shaping the modern world economy. It is also evident that the HIV-AIDS pandemic, particularly in sub-Saharan Africa, is having an equally devastating impact on economic development as well as on health.⁶

Tropical countries are further disadvantaged, Sachs suggests, by the fact that they have reduced food output per unit of input compared with countries in temperate zones. Low food productivity is linked with poor nutrition, and the combination of poor nutrition and a high burden of infectious disease leads to high infant and child mortality rates and low life expectancy. If infant mortality rates, the index of malaria transmission, and life expectancy are added to conventional economic indicators—education level, income, size of budget deficit, and inflation—the health related variables are usually the most powerful indicators of economic growth.

Communicable diseases are estimated to be responsible for 77% of the mortality gap and 79% of the gap in disability adjusted life years between the world's poorest and richest countries.⁷ Strategies to combat them are likely to be the most effective way of narrowing the health and wealth divide. Recent initiatives, include the Global Alliance for Vaccines and Immunisation (www.who.int/inf-fs/en/fact169.html), Roll Back Malaria (www.rbm.who.int), the International AIDS Vaccine Initiative (www.iavi.org), and Stop TB (www.stoptb.org). But Sachs argues that existing efforts fall well short of what is required. Rich countries do not realise the scale of the human catastrophe associated with communicable disease. Few people in the North have a clear concept of how people live in the worlds