shown elsewhere that old age, poor sur-
vival, DHA of residence, and place of
death were all positively associated with
DCO registration. We discuss this audi-
tonality and the impact of colorectal
cancer survival studies in this pa-
per.9 In their paper Ridge et al set out
to find the nature and rate of drugs
given in error in one National Health
Service (NHS) hospital. It is import-
ant to distinguish between the au-
thors’ focus, which was errors that
occurred at the time of the nurse
giving the drug, and prescribing
errors that originate with the doctor and
already exist on the prescription.
Prescrib-
ing errors were not examined by the
authors as their survey recorded only
those errors that could be classed as de-
aviations from the doctor’s medica-
tion order as written on the patient’s chart.
Although it is important that hospitals
do review the effectiveness of their cur-
rent drug supply and administration sys-
tems (as the authors suggest), it is incor-
correct to support the seriousness of this
argument with reference to the incomple-
teness of coroner’s records which con-
cluded that about a fifth of deaths relat-
ing to prescribing and giving
drugs were due to errors.
In this review, a total of 3277 deaths
came to inquest (3.8% of all deaths in
the years 1986–91) and the review of coro-
ners’ cases actually identified 46 relevant
deaths due to adverse drug reactions or
errors in prescribing or giving drugs.
Of these 46, death was attributed to errors in
medication in 10 cases, with an even mix of
primary and secondary care cases, but of
these 10 most were due to prescribing
errors with possibly only one death due to
a nurse giving a drug in error (and that
involved oxygen).
The overall risk of death due to errors in
adverse drug reactions was judged to be
very small – about one in 2000 of all
deaths during the study period, and of
course, unlike in the paper by Ridge et al,
there was no baseline for the number of
total events that were potentially adverse –
that is, the number of doses of medicines
prescribed and given during the six year
period.

Medication errors during hospital
drug rounds

Goodyear and Lloyd pointed out the
advantages of a preprinted assessment
sheet, but I would like to point out the
danger of implementing this method in
the hospital setup, especially for junior
medical students in training.
Good history taking in medicine has for
generations been the main method of
educating medical students and junior
doctors. Full evaluation of the history of
a patient’s complaints is crucial to making
a correct diagnosis, and helps in planning
the management. Every doctor spends
the rest of his or her professional life
relearning the lesson. The doctor’s first
task is to listen and observe, not only to
obtain information about the current
problem but also to understand the patient’s
genesis to help them to learn about
their life situation.
Symptoms identified by taking a history
provide some of the most important items
of information used in the process of
diagnosing a disease. When patients
describe the symptoms for which they are
seeking professional attention, they are
also reporting the story of an illness as
they have lived, and remembered it, and
so it can vary. To some extent, symptoms
are universal human experience. Virtually
every person experiences some discomfort
for which he or she is then able to help.
Talking with a patient has a third
function: it helps that person to feel that
he or she is understood, and it thereby
helps to establish a therapeutic relation.
A style of questioning narrowly shaped
for the sole purpose of diagnosing a disease
ignores much of what patients have
experienced and many of their concerns
and questions. It therefore often prevents
the development of a trusting relation,
and diminishes the chances of helping the
patient. Talking with a patient about the
experience of being ill, on the other hand,
can have great value even when nothing
can be done about the disease.
Collecting information with a pre-
printed assessment sheet, or computer
may be good, and may assist the junior
but is not advisable for young doctors in
training. It is the duty of the senior experi-
enced doctors to identify deficiencies in
history taking by a junior doctor, and help
him or her to rectify the deficiencies and
then guide them to good clinicians.
The disadvantage of a preprinted
assessment sheet is that you forget to
Medication errors during hospital drug rounds.

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Qual Health Care 1996 5: 121
doi: 10.1136/qshc.5.2.121

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