

gators may have been biased in assessing outcomes in patients undergoing ultrasound guidance. Randolph et al point out a limitation of interpreting these studies—variable definition of failed catheterisation across the studies and possibly in the same study. Most remarkably, in three of these eight trials the investigators did not even define the primary end point of their study. When unblinded studies give no a priori definition of failed placement, it is possible that more attempts could have been allowed with the ultrasound method. Bias of doctors is even more likely in unblinded studies when patients were quasi-randomised, particularly in view of the preference of most operators to use the ultrasound guided technique.<sup>6</sup>

Another concern is the number of patients investigated in the trials that compare techniques using anatomical landmarks with ultrasound guided cannulations. In a power analysis based on published data Lefrant et al hoped to detect a 10% reduction in complications, which were estimated to have an incidence of 15%.<sup>7</sup> Therefore a study including 276 patients was calculated to provide an 80% probability of rejecting the null hypothesis. Therefore one should assume that the sample size of reliable studies should substantially exceed 100 patients. Central venous catheterisation is a daily practice for specialists in anaesthesia and intensive care, so why is the sample size of most randomised trials less than 80—which means less than 40 patients per group. Focusing on randomised studies including more than 100 patients does not show a significant difference in carotid punctures and the overall success rate of cannulations.<sup>7-9</sup> Ultrasound guidance improved the number of attempts per cannulation and successful first attempts for catheterisation of the internal jugular vein but not the subclavian approach.<sup>3 7-10</sup> Well designed trials have given firm evidence for the application of real time two dimensional ultrasonography in children with respect to overall success, speed, and incidence of carotid puncture.<sup>11</sup>

Observational and randomised studies give suggestive evidence for the benefits of ultrasound guided catheterisation for selected patients at high risk of complications and when difficult central venous access is anticipated.<sup>12 4</sup> Additionally, inexperienced doctors might benefit from ultrasound guidance.<sup>4 10</sup> To minimise

complications of central venous access, the operators should limit the number of stabs with both the seeker needle and the definitive needle and have a plan for failure—either to choose another landmark or to use ultrasound support.<sup>1 12</sup>

Every anaesthetist and intensive care doctor should be able to place central venous catheters without an ultrasound device but with a dedicated knowledge of all methods of how to maximise the success and minimise the incidence of complications. Ultrasound assistance is a potential useful back up technique after failed attempts of blind cannulation and for patients in whom catheterisation is likely to be difficult and complications could be serious.

Manfred Muhm *professor of anaesthesiology*

Department of Cardiothoracic and Vascular Anaesthesia and Intensive Care, University of Vienna, Austria  
(manfred.muhm@univie.ac.at)

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## Influences of the media on suicide

*Researchers, policy makers, and media personnel need to collaborate on guidelines*

Reporting and portrayal of suicidal behaviour in the media may have potentially negative influences and facilitate suicidal acts by people exposed to such stimuli. Recent systematic reviews by others and ourselves (unpublished) have found overwhelming evidence for such effects.<sup>1</sup> Evidence for the influence of media on suicidal behaviour has been shown for newspaper and television reports of actual suicides, film and television portrayals of suicides, and suicide in literature, especially suicide manuals. The potential for "suicide sites" on the internet influencing suicidal behaviour remains to be proved, but anecdotal evidence of negative influences is accumulating.<sup>2 3</sup>

The impact of the media on suicidal behaviour seems to be most likely when a method of suicide is specified—especially when presented in detail—when the story is reported or portrayed dramatically and prominently—for example with photographs of the deceased or large headlines—and when suicides of celebrities are reported.<sup>4-6</sup> Younger people seem to be most vulnerable to the influence of the media, although limited evidence also shows an impact on elderly people. Another factor is similarity between the media stimulus or model and the observer in terms of age, sex, and nationality. An important aspect of the presentation of suicide in the media is that it usually

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oversimplifies the causes, attributing the act to single factors such as financial disasters, broken relationships, or failure in examinations. The most common factor leading to suicide, mental illness, is often overlooked.<sup>7</sup>

Tackling this problem is one component of preventing suicides, and it is included in the recently published *National Suicide Prevention Strategy for England*.<sup>8</sup> Relevant questions are, therefore, how this should be done and whether it can be effective. One approach has been to produce guidelines for the media, of which there are now several.<sup>9,10</sup> All these emphasise the need to avoid dramatic reporting or portrayal of suicide and specifying means used. Most highlight the desirability of providing accurate facts about causes, including due emphasis on mental health problems. At present no clear policy exists for the problem of "suicide sites" on the internet.

One potential drawback of guidelines is that, in isolation, they may be seen as dictating what the media can or cannot do and as threatening freedom of speech. Firstly, for them to have credibility with authorities in the media and with journalists they must be based on evidence. Secondly, they should be produced ideally as a collaboration between researchers, public health policy makers, and senior media personnel. Thirdly, which is perhaps most difficult, they should be shown to work. Some limited evidence exists of this. In an initiative in Switzerland it was shown that collaboration between researchers and the media resulted in a reduction of sensational and lengthy reports of suicides in newspapers.<sup>11</sup> No attempt was made, however, to measure the impact on suicide. Efforts to limit the reporting of subway suicides in Vienna through the collaboration of researchers and journalists were followed by a reduction in the number of suicides and suicide attempts by this method.<sup>12</sup>

A further but unanswered question is whether media portrayal of positive coping with adversity in circumstances that might have led to suicidal acts could provide a model that might also reduce suicidal behaviour. Steps in this direction are worth exploring but will

also need collaborative initiatives. Their evaluation will present a considerable but surmountable challenge.

Possibly the most influential approach to the problem of media and suicide will be through ensuring that training courses for careers in the media pay adequate attention to this important topic. Similar initiatives should be made available to those already established in media careers. Finally, inappropriate media portrayal and reporting of suicidal behaviour should be immediately highlighted. This should encourage producers and editors to remain aware of their potentially influential role in future suicides.

Keith Hawton *director*

Kathryn Williams *researcher*

Centre for Suicide Research, University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX

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## Making progress with competing interests

*Still some way to go*

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The *BMJ* and other journals are making progress with managing the problem of competing interests (or conflicts of interest, as most journals call them). Today we take two further steps forward by posting on our website the competing interests of editors, our editorial board, and our group executive ([http://bmj.com/aboutsite/competing\\_interests.shtm](http://bmj.com/aboutsite/competing_interests.shtm)) and by publishing a study we have conducted that shows that readers' reactions to research are strongly influenced by statements of competing interests.<sup>1</sup> We still, however, have some way to go to the fully transparent world that is desirable.

The history of medical journals and conflict of interest might be cruelly summarised as lots of rhetoric and not much action. The International Committee of Medical Journal Editors produced a policy on conflicts of interest as long ago as 1993,<sup>2</sup> but several studies have

shown that such conflicts are rarely declared in most journals—despite good evidence that most authors have them.<sup>3-7</sup> The international committee strengthened its policy in 2001 by stating that journals should declare the exact role of sponsors (often pharmaceutical companies) in studies and decline to publish studies where the sponsors controlled the decision on publication.<sup>8,9</sup> This policy too has yet to be widely implemented.<sup>7</sup>

At the *BMJ* all authors and reviewers of original articles, editorials, and most other material are asked to complete competing interests forms, and declarations of the competing interests of authors are made with every article.<sup>10</sup> We have now instituted a system to ensure that the role of sponsors is made clear, and anybody submitting a rapid response is required by the electronic system to make a statement on whether they have competing interests. Our main means of manag-

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