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Reporting System for Violent Deaths and Youth Suicide Reply

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JAMA. 2009;301(5):485-486 (doi:10.1001/jama.2009.46)

http://jama.ama-assn.org/cgi/content/full/301/5/485-a

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Reprints/E-prints reprints@ama-assn.org ing trainees to an ongoing increased risk of significant morbidity or mortality.

As Rice notes, no one knows the best way to balance all considerations, but there is more than sufficient evidence to appropriately question whether the current practice of scheduling residents to work 24-hour shifts (or longer) is optimal for either residents or their patients. Reducing resident work hours while accounting for concerns about continuity of care and medical education is a tremendous challenge, however, and rigorous assessment of different work hour reduction strategies across settings is needed. Given the high frequency of medical errors, it is unquestionably possible to improve on the status quo. It is necessary to test both the efficacy and effectiveness of different models for resident duty hour reduction that carefully weigh competing risks and consider the realities of acute and chronic sleep deprivation, circadian rhythms, and continuity of care. Shorter shifts, mandatory naps on extended duty shifts, or approaches to modifying work intensity and resident supervision all have conceptual merit and some empirical support and should be considered for wider-spread testing. Even, and perhaps especially, in the absence of data on the perfect solution, it is time to implement different evidencebased approaches in real-world settings, with a commitment to rigorous assessment and iterative improvement.

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Reporting System for Violent Deaths and Youth Suicide

To the Editor: The significant increase in youth suicides in 2004 and 2005 identified by Dr Bridge and colleagues¹ in their Research Letter is further evidence of the critical need for a truly national data system on the circumstances surrounding violent deaths in the United States, including youth suicide. As the authors point out, the raw data alone tell nothing about the causes, leaving only guesswork to guide devising preventive strategies.

This is particularly unfortunate because the National Violent Death Reporting System (NVDRS) gathers, links, and analyzes data on the circumstances surrounding violent deaths as captured in coroner reports, death certificates, law enforcement records, crime laboratory reports, and data from social agencies.² By linking this information, the NVDRS can provide a clearer picture of when, where, why, and how suicide occurs, thus providing the foundation for well-informed prevention strategies. Yet the current funding levels provided by Congress allow only 17 states to participate,² precluding a comprehensive national understanding of what underlies youth suicide and how it can be prevented. Although the additional research that Bridge et al call for is certainly needed to understand and address this alarming problem, so is full funding for the NVDRS by Congress.

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Financial Disclosures: None reported.

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In Reply: We agree with Dr Parkinson that further development and expansion of the NVDRS to all 50 states is an important next step toward understanding the causes and prevention of violent deaths in the United States, including youth suicide. It will also be imperative to continue to develop and implement the most promising suicide prevention and early intervention programs, including physician education in depression recognition and suicide risk evaluation¹⁻³; restriction of access to the most lethal means of suicide (eg, more restrictive legislation regarding firearms, changing the packaging of analgesics to blister packets, barriers on bridges)³; and screening for mental illness and suicidality in teenagers, with timely referral and follow-up care provided when indicated.^{3,4}

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(Reprinted) JAMA, February 4, 2009—Vol 301, No. 5 485

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Financial Disclosures: Dr Bridge reported that from 2001 to 2004, he participated as a coinvestigator of an open-label trial of citalopram for treatment of pediatric recurrent abdominal pain. The study was funded by an investigator initiated grant from Forest Laboratories (John V. Campo, MD, Principal Investigator). Dr Bridge reported having received no financial support of any kind from Forest Laboratories or from Dr Campo for his participation; salary support to Dr Bridge was provided by National Institute of Mental Health grant MH55123 and subsequently MH66371 (Advanced Center for Interventions and Services Research for Early-Onset Mood and Anxiety Disorder, David Brent, MD, Principal Investigator). Dr Bridge reported having received an honorarium from the Association Suisse d'Intervention de Crise et de Prévention du Suicide for an invited presentation at a suicide prevention conference in Bern, Switzerland; the conference was supported in part by unrestricted educational grants from Eli Lilly and Lundbeck. No other authors reported financial disclosures.

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A View on the Room

To the Editor: In their Commentary, Drs Detsky and Etchells¹ presented an overview of the debate about single-patient rooms, confirming the current status of private rooms as the industry standard for new construction in the United States. Their conclusion that single-patient rooms are "permanent physical features that potentially could improve safety and patient satisfaction without the need for ongoing staff training, audits, or reminders" presents a partial view of the realities of hospital planning. Notwithstanding the advantages of infection control and privacy, the social and psychological benefits of shared rooms should not be underestimated.

For some patient populations, notably those receiving palliative care, shared spaces may provide beneficial social supports for patients and families, decreasing the sense of alienation that commonly accompanies the hospitalization experience.² Results favoring shared occupancy among oncology patients in a British hospital described the wish to avoid isolation as the main factor in selecting shared rooms.³ A study of patients with advanced cancer reported that the majority expressed the desire for choice and flexibility in room type, depending on stage of illness.⁴

Rooms cannot be evaluated in isolation because the efficiency and effectiveness of patient room design is strongly related to the overall ward layout, including nursing unit and circulation design schemes. Consider-

ation of room occupancy does not provide a complete picture of patient care, costs, or infection issues. For desired outcomes, room occupancy needs to be considered along with other patient care factors, environmental changes, and management policy changes. Private rooms may not be a feasible design solution in all cases, especially in renovations or redesign of existing facilities where limited guidelines exist.

Although family zones are generally provided in each patient room, there may not always be visitors to fill the space and provide companionship. A design solution may include smaller private rooms with more area devoted to a variety of social spaces. This need not be limited to designated lounges found at the corridor's end, but the hallway space outside each room could be used by providing seating and alcoves to promote interaction while allowing an easy retreat when isolation or privacy is desired.

Before accepting the private room model for all medical wards, more research is needed to explore additional issues, including the effect on various patient populations. Through the design of flexible spaces to accommodate individual preferences, patients and families can maintain an element of choice for room type. Ultimately, one size may *not* fit all.

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Financial Disclosures: Dr Anderson reported full-time employment with WHR Architects Inc, which focuses on the design and planning of health care facilities.

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In Reply: We agree with Dr Anderson that some patients may prefer a roommate, as our Commentary stated. Anderson cites 1 survey of 50 oncology patients and families in which an important influence on preferences for shared rooms was the belief that patients in single rooms were more ill. If a hospice ward is predominantly single-patient rooms, this belief may be less prevalent, and the preference for shared accommodation may be less pronounced.

We also agree that providing single-patient rooms is one of many important considerations in hospital ward design. Different wards may have different needs for their specific patient populations, such as the need for shared communal space in a hospice. However, we believe that patients should have the choice as to when they have company and when they have privacy. This can only be

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