Letters

Smoke free hospitals

Challenges need to be faced

EDITOR—McKee et al criticised our decision to provide smoking rooms for patients' use.[1] We have also trained a substantial number of clinical staff to offer opportunistic advice about smoking cessation, offering nicotine replacement to all smokers who are admitted.

Jarvis et al drew attention to the prevalence of "hardcore" smoking in England and its links with age and socioeconomic deprivation.[2] Most patients in the Royal Victoria Hospital are elderly, and many come from deprived areas. Even among pregnant women, who are more motivated to stop smoking, complex interventions are required.[3]

Change in smoking behaviour is a process, not an all or nothing event. High intensity behavioural interventions with follow up such as we proposed are effective in promoting smoking cessation in hospital patients. Interventions delivered only during the hospital stay are, however, ineffective.[4] In all, 70% of our admissions are non-elective, with no opportunity for pre-assessment and intervention. Smoking cessation can be addressed in the population only with a strategy and service that links community with primary and secondary care. Without these, introducing a smoking ban in hospitals with the sole aim of sending a consistent message will be ineffective.

A ban on patient smoking is also impractical. For safety reasons we are unwilling to insist that patients who wish to smoke should leave the hospital building. Neither do we want smoking to take place in uncontrolled areas, which will expose others to secondhand smoke and increase the risk of fire. We also recognise the distress of terminally ill patients and relatives who may be smokers.

In these circumstances acute hospitals should provide limited and controlled smoking facilities for patients. Up to four rooms in a seven storey building will be made available at a cost of £390 000. We aspire to achieve a smoke free hospital, but we also have to recognise that patients don't leave their cigarettes and matches at home.

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Competing interests: All the authors are employed by the Royal Hospitals Trust.

1 McKee M, Gilmore A, Novotny TE. Smoke free hospitals. *BMJ* 2003;326:941-2. (3 May.)
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Smoke free hospitals are unethical

EDITOR—With reference to the editorial by McKee et al on smoke free hospitals,[1] to bar smoking for inpatients with smoking related disease seems reasonable.

To coerce smokers who happen to be in hospital with an unrelated condition into accepting smoke free behaviour as a condition of their care may be questionable.

When patients have no prospect of benefit from smoking cessation, and enforced abstention aggravates their existing distress, they are being managed unethically. Their best interests as a patient (which should be the medical profession's prime concern) are being subjugated to a broader policy that does them harm.

I have been asked by relatives to prescribe nicotine replacement for a terminally ill patient, whose last days in hospital were made worse for nicotine withdrawal. Also one of my patients with extensive stroke related brain damage and end stage peripheral vascular disease declined admission for adequate nursing care and analgesic adjustment because he would have to give up "his one remaining pleasure."

Such cases should not blunt the public health message. Both patients were dying of smoking related disease. But making their last days more distressing than they would otherwise have been reflects an uncritical policy enforcement that adds a cruel and condescending twist to how doctors and health managers as much as the international tobacco industry are able to create smoking related suffering.

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1 McKee M, Gilmore A, Novotny TE. Smoke free hospitals. *BMJ* 2003;326:941-2. (3 May.)

Example was set in Canada

EDITOR—McKee et al put the case for smoke free hospitals.[1] At St Joseph's Health Care in London, Ontario, we used to have smoking in the surgeons' lounge and in a designated smoking room for patients. Now, patients who have "bad chests" and who smoke are made to stop if they wish to have elective procedures. Anaesthetists will cancel operations if this is not adhered to.

About five years ago all smoking in this hospital disappeared. Non-medical members of staff smoked at the outpatient entrance, as did a few desperate patients in wheelchairs, often with intravenous drips.

This practice was made illegal by hospital bylaw. Now neither staff nor patients smoke within 30 feet (10 m) of the hospital. Cigarette ends in disused corridors have gone.

The city of London followed by making smoking illegal in all restaurants and public places. Bars have to decide whether they serve food. If not, smoking is allowed in them.

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1 McKee M, Gilmore A, Novotny TE. Smoke free hospitals. *BMJ* 2003;326:941-2. (3 May.)

Community clinics can treat sexually transmitted infections

EDITOR—The House of Commons Public Health Select Committee on Sexual Health recently highlighted the "appalling sexual health crisis" in the United Kingdom and the inability of existing specialist services to meet the demand caused by increasing incidence of sexually transmitted infections.[1 2] Recommendations to increase funding to existing hospital based services are to be welcomed, but more innovative solutions should also be considered.

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A community based service for the management of uncomplicated genital infections has been running since November 2001 in Lewisham, south east London, an area with high rates of sexually transmitted infections. During the first year 648 infections were treated in 11 community family planning clinics (36 327 client attendances in 2001-2). Chlamydia and chlamydia/non-specific urethritis/non-specific genital infections account for most (70%) of the infections treated.

Demand for the service is growing, and the average number of infections treated weekly has progressively increased from 10 in the first three months to 15 at the end of the first year.

Detailed analysis at the largest clinic has shown that 82% of clients with sexually transmitted infections were treated in the clinic (compared with 52% when clients had to be referred to a specialist clinic),[3] and treatment can be verified for 0.43 sexual partners per case of chlamydia treated.

Our experience in Lewisham shows that uncomplicated sexually transmitted infections can be managed in community clinics, which provide an accessible service in a familiar environment. Uptake seems to increase without formally advertising to clients.

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Competing interests: JAE is a community family planning doctor and contributes to the management of this community service for sexually transmitted infections.

1 Dyer O. Government fails to meet targets for sexually transmitted infections. *BMJ* 2003;326:900. (26 April.)
2 Djuretic T, Catchpole M, Bingham JS, Hughes A, Kinghorn G. Genitourinary medicine services in the United Kingdom are failing to meet current demand. *Int J STD AIDS* 2000;12:571-2.
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Reply to letters on ethics of trials from bayesian perspective

Editor—In response to my paper Kunkler disagrees that telling people emphatically that "the best treatment is unknown" suppresses sophisticated questioning by the patient.[1 2] But this was not my opinion: I was merely quoting what Donovan et al reported in their original paper.[3] I was therefore pleased that instead of following Donovan et al's injunction to be unequivocal about uncertainty Hamdy et al give those invited to the ProtecT study "precise information on risks and benefits of treatments based on current evidence for particular tumours."[2]

Yet Frankel et al describe such "prior" information not by the conventional term belief but by the pejorative term prejudice.[2] From global warming to the chance of rain tomorrow we form stronger or weaker beliefs, and it is perfectly rational to use these in decision making, even when the evidence falls short of proof. So, Hamdy et al are quite right to vary what a man is told according to, for example, his particular tumour, and not simply tell all comers that the best treatment is unknown without further amplification.

The remarks in my paper pertained entirely to what was written in the paper by Donovan et al about what those invited should be told, not what they are told since I am not party to that information. Frankel et al point out that without a trial some men may not be told about the possibility of conservative management. However, even if this is true, it is not justifiable to dilute or curtail what those invited are told on the grounds that they were jolly lucky to be invited in the first place. Any double standard created by the imperative to explain each trial option more carefully than typical of standard practice requires standard practice to be improved, not trial practice attenuated.

As I have argued elsewhere, I agree with Senn's provocative point that there are strong arguments to restrict availability of new treatments to those who will accept randomisation.[2]

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Competing interests: None declared.

1 Lilford RJ. Ethics of clinical trials from a bayesian and decision analytic perspective: whose equipoise is it anyway? *BMJ* 2003;326:980-1. (3 May.)
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Neuraminidase inhibitors for influenza A and B

Study showed benefits of treatment are marginal

Editor—The paragraph for This week in the *BMJ* accompanying the systematic review and meta-analysis by Cooper et al of the effectiveness of neuraminidase inhibitors for influenza is at odds with the paper's results.[1] It states: "The treatment also lowers the risk complications that require antibiotics by 29-43% when it is given within 48 hours of onset of symptoms."

Cooper et al state that only one study (WV15670) in otherwise healthy adults reported a non-significant relative reduction (oseltamivir *v* placebo, 43%) in the odds of complications requiring antibiotics in the intention to treat population and a significant relative reduction (87%) in the flu positive population. Among children, a 35% relative reduction in the odds of complications requiring antibiotics was observed in one study (WV15758). Cooper et al looked at 17 studies in total. They do not comment on the effect on antibiotic requirements in their abstract, presumably because of the limited evidence available.

As a general practitioner I read the paragraph for This week in the *BMJ* with interest thinking a new and dramatic benefit had emerged, but the evidence for the statement that antibiotic requirements are reduced seems far from compelling on reading the paper. That together with a reduction in duration of symptoms of only half to one day with early treatment still makes me highly sceptical about promoting these costly drugs in a cash strapped NHS.

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Competing interests: None declared.

1 Cooper NJ, Sutton AJ, Abrams KR, Wailoo A, Turner D, Nicholson KG. Effectiveness of neuraminidase inhibitors in treatment and prevention of influenza A and B: systematic review and meta-analyses of randomised controlled trials. *BMJ* 2003;326:1235-40. (7 June.)

PROSE may be as useful as POEMs

Editor—Perhaps the *BMJ* would consider publishing PROSE as well as POEMs: pharmaceutical-driven research offering specious evidence.[1]

Preventing and treating influenza with "amivirs" would be an example.

Since these drugs are the subject of guidance from NICE in 1999 and 2000, as well as an editorial based on a NICE commissioned study, both in the *BMJ* of 7 June,[2 3] patients and doctors might be forgiven for thinking they are helpful. Their proved benefit amounts to one day less (out of an average of six) of feeling unwell from flu when used as treatment and a reduced odds ratio for healthy subjects of getting flu when used as prevention: no fewer complications, no fewer deaths.

How were these clinically irrelevant results ever graced with NICE guidance? And how did the drugs attract the epithet of clinically effective based on these outcomes? This is the exact opposite of evidence that matters.

Most evidence that doesn't matter never sees the light of day. When it does, I hope that the *BMJ* will recognise it for what it is and PROSE it.

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Competing interests: None declared.

1 Berger A. What do you think of the *BMJ*'s POEMs? *BMJ* 2003;326:1228. (7 June.)
2 Stöhr K. Preventing and treating influenza. *BMJ* 2003;326:1223-4. (7 June.)
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Antivirals need to be protected from adverse conditions to retain effectiveness

Editor—Cooper et al outlined the role of neurominadase inhibitors in prophylaxis against and treatment of influenza.[1] These agents would be important during the early

phase of any outbreak of influenza. Nevertheless, their efficacy would be reduced if they were not primed to resist the adverse conditions encountered in the field.

Like vaccines, the potency of antiviral drugs is only maintained during storage at controlled temperatures not exceeding 25-30°C.[2] Inadvertent exposure to temperatures above this could easily happen. Also, in 1992 temperatures inside refrigerators in paediatric clinics in Los Angeles exceeded 8°C in 22% of cases.[3] Power cuts are also a threat.

Designers of prospective influenza vaccines and chemotherapeutics should therefore ensure that such products can withstand environmental rigours while being transported at short notice to different continents during a pandemic. Adding pirodavir and deuterium oxide to the most labile of the childhood vaccines, live poliovirus vaccine, has resulted in vaccine immunogenicity being maintained after 10 hours of exposure to 42°C.[4] Practitioners of clinical medicine and public health need also to appreciate the value of storing influenza therapeutics or prophylactics according to manufacturers' recommendations during epidemics.

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1 Cooper NJ, Sutton AJ, Abrams KR, Wailoo A, Turner D, Nicholson KG. Effectiveness of neuraminidase inhibitors in treatment and prevention of influenza A and B: systematic review and meta-analyses of randomised controlled trials. *BMJ* 2003;326:1235-40. (7 June.)
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Scope of EPOC is clarified

Editor—Øvretveit and Gustafson say that the Cochrane Effective Practice and Organisation of Care Group (EPOC, www.epoc/uottawa.ca) has developed methods to assess observational studies.[1] This is incorrect, and we here clarify the group's scope.

The group reviews interventions designed to improve professional practice and the delivery of effective health services. This includes various forms of continuing education, quality assurance, and informatics, as well as financial, organisational, and regulatory interventions that can affect the ability of healthcare professionals to deliver services more effectively and efficiently.

Although we consider randomised controlled trials to be the gold standard for evaluating quality improvement interventions,[2] EPOC recognises that it may not be feasible to evaluate many organisational, professional, or financial interventions in a randomised controlled trial.

Therefore, in addition to randomised controlled trials, the group allows any of the following study designs be included in its reviews: patient randomised controlled trials, cluster randomised controlled trials, patient or cluster allocated controlled clinical trials, controlled before and after studies, and interrupted time series designs. Members have worked to advance the methods of reviewing in our area. For example, we have developed appraisal criteria for controlled before and after studies and interrupted time series designs.

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Competing interests: None declared.

1 Øvretveit J, Gustafson D. Improving the quality of health care: Using research to inform quality programmes. *BMJ* 2003; 326:759-61. (5 April.)
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Altitude sickness

Hyperventilatory capacity may predict altitude sickness

Editor—Barry and Pollard reviewed altitude sickness.[1] Tibetans and Sherpas (of Tibetan origin) have better physical performance at high altitude than white people,[2] possibly because of genetic differences.[3] Acute adaptation to high altitude and low oxygen supply is primarily by hyperventilation, which both improves oxygen saturation and increases blood pH. The capacity to correct respiratory alkalosis is thus crucial for acute adaptation to high altitude.

During a hiking tour at high altitude (Mount Kailash, Tibet) we measured partial oxygen pressure in nine white Austrians (4 men and 5 women, aged 43–62 years) and seven Sherpas (5 men and 2 women, aged 28-62 years). Preadaptation periods and physical fitness in both groups were about the same before the test was performed. Basal oxygen saturation was measured at rest and during one minute of forced hyperventilation at altitudes of 5100 m and 5600 m with a small portable transdermal pulse oximeter.

Sherpas had significantly lower resting oxygen saturation, but on hyperventilation they were able to raise their oxygen saturation up to over 90%, whereas the white climbers had higher basal oxygen saturation and a significantly lower capacity to raise this. In both groups the increase in oxygen saturation over baseline values (hyperventilation capacity) was significantly lower at 5600 m compared with the hyperventilation capacity at 5100 m. Subjects with a hyperventilation capacity $<5\%$ at 5100 m showed mild signs of acute altitude sickness, such as headache, dyspnoea, and subcutaneous oedema, when they ascended to 5600 m, whereas those with a hyperventilation capacity $\geq 5\%$ at 5100 m had no complaints.

We conclude that hyperventilation capacity decreases with increasing altitude, and its measurement might be a suitable approach to predict the development of altitude sickness.

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1 Barry PW, Pollard AJ. Altitude sickness. *BMJ* 2003;326:815-9. (26 April.)
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Gingko biloba does not prevent altitude sickness

Editor—Barry and Pollard say in their clinical review of altitude illness that gingko biloba may be more effective than placebo in preventing symptoms of acute mountain sickness.[1]

The PHAIT study, carried out by Gertsch et al in Nepal from October to November 2002, compared gingko biloba, acetazolamide, and placebo in a randomised controlled trial of trekkers ascending from Pheriche (4250 m) to Lobuche (4850 m). A total of 614 subjects were enrolled, and the results showed a marginal increase in symptoms of acute mountain sickness in the gingko biloba group (61.3%) compared with the placebo group (53.8%); the lowest incidence of symptoms was found in the acetazolamide group (21.2%) (J Gertsch, personal communication).

On the basis of these data I think that gingko biloba cannot be recommended as prophylaxis against symptoms of acute mountain sickness.

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Competing interests: PAK was a volunteer doctor at Himalayan Rescue Association Aid Post Pheriche during the period of the PHAIT study, although not directly involved in the study.

1 Barry PW, Pollard AJ. Altitude sickness. *BMJ* 2003;326:815-9. (26 April.)

Chronic low back pain

Patient had chronic rather than acute pain

EDITOR—Several concerns arise from the 10-minute consultation on chronic back pain by Samanta et al.[1] The case presented is that of a man with a two year history of chronic back pain. The advice given is in line with the suggested management of a person with acute back pain, not one with an exacerbation of a chronic condition.[2]

The assessment of "yellow flags" is essential,[2] but not, as the authors suggest, to identify factors that cloud assessment and treatment, but to identify those factors suggestive of a poor outcome if they are not managed appropriately.[3] In this regard they illuminate and inform the management of the patient.

The patient's reactions to pain must not be seen as extraneous noise but indicators of the type of treatment required. The suggestion that one must assess for depression or unhappiness at work is rather simplistic. People with back pain only occasionally require treatment for clinical depression, although low mood, fear of a recurrence of pain and difficulty managing work are common findings.[3 4]

The advice to let pain be one's guide has been refuted repeatedly in guidelines for the management of chronic back pain.[2] The patient must be encouraged to engage in increasing activity, and appropriate symptom management is essential to promote this. People with chronic low back pain should be referred to an active rehabilitation programme that increases physical activity and promotes early resumption of activity including return to work. The programme should incorporate the management of yellow flags including fear of (re)injury, flare-up management, low mood, and workplace issues. Simple educational approaches, with or without written information alone, are not effective in managing patients with chronic pain problems.[5]

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1 Samanta J, Kendall J, Samanta A. 10-minute consultation: Chronic low back pain. *BMJ* 2003;326:535. (8 March.)
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More relevant guidelines have been published

EDITOR—The Faculty of Occupational Medicine has published relevant guidelines on the management of low back pain.[1] These are recommendations based on an evidence review, and are primarily concerned with occupational aspects such as prevention and rehabilitation into work. None the less, they include clinical management and in general concur with the advice Samanta et al give in their article.[2]

Samanta et al suggest that patients let pain be their guide when judging activity levels. The faculty guidelines, reflecting the Royal College of General Practitioners' guidelines on clinical management, have a subtle but important difference. They emphasise the importance of continuing ordinary activities as normally as possible despite pain.[1] There is strong evidence that this leads to better outcomes than "traditional" treatment, which includes the comment "let pain be your guide." This may seem trivial, but the importance of psychosocial factors, especially in chronic pain, is well established.

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Competing interests: MD is a member of the faculty of occupational medicine board but was not involved with the production of the faculty's guidelines.

1 Carter JT, Birrell LN, eds. *Occupational health guidelines for the management of low back pain at work*. London: Faculty of Occupational Medicine, 2000.
2 Samanta J, Kendall J, Samanta A. 10-minute consultation: Chronic low back pain. *BMJ* 2003;326:535. (8 March.)

Ranking heart surgeons has pitfalls

EDITOR—Dyer reports that heart surgeons are to be rated according to success in bypass surgery.[1] Cardiac surgery is a team sport, and each player can influence the score. The dilemma I face as a surgeon is that the result is mine, although the poor performance may not always be.

Furthermore, the potential problems with ranking cardiac surgical performance have been well described previously.

The cardiac surgery reporting system was mandated for all cardiac surgeons in New York State by its department of health in 1989. It was the first doctor specific mortality report published. As a result of successful application under freedom of information legislation by Newsday, both institutional and individual outcomes have appeared in the popular press from 1991.

Burack et al reported in 1999 that 40% of surgeons admitted to gaming with risk factors, and that 62% admitted to refusing to operate on high risk patients as a consequence of the review (those patients who stand to gain the most from a successful procedure).[2]

Shahian et al also emphasise these difficulties in their comprehensive review of "report cards," and they comment on the flawed statistical methods used.[3]

Polonieki keenly observed that half of all doctors are below average and that poor statistics alone can make a surgeon's performance appear to be an outlier.[4]

Consequently, publication of individual surgeon's outcomes is not without detrimental effects. Those who mandate and apply such comparisons should be aware of these consequences.

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1 Dyer O. Heart surgeons are to be rated according to bypass surgery success. *BMJ* 2003;326:1053-a. (17 May.)
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Two questions help determine validity of bed occupancy

EDITOR—Alijani et al investigated the appropriateness of surgical bed occupancy and devised a tool to validate it.[1] With the current heavy pressure on using acute beds, patient flows must be maintained and doctors be seen to be asking two questions.

The first is obvious: How sick is this person? The second sometimes escapes attention: What are we doing for this patient? In other words, what value are we adding to that person's care that cannot be delivered in some more appropriate environment?

The added value may consist of treatments, observation of vital signs, or clinical interventions that are available safely only in acute wards. Waiting for test results and keeping people in hospital just because they are "not well" are not valid reasons. This point was highlighted for me by the first three criteria in the assessment tool. As a gastroenterologist my outpatient clinics are full of people with unexplained abdominal pain, nausea, and abdominal tenderness. Heaven forbid I should admit them all.

Thinking about the two reasons is even more important when doctors are dealing with acute relapses of chronic diseases. In such cases the need for an acute hospital bed disappears very quickly—if it ever existed in the first place.

This is not just an issue in the arguments about beds and emergency targets. Hospitals are dangerous places for patients. Doctors need to re-educate the public and remind themselves about the reasons for patients being there.

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1 Alijani A, Hanna GB, Ziyaie D, Burns SL, Campbell KL, McMurdo MET, et al. Instrument for objective assessment of appropriateness of surgical bed occupancy: validation study. *BMJ* 2003;326:1243-4. (7 June.)