# SHORT CUTS

**ALL YOU NEED TO READ IN THE OTHER GENERAL JOURNALS**

**Alison Tonks, associate editor, *BMJ* atonks@bmj.com**

## Doctors and patients feel the same after medical errors

When doctors make serious mistakes they feel guilty, afraid, and alone. Patients and families harmed by those mistakes feel the same guilt, the same fear, and the same isolation say two US doctors who interviewed victims of medical error while making a film.

Relatives feel guilty because they weren't around to protect their loved one. Patients and families fear retribution or poor care if they speak out. Both emotions are exacerbated when doctors back away, too paralysed by their own feelings to speak openly, discuss their mistakes, and maybe even say sorry. Hospital managers, lawyers, and insurers don't help by telling doctors to choose their words carefully and avoid accepting liability. The result is an impersonal dialogue that seems cold and uncaring.

About 30 US states already have "I'm sorry" laws under which doctors' comments to patients after a medical error are inadmissible for the purposes of establishing fault. These laws should be universal, say the doctors. It is also time to build a formal structure for coping with the aftermath of medical error that removes stigma and supports direct and sympathetic communication. Whatever that structure finally looks like, patients and their families must help to build it.

***N Engl J Med*** 2007;357:1682-3

## Still no consensus over link between hysterectomy and incontinence

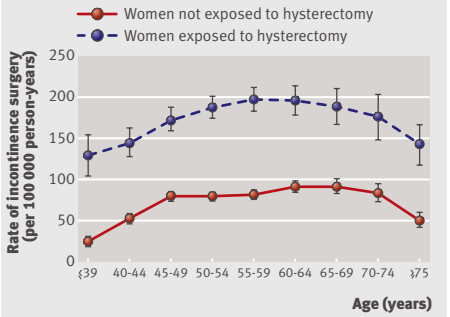
Hysterectomy is a common operation in developed countries, and experts have been arguing for years about possible late side effects including urinary incontinence. The latest evidence comes from a large observational study comparing 165 260 women who had a hysterectomy for benign disease with 479 506 age matched controls who didn't. Women who had had a hysterectomy were more than twice as likely to need surgery for stress incontinence (hazard ratio 2.4, 95% CI 2.3 to 2.5), particularly in the first five years after surgery.

Having children multiplied the risk, which was more than 16 times greater for women having four or more vaginal births. The authors are now fairly certain that hysterectomy causes incontinence, and urge women and their doctors to try less invasive treatments before opting for surgery.

At least one commentator disagrees (p 1462). Despite its size, this observational study simply isn't robust enough to resolve the debate either way, he says. Perhaps hysterectomy does predispose women to later incontinence, but it is just as likely that some other factor is behind both. These authors had no data on smoking or body mass index, for example.

***Lancet*** 2007;370:1494-9

**EFFECT OF HYSTERECTOMY ON RATE OF INCONTINENCE**




Adapted from *Lancet* 2007;370:1494-9

## Provide for the world's poorest first

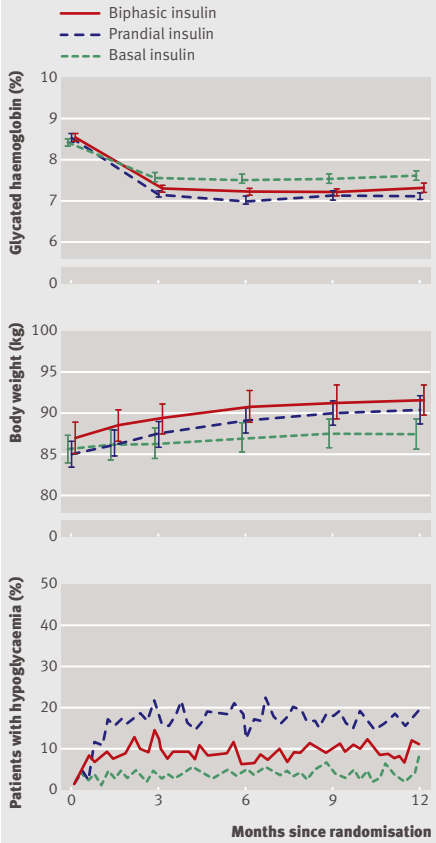
In 2000, the United Nations set a target to reduce global child mortality by two thirds between 1990 and 2015 (Millennium Development Goal 4). Progress has been slow in many developing countries. To find out how to target resources better in the regions that are lagging behind, researchers looked at the likely effect on child mortality of better nutrition, clean water, and cleaner fuel in Latin America and the Caribbean, South Asia, and sub-Saharan Africa.

After a complex analysis of published research and national survey data they concluded that child mortality would fall 14-31% a year if interventions to clean up water, provide clean fuel for cooking, and improve children's nutrition reached everyone who needed them. If coverage was a more realistic 50%, then the poorest families should be targeted first. The researchers estimate that such a strategy would reduce child mortality 30-75% more than targeting the wealthier (but still poor) end of the socioeconomic spectrum. It would also be more ethical.

***JAMA*** 2007;298:1876-87

## Basal insulin safest in badly controlled type 2 diabetes

**EFFECT OF DIFFERENT INSULIN TYPES ON GLYCAEMIA AND WEIGHT**




Adapted from *N Engl J Med* 2007;357:1716-30

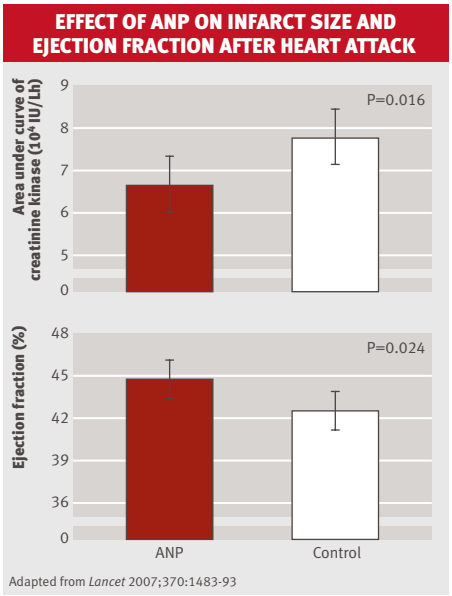
Many patients with type 2 diabetes eventually need insulin. But which regimen works best for people with poor control despite maximum doses of oral agents? In one trial, none of the options worked particularly well. Only a minority of patients in each group reached their target concentration of glycated haemoglobin during the first year of treatment (16% of all 708 participants). Participants who took their insulin before each meal or had biphasic insulin twice a day did significantly better than those who took basal insulin at bedtime. But both regimens were associated with worse

hypoglycaemia and substantial weight gain. Patients on prandial insulin gained more than 5 kg on average.

The authors hesitate to make final recommendations as their study is continuing for another two years and the findings may look very different in the end. An editorial agrees that doctors shouldn't change their practice in response to these interim results (p 1759). Basal insulin is still the best and safest first line option for those who need it. Aggressive management of blood pressure, lipids, platelets, and lifestyles is equally important.

***N Engl J Med*** 2007;357:1716-30

## Atrial natriuretic peptide helps limit infarct size after heart attack




Early treatments for heart attack have come a long way in recent years, but researchers are still looking for a drug to help protect what's left of the myocardium from ischaemic and reperfusion injuries. Atrial natriuretic peptide (ANP) is one candidate that looked promising in a recent clinical trial. Patients given the drug for three days after a percutaneous coronary intervention ended up with infarcts that were nearly 15% smaller than placebo controls (95% CI 3.0% to 24.9%). They also had slightly better ventricular function at six months and a lower risk of heart failure or death from cardiac disease (hazard ratio 0.27, 0.09 to 0.8). Another candidate drug, nicorandil, worked no better than placebo in a parallel trial by the same authors. Both drugs caused more serious hypotension than placebo.

ANP and nicorandil target a mitochondrial pore that is central to mechanisms of cell death during myocardial infarction. So it is odd that they performed so differently in these trials, says an editorial (p 1461). Perhaps the dose of nicorandil was too low. Or perhaps we have more to learn about the way it works. The evaluation of ANP is still at an early stage too, say the editorial's authors. Patients and doctors must wait for better data on dosing and safety, preferably from double blind trials.

***Lancet*** 2007;370:1483-93

## Hepatitis A vaccination is effective after exposure

A recent large trial from Kazakhstan suggests there is little to choose between vaccination and immune globulin for post exposure prophylaxis against hepatitis A.

Contacts of people with hepatitis A were given an intramuscular injection of immune globulin or vaccinated against the virus at some time during the two weeks after exposure. Fewer than 5% of both groups developed symptomatic hepatitis A (25/568 (4.4%) receiving the vaccine *v* 17/522 (3.3%) receiving immunoglobulin). The small difference wasn't significant and the authors declared the vaccine "non-inferior" to immunoglobulin.

Vaccination is more convenient and potentially less painful than an injection of immunoglobulin. It is also more readily available. In the US, for example, the public health authorities rely on a single supplier of immunoglobulin. Stocks are limited and prices are rising.

These difficulties, coupled with worries about the safety of blood products, have prompted many developed countries to switch from immunoglobulin to vaccination for post exposure prophylaxis. This first head to head trial suggests their citizens will come to no harm. Authorities in the US have just reached the same conclusion and announced a change in policy.

***N Engl J Med*** 2007;357:1685-94

## An unhealthier future for most Americans

Most Americans are getting poorer. Incomes are going down and the proportion of families below the poverty line is going up. Only the rich are getting richer, says one public health expert from Virginia. Chief executives of US corporations earn 245 times more than their employees. Apart from the obvious injustice of this situation, worsening poverty means worsening health. Future generations of all but the richest Americans will have more cardiovascular disease, diabetes, and cancer than the generations alive today. The current healthcare system is already under strain and is unlikely to cope with the extra burden, he writes.

Training more health professionals and building more hospitals and other facilities is one option. But it won't be enough, even if it were possible. Policy makers must instead tackle economic hardship head on. Changing tax policy, increasing the minimum wage, promoting new job sectors, and setting up initiatives to get people into jobs with prospects could all help increase incomes across the board. Education may be even more important. If all US adults had college degrees, the prevalence of heart disease could fall by 40%, and the prevalence of diabetes and stroke by 50%, he writes. The economy would be healthier too.

***JAMA*** 2007;298:1931-3

## Inequality drives the HIV epidemic

HIV and poverty go hand in hand. Poor countries have a higher prevalence of infection, and the poorest people in those countries are disproportionately affected. Poverty is part of the cause of HIV and is also its inevitable result. A closer look at the economic reality of HIV, however, suggests that inequality—not just poverty—is the dominant driving force behind the epidemic, say experts from the Joint United Nations Programme on HIV/AIDS.

In sub-Saharan Africa, countries with the most unequal distribution of wealth such as Botswana, Namibia, and South Africa have the highest prevalence of HIV. Inequality between the sexes is also important. Women who are financially dependent on men have little power to negotiate safe sex. The link goes beyond the purely economic to marginalised groups such as drug users and migrants who have unequal access to social benefits and human rights, say the experts.

Controlling the spread of HIV will be a lot more complicated than alleviating poverty, which is complicated enough. Economic development may even fuel the epidemic by exacerbating inequality. Projects to reduce poverty and encourage development must be aimed at the poorest, be aware of HIV, and be tailored to the conditions, particularly the inequalities, operating locally.

***PLoS Med*** 2007;4:e314 doi: 10.1371/journal.pmed.0040314

On bmj.com: for a weekly review of the general medical journals, visit Richard Lehman's blog at http://blogs.bmj.com/bmj/category/comment/richard-lehmans-weekly-review-of-medical-journals/