

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

A national database of medical error

The thoughts of Dr Sheikh and Professor Hurwitz (November 1999 *JRSM*, pp. 554–555) struck a resonant chord. In 1959, one of the things I did as a young gynaecologist to make ends meet while building up my patient base was to review cases for the California State Maternal Mortality Committee. (They paid travelling expenses and, as I remember, fifty dollars per case.) The public health authorities had, some years before, established this committee to review all maternal deaths in the state; the rationale being that no one hospital had enough cases to produce enough data to be meaningful, and accumulation of data which might help protect women in childbirth was a worthwhile public health endeavour. And, indeed, some worthwhile information was brought to light and published.

The committee continued statewide for some years until about 1970 when the state, in one of those familiar fits of bureaucratic thrift, withdrew funding. In Santa Clara County, where I lived, the baton was taken up by the local medical association and we all continued to investigate cases as they arose (now, without pay or expenses). Again, meaningful data emerged and some of this material was published by our chairman, the late Leon Fox. However, in the last few years, hospitals, citing privacy and the threat of litigation, were beginning to refuse permission for us to review cases.

We were, in California, some twenty years ahead of Britain in the liability business, so my word to Dr Sheikh and Professor Hurwitz is that, unless a national database of medical error has some teeth in it, the local hospital people will, Bristol notwithstanding, find all sorts of reasons for not wanting to report adverse incidents, however you define them.

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Fibrolipoma of the median nerve

The magnetic resonance scans in the case report of Mr Berry and colleagues (August 1999 *JRSM*, pp. 408–409) correlate well with the operative findings in a middle-aged woman who presented with an aching palmar lump, without median nerve symptoms, on whom I operated without magnification 23 years ago. Their transverse scan showing adipose tissue in the median nerve is reflected in

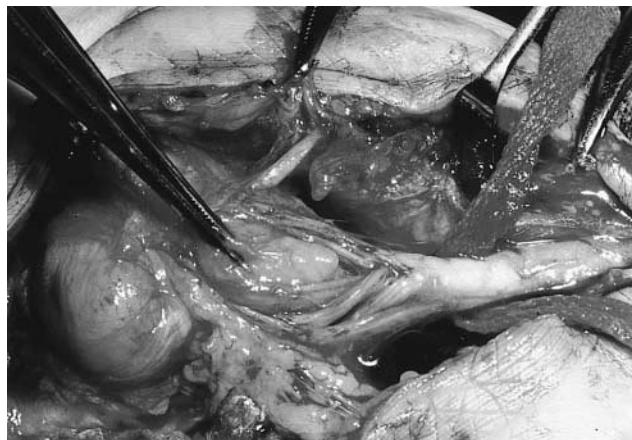


Figure 1 Operative photograph

the 'fatty' appearance I observed above the main lesion (Figure 1). Like their coronal scan, the operative photograph of my patient shows the fasciculae around the lesion, which clearly developed internally, pushing them peripherally and stretching them. The lack of median nerve symptoms was surprising. The main lesion was removed intact by gently teasing off the fasciculae and there was only transient numbness of the tip of the index finger. There was no indication to remove the proximal fatty deposits, of which the main lesion is presumably a local overgrowth.

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The struck-off mystery

One aspect of a general practitioner's work is the 'gatekeeper' function, controlling not only the issue of certificates but also referrals to hospital departments in other areas and alternative-medicine providers. In the three years I spent answering calls on a charity helpline the most virulent criticism of doctors I heard came from those who had had what they thought a reasonable request refused. Frustration of this kind can spill over into violence, physical or verbal.

Dr Buntwal and her colleagues (September 1999 *JRSM*, pp. 443–445) suspect that psychiatric patients are at special risk of being removed from GPs' lists. The mentally disturbed have always been with us and their problems can take up a lot of time but their needs are compelling. Neither I nor my colleagues removed them from our lists for that reason alone. Repeated harangues from someone determined on their 'rights' and oblivious of the needs of others are more difficult to tolerate.

My 'German family' pay extra for facilities, such as a private room, but everyone in Germany is entitled to the same basic service and there seems to be no doubt as to what that entitlement includes. We urgently need some

such system here and some monitoring of the advice being dispensed by helplines. One woman, who had her mind set on a certain operation, was told by a 'helper' to visit all the GPs in the area until she found one who would refer her.

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The limits of pressure sore prevention

The article by Dr Hagsawa and Professor Barbenel (November 1999 *JRSM*, pp. 576–578) accords with my own view that there is a current limit to pressure sore prevention. Despite excellent nursing care they found an incidence of 5.1%. Interestingly, when I conducted a prospective study of patients admitted to a British orthopaedic hospital, from 1985 to 1988, I found an incidence of 4.3% (53 of 1244 admissions). None of these patients had sores when admitted¹. At the time of this study, the hospital had two trauma wards, as well as a spinal injury unit (one ward). The majority of the other patients, in seven wards, were planned admissions for either surgery or investigations. Sores were defined by the Stanmore Classification², and this is slightly different from the NPUAP scale used by Hagsawa and Barbenel.

Just after my 1985–1988 study, when the incidence of patients with sores was still being monitored, the two trauma wards at the orthopaedic hospital had closed. During this year (1990) the overall incidence (in patients without previous sores) was usually about 2%. Even so, on the spinal injury unit the equivalent figure was in the region of 18–27%.

In the case of the 'internal medicine ward' study reported by Hagsawa and Barbenel, I would have expected an incidence in the region of 15–25%. This inclines me to agree with their conclusion that the patients concerned received high-quality preventive care.

Incidentally, although the Braden scale used by Hagsawa and Barbenel is obviously useful, the claim to 100% sensitivity is based on only two small studies. In one of these, just seven patients developed sores, in the other, nine. Although Hagsawa and Barbenel's data support this earlier work, other studies of the Braden scale have yielded poor results³. In contrast, the validation study for the Pressure Sore Prediction Score (the chief aim of my 1985–1988 study) produced a sensitivity of 89% based on 53 patients' developing sores¹.

Many other pressure sore risk-assessment scales have been developed, but there is still a lack of agreement as to which is the most successful^{3,4}.

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Non-senile squalor

In response to the report on senile squalor by Dr Clark (March 1999 *JRSM*, pp. 137–140) and the letter from Dr Keane (August 1999 *JRSM*, p. 438) I describe two situations in which senility was not a feature.

A middle-aged couple, visited in response to a request for a house call, were found seated in armchairs at an angle to one another; their request was a mundane one relating to a prescription. The approach to the armchairs from the front door was via a narrow corridor between compacted rubbish which was greater than knee-high at the sides of the corridor and consisted mainly of paper, food scraps, cartons and empty bottles. The corridor forked before the final approach to the armchairs. It seemed probable that these two ate and slept in their armchairs, and one of them went round to the corner shop to collect supplies and cash the pension cheque. The electricity was disconnected. The other rooms in the house were similarly full of rubbish.

A middle-aged woman and her teenage daughter lived in an unremarkable house in suburbia which had all the amenities that one would expect. Whenever these two had no further use for what they were holding in their hands, they dropped it on the floor. There was no space in any room in the house where one could put a foot on the floor without encountering some flotsam—discarded clothing, food scraps, cartons, bottles, magazines, newspapers.

I have seen squalor many times but never to the degree exhibited by these people. They seemed to exhibit a form of folie-à-deux, and will doubtless lapse into senile squalor syndrome as the years go by.

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Ethics committees

The frustrations experienced by Miss Larcombe and Professor Mott (October 1999 *JRSM*, pp. 500–501) in

dealing with multicentre (MREC) and local research ethics committees (LREC) partly reflect initial teething troubles of a new system and confusion over the competence of the various committees. Once a research proposal has passed the MREC stage and passed to the LREC the only areas where the LREC has a right to comment are: the suitability of the local researcher; the suitability of the site, including research facilities and impact on local health care provision; the suitability of subjects, whether the research is appropriate for the local population; the local information contained in the information sheet and consent form. These are the only matters on which the LREC has grounds to delay the application. In North Staffordshire, where I chair the LREC, we have taken the view that we are only approving the areas of our competency, when we pass an MREC study. Concerns about the ethics of the whole project have to be directed to the chair of the MREC that passed the project.

The political climate in which research is being conducted is changing and rigorous ethical review is as much a protection for the researchers as it is for potential subjects. The scope for chair's action is becoming increasingly limited. The days when the chair could decide what is or is not ethical are now over and the whole committee has to take responsibility for decisions. Running an LREC I am aware that most members of our committees are unpaid volunteers. The demands one can make on their

availability and time are limited. If one wanted rapid and professional ethical review then it would cost a lot more than the current system.

While rigorous ethical review is important and researchers need to anticipate that this will take some time, maladministration is inexcusable and is in itself unethical. Our ability as physicians to do good depends on our knowledge base, so to hinder the acquisition of new knowledge (research) unjustifiably is unethical.

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A Harley Street address

In his letter (October 1999 *JRSM*, p. 548) H E Reiss might have added that Lord Edward Harley succeeded to the Earldom of Oxford in 1724. Besides giving his and his wife's names to the streets that were mentioned in the Marylebone area, it was one on the edge of their property that has become even more famous than Harley Street, namely Oxford Street.

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This month in history



The scientific genius, imagination, and foresight of Alexis Carrel (1873–1944) made the seemingly impossible feats of suturing severed limbs, grafting vessels, preserving and transplanting organs, and immortalizing tissues a reality. Doing the unthinkable and accomplishing the unimaginable was quite commonplace in the extraordinary career of this Nobel Laureate. Whilst at the Rockefeller Institute, New York, Carrel became engrossed in the problem of successful organ transplantation. In his quest to find a way of preserving tissues outside the body for a few days, Carrel performed the following experiment. On 25 February 1907, Carrel extirpated a segment of carotid from a dog thirty-five minutes after death. He preserved it in a tube of Locke's solution in cold storage. On 6 March this arterial segment was transplanted into the left carotid artery of a dog. Examination on 3 May and 15 May revealed that the transplanted segment had the same appearance as the rest of the artery. Although there were histological changes in the transplanted segment, the anatomical results of the anastomosis were excellent. This ingenious experiment proved Carrel's premise that a vessel transplanted after cold storage for days or weeks can function normally, and 'a segment of artery preserved in cold storage acts as a living vessel for a long time'.

Figure 1 Alexis Carrel

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