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LETTERS

PARENTERAL DRUG ERRORS

Reported error rates are likely to be underestimation

The reported error rates in Valentin and colleagues' study on errors in administration of parenteral drugs in intensive care units are likely to underestimate the true incidence of errors.[1]

Firstly, errors were identified using self reporting by hospital staff. Only about 1 in 100 prescribing errors and 1 in 1000 administration errors are reported using established incident reporting systems.[2 3] The error rate was 7% of all doses given, which is substantially lower than the error rates of 18-173% found in other studies in intensive care and other wards using the "gold standard" of independent observers.[4 5]

Secondly, the authors assessed only five specific types of error. Other potentially common administration errors associated with parenteral treatment, including use of the wrong diluent, incompatibility errors, and wrong administration rates, seem to have been excluded. Conducting regression analyses on the basis of a potentially small subset of reported errors is therefore likely to be flawed.

Valentin and colleagues gave no information on the role of pharmacists, although pharmacists are routinely part of the critical care team in many of the countries included. Pharmacists reduce adverse events due to prescribing errors in critical care, and having a pharmacist in a multidisciplinary team is likely also to be associated with reduced administration errors.

We advocate the use of independent observers collecting data on actual practice to understand the true incidence and causes of administration errors in intensive care,[5] as well as controlled studies to identify the true impact of interventions.

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Competing interests: None declared.

1 Valentin A, Capuzzo M, Guidet B, Moreno R, Metnitz B, Bauer P, et al. Errors in administration of parenteral drugs in intensive care units: multinational prospective study. *BMJ* 2009;338:b814. (12 March.)
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Cite this as: *BMJ* 2009;338:b1814

HYPERTENSION IN YOUNG PEOPLE

Who to investigate?

Hammer and Stewart suggest that ambulatory blood pressure measurement in young people with hypertension is warranted "if white coat hypertension is suspected" without giving any guidance about how it might be suspected.[1] It is a popular misconception that such individuals can be identified by any clinical characteristic, so you either perform ambulatory monitoring on every young person with high blood pressure (shown to be cost effective) or check self monitored blood pressure first (as promoted by the American Society of Hypertension). UK guidelines do not help us. The authors suggest investigation for a secondary cause in people under 40. British guidelines say under 30, but any figure will be a little arbitrary. To perform a full screen for a secondary cause in anyone under 40 (this being the only criterion) would be expensive and without an evidence base.

To say that primary hyperaldosteronism accounts for 5-10% of all hypertension is misleading. The authors define it as starting with a screening test with a high plasma aldosterone concentration and suppressed plasma renin activity. If so, then the prevalence will be much lower than 10%, or even 5%. When the definition shifts (as it does in the learning points box) to describe the ratio of aldosterone to renin, the prevalence seems to increase.

As the ratio of aldosterone to renin is largely driven by plasma renin activity, the concomitant use of β blockers, which suppress renin, should not be allowed at the time of testing.

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Competing interests: None declared.

1 Hammer F, Stewart PM. Investigating hypertension in a young person. *BMJ* 2009;338:b1043. (6 April.)

Cite this as: *BMJ* 2009;338:b1733

TRANSIENT ISCHAEMIC ATTACK

Giant cell arteritis and transient visual loss

Monocular transient visual loss due to emboli or ocular hypoperfusion usually occurs in isolation rather than accompanying a transient neurological deficit.[1] Adhiyaman and Adhiyaman did not mention that giant cell arteritis is an important cause of transient visual loss in their 10 minute consultation on transient ischaemic attack.[2] Transient visual loss occurred in over 30% of patients with giant cell arteritis and ophthalmic involvement in one series and is a strong predictor of permanent visual loss.[3 4] Delayed diagnosis and treatment of giant cell arteritis is associated with bilateral blindness in patients with visual symptoms.[4]

The authors also do not mention measuring inflammatory markers in the recommended investigation of transient ischaemic attack,[2] but we would advise checking erythrocyte sedimentation rate, C reactive protein, and platelet count in older patients with transient monocular visual loss. High dose glucocorticoid treatment (prednisolone 1 mg/kg, maximum 60 mg, or pulsed methylprednisolone) should be started before temporal artery biopsy in patients with suspected giant cell arteritis.[5]

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Cite this as: *BMJ* 2009;338:b1809

QUALITY IN PRIMARY HEALTH CARE

A simple approach to quality

"When I use a word, it means just what I choose it to mean—neither more nor less," said Humpty Dumpty. Today's word is "quality," and Heath and colleagues' specific vagueness of the "way forward" to measure quality in primary care suggests we won't be able agree what we mean for many years.[1]

"If you don't know where you are going, any road will get you there," said the Cheshire Cat. Quality is not a destination: it's a journey of aspiration and achievement rather than completion. It will always mean different things to different people at different times.

The problem with the quality journey is that, although we may know what route we think we need to take, we don't know where we are going, or when we are going to get there. Guides like the quality and outcome framework (QOF) are like satellite navigation: authoritative and useful but sometimes prone to error at critical junctions.

We are not there yet, but over the past 20 years our journey has advanced considerably with more aspirations for outcomes and real achievements in the structure and processes for quality in primary care. Imperfect as QOF is, it is an example of the vertical advance. Examples of other more horizontal advances include the quality practice award, appraisals, and the core curriculum. QOF confirms that rapid advance in any direction is fuelled by financial incentives.

A simple approach to quality as we continue on our journey is to run through an A to F checklist on our dashboard to make sure we are still headed in the right direction.[2] Always check: A, we provide good access to our service, B, the best treatments are available, C, the customers are satisfied with the service, D, we provide a depth of care, E, the service is efficient and effective, and F, we treat everyone fairly.

Lewis Carroll's advice: "Begin at the beginning and go on till you come to the end; then stop."

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Competing interests: None declared.

1 Heath I, Rubinstein A, Stange KC, Driel ML. Quality in primary health care: a multidimensional approach to complexity. *BMJ* 2009;338:b1242. (2 April.)
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Cite this as: *BMJ* 2009;338:b1812

The shaman and QOF

Heath and colleagues use a case study of a person who has hypertension and a complex tale which includes oesophageal cancer, bronchiectasis, and a sorry family history to question whether the achievement of a blood pressure of 150/90 mm Hg in any way assesses quality of care.[1] We don't know what the patient's blood pressure is, and, more crucially, what the patient wants to do about it.

The quality and outcomes framework (QOF) is explicit about exemption reporting: if the patient does not wish to have treatment she can be exempted at no loss to practice income. It is then up to the doctor to discuss with the patient what she wants to do about her blood pressure, not decide for her. QOF is then about empowering patients rather than invoking professionalism and complexity, which can encourage doctors to continue in their paternalistic ways. Appealing to complexity, and therefore almost invoking the shaman in general practice, can lead to disempowerment of patients. Such an approach needs to be handled with as much care as the overenthusiastic application of guidelines.

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Competing interests: None declared.

1 Heath I, Rubinstein A, Stange KC, Driel ML. Quality in primary health care: a multidimensional approach to complexity. *BMJ* 2009;338:b1242. (2 April.)

Cite this as: *BMJ* 2009;338:b1813

EUROPEAN WORKING TIME DIRECTIVE

Running out of time?

Richards sums up the conflicting views on the European Working Time Directive.[1]

Monthly returns from strategic health authorities seem to be at odds with the view from the medical frontline. The Department of Health is therefore working with the royal colleges to check the returns on an individual trust basis. The results should be available well before the deadline for derogation.

Although many trusts may have 48 hour compliant rotas on paper, the practicality of these rotas is worrying. UK medical registrars usually work 4 hours more than their contracted hours.[2]

Parliament has shown little sympathy for health professionals' views on the working time directive because of lack of evidence of its negative effects beyond surveys of opinion. The profession needs to provide such evidence, and quickly, to get any MPs' support.

However, MPs support the opt-out for UK doctors from the directive. The opt-out gives additional flexibility for service provision and training opportunities, but it should not be seen as the only solution.

Doctors may not be aware of the large amount of recurrent money the Department of Health has given trusts to support the working time directive—for example, by employing additional acute physicians. This amounts to 0.2% of tariff income, or £300 000 a year for a typical acute trust. Some trusts may have kept this funding quiet to allow the money to be used elsewhere, but it is urgently needed if the directive is not to be the disaster we fear.

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Competing interests: None declared.

1 Richards T. Running out of time. *BMJ* 2009;338:b1507. (14 April.)
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Cite this as: *BMJ* 2009;338:b1815

"I WANT TO SEE THE CONSULTANT"

Patients' long and winding road

I have to ask whether Crampsey or any of his family or friends has experienced the long and frustrating road for patients referred to a "specialist," particularly when the correct rapid diagnosis and management may mean the difference between life and death.[1] The wait for the appointment, the sitting in a crowded waiting room for some hours, the eagerness to be put on the correct path immediately in order to survive. Who better to do that than the highly trained and experienced consultant, rather than the unknown quantity of a trainee with varying degrees of training, experience and ability, who may not necessarily defer to the consultant.

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Competing interests: None declared.

1 Crampsey DP. "I want to see the consultant". *BMJ* 2009;338:b1399. (15 April.)

Cite this as: *BMJ* 2009;338:b1810

Continuity of care is important

"I want to see the consultant" is often the most practical way for patients to state that they want continuity of care and a doctor-patient relationship based on trust.[1] Our members most frequently complain that, on their outpatient check-ups every six months or annually, they have seen four different registrars or trainees on four consecutive visits, with the consultant's experience or guidance an unspoken absence.

Several years ago we established an electronic discussion group (forum), and our members now explicitly discuss the variability in standards of treatment at UK hospitals.

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Competing interests: None declared.

1 Crampsey DP. "I want to see the consultant". *BMJ* 2009;338:b1399. (15 April.)

Cite this as: *BMJ* 2009;338:b1811