day with a myocardial infarction and left ventricular failure, who still smokes two packs of cigarettes a day. I also think of the politicians who continue to vote for measures to keep the price of tobacco down while throwing millions of dollars away on a Federal Tobacco Reduction Program that is doomed to failure, just like those World War I offensives.

Churchill suggested an alternative to the frontal attacks in France. He and others hoped that an offensive at Gallipoli would bring an early and less bloody end to the war. Unfortunately, because of failure of execution at the critical moment, Gallipoli failed and Churchill was subsequently banished from the admiralty.

Is it not time for the medical profession to suggest to our political masters some innovative approach to beating the smoking problem before it bankrupts the system? Where are the leaders of our profession who are willing to chance a Gallipoli in the hope of victory?

Are we doomed to another generation of cheap tobacco, epidemic illness caused by smoking and a lack of individual responsibility for health? Are we all too complacent, even thankful, to have all those tobacco-wrecked bodies on which to practise the marvels of modern medicine, such as repeat angioplasty, lung surgery and lung transplants for patients with end-stage emphysema?

John C. Acres, MD, FRCPC
Moncton, NB

COMMUNICATIONS RESEARCH

We read the recent article "Effective physician–patient communication and health outcomes: a review" (*Can Med Assoc J* 1995; 152: 1423–1433), by Dr. Moira A. Stewart, with interest. We agree that there is good evidence that the quality of communication can affect patient health outcomes, but we have some concerns about the concepts and methods used in this review and the conclusions reached.

The review tried to embrace all aspects of physician–patient communication, including communication-skills training for physicians and patients, patterns of interaction during consultations, various forms of information provision to patients, agreement between patients and professionals and provision of patient choice. This lack of focus makes it almost impossible to identify all relevant studies and makes data synthesis and interpretation problematic.

Several published studies of the provision of information to patients that appear to meet the inclusion criteria did not appear. For example, Suls and Wan[1] identified 21 controlled trials of the provision of procedural and sensory information to patients undergoing medical or surgical procedures. Studies of patient information and education about the management of chronic conditions have also been reviewed.[2–4] It is unclear whether these studies were considered and excluded, or simply not identified through the search.

The reported search strategy had weaknesses. There is contradictory information about the period covered by the review: the opening paragraph refers to 25 years of research, yet the MEDLINE search covered only 1983 to 1993. The search also relied on the MeSH term "physician–patient relations." MeSH terms are not consistently applied to all articles, and some of the studies eligible for inclusion in this review may have been indexed under "patient participation" or "patient education."

The complex nature of professional–patient communication and the difficulties of evaluating the relative importance of variables influencing outcomes are not discussed. The conclusions reached are not fully justified by the data presented. In some cases, the association of a particular aspect of communication with a particular patient outcome is justified by evidence from only one study. It is inappropriate to assume that particular aspects of communication are universally beneficial and should be adhered to, even when their effects are, on balance, positive. Patients' preferences, as well as their ability to process information and participate in decisions about their health care, vary.[5,6]

Reviews in this area face problems involving definitions, scattered literature and inconsistent terms as well as a wide range of variables and of reported outcomes. Development of appropriate systematic review methods is difficult. Although Stewart's article covers some issues in a useful manner, it cannot be regarded as conclusive.

Vikki Entwistle
Ian Watt
National Health Service Centre for Reviews and Dissemination
University of York
York, England
Heather Buchan
Public Health Branch
Health and Community Services
Melbourne, Australia

References

1. Suls J, Wan CK: Effects of sensory and procedural information on coping with stressful medical procedures and pain: a meta-analysis. *J Consult Clin Psychol* 1989; 57: 372–379
2. Hirano PC, Laurent DD, Lorig K: Arthritis patient education studies, 1987–1991: a review of the literature. *Patient Educ Couns* 1994; 24: 9–54
3. Dolan-Mullen P, Green LW, Persinger GS: Clinical trials of patient education for chronic conditions; a comparative meta-analysis of intervention types. *Prev Med* 1985; 14: 752–781
4. Bernard-Bonnin AC, Stachenko S, Bonin D et al: Self-management teaching programs and morbidity of pedi-

atric asthma: a meta-analysis. *J Allergy Clin Immunol* 1995; 95: 34–41
5. Degner LF, Sloan JA: Decision making during serious illness: what role do patients really want to play? *J Clin Epidemiol* 1992; 45: 941–950
6. Silverstein MD, Stocking CB, Antel JP et al: Amyotropic lateral sclerosis and life-sustaining therapy: patients' desires for information, participation in decision making and life sustaining therapy. *Mayo Clin Proc* 1991; 66: 906–913

[The author responds:]

I am heartened that my review of the literature on effective physician–patient communication and health outcomes has generated numerous reprint requests and has stimulated a discussion of several important issues in communications research. Thoughtful consideration of the issues (such as the strengths and limitations of any search strategy, the complex nature of communication and the varying preferences of patients for information and involvement in decision making) will move the field forward.

There are two points I wish to comment on. First, I welcome Ms. Entwhistle, Mr. Watt and Ms. Buchan's confidence in the bottom line (i.e., that there is good evidence that the quality of communication can affect patient health outcomes). Such confidence is warranted not only as a result of my literature review, but also thanks to other reviews that I cited and several recently published reviews in this fast-moving field.[1,2]

The second point is that I deliberately chose a broad approach in order to reflect the clinical reality of the intended audience accurately. Being restrictive could have led to the omission of an important portion of what doctors do (e.g., gathering information, giving emotional support, providing information and diagnosis and sharing management decisions).

We advocate a broad conceptual framework, which was developed by clinicians from their reflections on their everyday encounters with patients. Called patient-centred medicine,[3] this approach requires that the physician follow the patient's cues in any interaction, which implies a sharing of control between the physician and the patient. A patient-centred approach includes six interactive components: exploring the patient's disease and illness experience, understanding the whole person, finding common ground, enhancing prevention and health promotion, enhancing the patient–physician relationship and being realistic.

Attempts to bridge the gap between research and application, such as my review, always walk a fine line between a narrow focus and enough breadth to be relevant to clinical practice.

Moira Stewart, PhD
Professor
University of Western Ontario
London, Ont.

References

1. Lipkin M Jr, Putnam SM, Lazare A (eds): *The Medical Interview*, Springer-Verlag, New York, 1995
2. Ong LML, De Haes JCJM, Hoos AM et al: Doctor–patient communication: a review of the literature. *Soc Sci Med* 1995; 40: 903–918
3. Stewart M, Brown JB, Weston WW et al: *Patient-Centered Medicine*, Sage, Thousand Oaks, Calif, 1995

CMA SILENT ON BILL TO PROTECT GAYS AND LESBIANS

The publication of this letter was inadvertently delayed by CMAJ. — *Ed.*

I have found it interesting to see the involvement of the CMA in various issues that it deems important. There has been a hue and cry over registered retirement savings plans (RRSPs). Gun control and the