

Theme issue for patients

A picture tells a thousand words

EDITOR—It's become a ritual. First thing every Friday morning I log onto the *BMJ*, anticipating some interesting feature, latest research news, and generally to keep myself informed. This morning, however, was a disaster. Smith talks of "patient partnership"—but what I saw smacks of paternalism and tokenism.¹ I am not necessarily referring to the content.

The layout, design, and visuals are enough to confirm my point. Why does an issue for patients have to be adorned with huge headers, glossy pictures, and a delicate swirl of colour here and there? Is the assumption that patients' attention span is possibly less than that of a health professional, or that their eyesight is generally poorer, or that their intellectual interest will be attracted only via the visual? It is ironic that an issue claiming to spur on this collaborative and "equal" relationship between doctor and patient should so blatantly reinforce the stereotypical and assumed differences.

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Competing interests: None declared.

¹ Smith R. From the editor. *BMJ* 2003;326. (14 June.)

Losing core readers?

EDITOR—I'm not sure I like the new look *BMJ*. It's difficult to tell the adverts from the articles. The guest editor, Lynn Eaton, talks about managing the changing doctor-patient relationship and says it's going to be a challenge for everyone involved in health care.¹

Thinking about this, I wonder why asking for the date of women's last menstrual period (for example, on x ray request forms) is still used as a substitute for asking them if they could be pregnant. It implies they can't be trusted to know.

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Competing interests: None declared.

¹ Eaton L. Saddle up, partner. *BMJ* 2003;326:1275. (14 June.)

Target audience is of interest

EDITOR—With reference to the article by Eaton,¹ I am curious to discover the real target audience of this issue. I was directed to it by an enthusiastic and exceptionally approachable paediatrician—now how often does that happen?

Certain sections of the public and patients will continue to use information, research, and services beyond what is meted out by the NHS and its practitioner body, and others would not and cannot. Is that what is meant by a two tier healthcare system?

Having said that, access to information does not necessarily empower the enquiring patient unless the qualified practitioner is willing and sensitive enough to put it in perspective for practical application. Some professionals feel threatened, others are still open to new approaches from unexpected sources, although this is initially demanding of their time and resources. In the long term it would decrease demand as the element of self management comes into play.

Maybe one could argue that the sense of powerlessness and disenfranchisement experienced by a sizeable section of the population could be measured against the above as equally undemanding of their first line service providers' time.

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Competing interests: None declared.

¹ Eaton L. Saddle up, partner. *BMJ* 2003;326:1275. (14 June.)

Why does the media want to lead doctors?

EDITOR—The editorial comment by Smith is characteristic of the worst kind of wrong thinking—in that it is only half wrong and so escapes comment on the basis of the part that is half right.¹

He is right that we all consider patient interests of the greatest importance and acknowledge the need to represent their views in clinical issues. He is right that the interests of individual patients have sometimes been placed second to the educational

value of presenting them. The recent departures with evolving case histories were interesting, including the patients' contribution. However, he is wrong on all the rest. He is wrong to scorn the NHS on the basis that it does not share the priorities and infrastructure of a commercial supermarket. He is wrong to consider it offensive to patients that doctors write professional letters to each other that contain information that is more complex and less accessible than a patients' information leaflet.

It is offensive to doctors to read his proclamation of his mission to lead us into his perceived territory of our politically directed destiny. The general media are already full of poorly expressed and unrepresentative material that has more to do with the egos of journalists than the subject matter. The BMA has recently shown how unhitched it has become from mainstream doctors by the attempt to thrust politically engineered contracts down our throats.

Perhaps Smith's comment is a warning of the same disease affecting the priorities in the editorial office of the *BMJ*. There may be a vacuum of effective medical leadership, but that is not an invitation to medical editors to step into the breach.

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¹ Smith R. From the editor. *BMJ* 2003;326. (14 June.)

Real issue is time and money

EDITOR—I read with interest the patient centred issue,¹ but I looked in vain for discussion of two vital and related issues—time and money. Although doctors want to do the best for their patients, they increasingly lack one of the most important resources required, namely time. Government targets cause clinics to be overlooked; managers urge their clinicians to aim for the five minute consultation; more and more non-clinical activities are introduced into the working week, reducing time spent with patients. It is not possible to have the discussions that patients want when there are 20 more people sitting outside the door and the registrar is absent after a night on. All the empowerment of patients in the world



will not free up doctors to listen to the degree that they would wish, and until consideration is given to this problem there will be limited scope for the partnership that you promote and doctors and patients seek.

Related to this is the fact that patients can only get the NHS that they are prepared to fund. If they will only pay enough taxes to purchase a second hand car it is no use turning up in clinic expecting a Rolls-Royce service. In your consideration of the doctor-patient partnership I see no exploration of this direct relationship between the taxpayer and patient and the service that is available, nor any attempt to imply that the patient may bear some responsibility for a less than adequate health service.

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1 Eaton L. Saddle up, partner. *BMJ* 2003;326:1275. (14 June.)

Negative stereotypes are becoming ingrained in national psyche

EDITOR—I found the patients' issue thoroughly depressing.¹ As a doctor in training, I am presented, on a daily basis, with evidence implying that doctors are, variously, self serving, arrogant, poor communicators, unconcerned with their patients, lazy, insufficiently expert, dangerous, negligent, in the pay of big business, reactionary, Luddite, and rude. These stereotypes are peddled by the media and are becoming ingrained in the national psyche.

I was disappointed to see very few (if any) contributions to the patients' issue from doctors who currently face patients in an emergency, at unsocial hours, in dismal surroundings. These patients present with unrealistic expectations, which have been constantly inflated by government spin and the gross commercialisation of society. I believe that the patients' issue merely served to add insult to a group of healthcare workers who, in general, are striving to provide better care every single day, in difficult circumstances, and I was galled to have my perceived shortcomings yet again highlighted, in a journal so closely allied to my union and professional organisation. It may well be that the BMA does not actually fund the *BMJ* directly, but I, for one, will be asking the association to clarify this relationship in more detail.

A better relationship between doctors and patients is a fantastic goal, but it will not be advanced by sending covert messages that doctors are always to blame when things don't go right.

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1 Smith R. From the editor. *BMJ* 2003;326. (14 June.)

Summary of rapid responses

EDITOR—The theme issue for patients with its unusual layout and unfamiliar articles resulted in a predictably large number of responses, most from the United Kingdom. They were penned mainly in reaction to Smith's introductory note, From the editor, which offered an analogy between hospitals and supermarket car parks; to the guest editor's comment, and to Hammond's end piece.¹⁻³

Many respondents did not like the layout and design of the issue. Patricia Wilson found it only slightly overdone, although she appreciated that it was for a different target audience. John Baines just said "No!" and Philip Munro found it difficult to read. Peter Wilson, also from the United Kingdom, even threatened to resign his membership from the BMA if this were the future look of the journal, a sentiment echoed by his compatriot Mary Lyons.

Elizabeth Campbell found the issue more modern, and Frank Wells regarded it as a breath of fresh air. Jay Ritzema wanted to know whether it would be competing with magazines and whether the cover price would be reduced accordingly. Andrew Beggs was firm that the *BMJ* is for doctors and is not the *Nursing Times*.



Opinions on content were similarly divided. Several criticised the analogy of supermarket car parks because doctors, unlike supermarkets, do not need more customers (Declan Fox, Canada) and no supermarket staff would help customers at 2 am (Heinz Weizel, Canada). Syed Viqar Ahmed pointed out that, like supermarket staff, doctors also need good working conditions. Paul Duff from Australia simply concluded that the *BMJ* had gone soft.

The idea of partnership between doctors and patients found various reactions. Elizabeth Campbell recommended that doctors should all be talking to patients more. Various authors thought that partnership had always been at the heart of medicine, although the relationship might need clarification. Sergio Stagnaro (Italy) and Susanne Stevens both emphasised the

"we" approach to partnership that both doctors and patients should be taking.

In her letter (above) Jacky Davis takes the argument further in pointing out that the responsibility for partnership lies with both parties. However, a lack of time and money currently limits the scope for the partnership that is promoted. Time for serious thought about partnership on both sides of the fence?

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Competing interests: None declared.

1 Electronic responses. Preparing for partnership. *bmj.com* 2003. bmj.com/cgi/eletters/326/7402/0 (accessed 30 Jul 2003).

2 Electronic responses. Saddle up partner. *bmj.com* 2003. bmj.com/cgi/eletters/326/7402/1275 (accessed 30 Jul 2003).

3 Electronic responses. The whole truth? *bmj.com* 2003. bmj.com/cgi/eletters/326/7402/1340 (accessed 30 Jul 2003).

Digestive and nutritional factors may explain lower prevalence of coronary disease in indigenous peoples

EDITOR—The report *Health Disparities Experienced by American Indians and Alaska Natives*, which was summarised in the *BMJ*'s news section,¹ shows that American Indians and Alaska Natives have a much higher prevalence of diabetes than all other US racial populations, but it does not refer to the reverse of this disparity in coronary heart disease.

Pima Indians and Alaska Natives experience less coronary heart disease than American whites and, outside the United States, Afro-Caribbeans, and South African blacks also have less coronary heart disease than white people despite a high prevalence of diabetes. Greenland Eskimos, the Masai, Tibetan highlanders, and some Polynesians and Melanesians are other indigenous peoples who experience less coronary heart disease than expected.² All these peoples have in common a low prevalence of persistent high lactase activity in adulthood, which is associated with a low intake of lactose from milk.³

These digestive and nutritional features contrast with those of the "coronary prone" north Europeans and their overseas descendants, who have a high prevalence of persistent high lactase activity and a high intake of lactose. Persistent high lactase activity is genetically dominant, and milk is an inexpensive source of nutrition, so global health could require trends in prevalence of persistent high lactase activity and in milk intake of indigenous peoples to be monitored.² It is also high time for the hypothesis that a high intake of lactose is a risk factor for coronary heart disease to be tested by clinical trials of minimal lactose intake for prevention.^{2,4}

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Competing interests: None declared.

- 1 Tayal U. Report shows health disparities in American Indians and Alaska Natives. *BMJ* 2003;327:305. (9 August.)
- 2 Segall JJ. Plausibility of dietary lactose as a coronary risk factor. *J Nutr Env Med* 2002;12:217-29.
- 3 Simoons FJ. The geographic hypothesis and lactose malabsorption: a weighing of the evidence. *Am J Dig Dis* 1978;23:963-80.
- 4 Segall JJ. Hypothesis: is lactose a dietary risk factor for ischaemic heart disease? *Int J Epidemiol* 1980;9:271-6.

Patients' preferences need thinking through for the NHS

EDITOR—Kennedy comments that a mature culture will settle on sharing power and responsibility, on a subtle negotiation between professional and patient about what each wants and what each can deliver.¹ But how will clinicians and health policy makers react to patients who want the least effective treatment, which may also be less cost effective for the health service in the longer term?

That this scenario could arise is indicated by the results of our pilot survey among patients with angina of their preferred treatment for coronary artery disease. Patients' views on the range of invasive to less invasive treatments were diverse. However, although surgical treatments (such as coronary bypass surgery) were generally perceived as effective, they were also described by respondents in negative terms, such as invasive and frightening, and were to be avoided altogether or delayed until they became unavoidable (until the condition becomes life threatening). This attitude was particularly prevalent in women and in older patients (aged 75 and over).

A larger study, including modelling the results on healthcare costs and outcomes, is required next, but the consequences for the NHS of large numbers of patients opting for treatments other than those that are clinically indicated need thinking through.

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The following are coauthors of this letter: Shah Ebrahim, professor of epidemiology of old age, Department of Social Medicine and MRC Health Services Research Collaboration, University of Bristol; Richard Thomson, professor of epidemiology and public health, School of Population and Health Sciences, University of Newcastle on Tyne; and Michael Laurence and Jamie Dalrymple, general practitioners, Norwich.

Competing interests: None declared.

1 Kennedy I. Patients are experts in their own field. *BMJ* 2003;326:1276-7. (12 June 2003.)

Doctor-patient communication in developing countries

EDITOR—As in the United Kingdom, patients in Guinea consider communication with health professionals important.^{1,2} Unfortunately, in developing countries, biomedicine is the dominant paradigm,³ and poor communication is the rule in public services.⁴ Why does communication weigh so little in health policies in developing countries?

The biomedical model was widely disseminated during the colonial period. Fifty years later, interventions to control disease are still the key delivery pattern for public services. Quantitative objectives predominate and clinical decision making is hyperstandardised at the expense of individually tailored care.

The problem is not limited to public facilities. Although the private sector may have a reputation for offering a better doctor-patient relationship and more confidential care, there are plenty of reasons to doubt the presence of a patient centred approach even here:

- Patient centred care is barely reflected in the medical curriculum in developing countries⁵
- Private practitioners may have little interest in non-lucrative preventive actions⁵
- Maximisation of income may conflict with promoting patient autonomy.⁵

Consequently, shared decision making about case management, an essential element of patient centred care, is difficult to achieve. Greater emphasis on patient centred care could improve communication between doctors and patients in developing countries and increase the effectiveness of care just as it can in developed countries. We urge aid agencies and governments to consider the patient centred approach as the object of a specific initiative encompassing in service training, coaching, and reorganisation of health services for these regions.

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Competing interests: None declared.

- 1 Tarrant C, Windridge K, Boulton M, Baker R, Freeman G. Qualitative study of the meaning of personal care in general practice. *BMJ* 2003;326:1310. (14 June.)
- 2 Haddad S, Fournier P, Machouf N, Yatara F. What does quality mean to lay people? Community perceptions of primary health care services in Guinea. *Soc Sci Med* 1998;47:381-94.
- 3 Unger JP, Van Dormael M, Criel B, Van der Vennet J, De Munck P. A plea for an initiative to strengthen family medicine in public health care services of developing countries. *Int J Health Serv* 2002;32:799-815.
- 4 Jewkes R, Abrahams N, Mvo Z. Why do nurses abuse patients? Reflections from South African obstetric services. *Soc Sci Med* 1998;47:1781-95.
- 5 Thaver JH, Harpham T, McPake B, Garner P. Private practitioners in the slums of Karachi: what quality of care do they offer? *Soc Sci Med* 1998;46:1441-9.

Copying letters to patients

Mental health professionals are in fact likely to support this initiative

EDITOR—Copying letters to patients is more exciting and more challenging than Essex allows in his perspective.¹ How sad that he chooses to single out groups that he thinks make “most objections to copying letters to patients”: administrators, providers of health services to adults, and mental health professionals. He says that mental health professionals rarely communicate with others, commenting that “no one knows what they do, and they can't be accused of not sending copies of letters if there are no letters.”

Mental health professionals have been providing copies of the care programme approach plans to patients and carers for many years. This documentation normally includes assessment of need, the care programme (who is carrying out what tasks as well as including drug treatment and side effects), a contingency plan (what to do to prevent something going wrong), and crisis plans (what to do in a crisis if things do go wrong).

Essex may also not be aware that psychiatrists have been preparing detailed reports for mental health review tribunals for many years and that these reports have been routinely made available to the patient; only on rare occasions is a piece of information kept hidden after an assessment of risk.

I am optimistic that mental health services in general, and psychiatrists in particular, will be enthusiastic supporters of copying letters to patients, provided that the operation of the process is planned properly and rare risk exceptions in which the patient or others could be seriously harmed are carefully articulated.

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Competing interests: None declared.

1 Essex C. Copying letters to patients is coming to a clinic near you. *BMJ* 2003;326:1330-1. (14 June.)

Doctors should tailor their practice to cater for individual patients' needs

EDITOR—We agree with some aspects of Essex's article but think that his comments on mental health professionals lack insight.¹ Open communication is a crucial part of the therapeutic relationship, and we know patients appreciate having written information about their care.²

A survey we performed of 50 older adult psychiatric outpatients and 38 carers showed that most (89%) wanted a letter about their treatment and care. Essex thinks that this should ideally be in the form of a letter written to the patient. Again, our survey supports this idea as most subjects (75%) wanted their own letter rather than a copy of the one sent to the general practitioner. However, this does not

reflect the proposal laid down in the NHS Plan, which states that all correspondence between clinicians about a patient will be copied to the patient automatically.³

In psychiatry copying letters to a patient is not advisable in certain circumstances: if the patient lacks mental capacity or when there are serious concerns about risk. Our anxieties are not founded in our own fears of having to share difficult information or being accountable for our actions, policy being inflexible and politically correct rather than evidence based.

Paradoxically, the plan is itself a paternalistic manoeuvre, implying that the "powers that be" know what is best practice for patients. A better way would be to treat patients as individuals and tailor doctors' practice to suit each patient's wishes and needs.

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- 1 Essex C. Copying letters to patients is coming to a clinic near you. *BMJ* 2003;326:1330-1. (14 June.)
- 2 Meredith B. Policy should be implemented as soon as possible. *BMJ* 2002;325:1359.
- 3 Department of Health. *The NHS Plan*. London: Stationery Office, 2000.

Most patients want copies of letters from outpatient clinics and find them useful

EDITOR—Chantler and Johnson proposed action research on the proposal to send patients copies of clinical correspondence, and Essex discussed the issue of copying letters to patients in the patient issue.^{1,2}

Since April 2002 we have offered all patients the option of receiving copies of letters to their general practitioner from a chest and cardiology clinic. Of 1717 monitored consultations, 1504 patients (87.6%) wanted copy letters. This rate has increased to above 90% and stabilised. There was no difference between the choices of new patients or patients being followed up or between general clinics and a designated lung cancer clinic.

Altogether 63 patients who had received copy letters completed a questionnaire; 62 had read the letter and only two were dissatisfied with the content. A total of 59 patients (94%) would wish to receive further letters. Patients found that the letters helped them understand their diagnosis and treatment and to communicate with their doctors.

No patient was offended by any letter, but two patients were confused by the content. Altogether 14 patients were a little worried by the content, but only one patient was very worried. Two patients reported wrong information about their illness (none major) and one patient reported errors in the drug list.

Some of the clinicians now dictate the letters while the patient is present to further reduce these errors.

We agree with Chantler and Johnson that most patients (even those with cancer) wish to receive copy letters and most patients find them useful. However, it is essential to offer patients a choice in this matter because some patients do not wish to receive copy letters.

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Competing interests: None declared.

- 1 Chantler C, Johnson J. Patients should receive copies of letters and summaries. *BMJ* 2002;325:388.
- 2 Essex C. Copying letters to patients is coming to a clinic near you. *BMJ* 2003;326:1330-1. (14 June.)

Involving children is important

EDITOR—Your otherwise commendable issue on patients' involvement of 14 June omitted an important part of the debate: the health care of children and young people. Typically when we say patient we think adult. The result is the unintentional exclusion of a high proportion of patients: those under 18.

As Alexander asserts,¹ the NHS patient is in a weak position—and if this is true for adults, it is doubly so for children. Parents and carers may be key mediators during the early years, but as children grow in competence they will want to ask their own questions and have them answered in ways they can understand. As they reach the teenage years they may well wish to be in complete control of communication about their health.

Like adults, children and young people want to be partners in their own health care, especially those children with conditions that will require a lifelong engagement with health professionals. We have to take responsibility for providing a service that can fulfil that aim. Listening to children is a requirement for all government departments, monitored by the children and young people's unit. Patients' involvement in the NHS is no exception. By giving healthcare professionals both the skills and the will to engage proactively with children we can help deliver a relevant, well loved, and well used public service—a mission that must surely be in all our interests.

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Competing interests: None declared.

- 1 Alexander M. The focus is on patients' clinical needs and distress. *BMJ* 2003;326:1332-3. (14 June.)

Cabbage leaves



Cabbage leaves can help inflammation of any body part

EDITOR—I was amazed to see the photograph submitted by Utting and Currall.¹ Not amazed that a cabbage leaf was used, but that this was considered newsworthy.

Cabbage leaves are often used by breastfeeding women to soothe engorged painful breasts. Their success in my personal trial of one has led to my recommendation of them, not only to breastfeeding women but to any one with an acutely inflamed bodily part, with reasonable success.

A cabbage stored in the fridge is cheaper than any of the exciting gel filled pouches you can buy, and the leaves conform well to a variety of anatomical shapes.

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Competing interests: Mother and user of product.

- 1 Minerva. *BMJ* 2003;326:1406. (21 June.)

Cabbage leaves are poor man's poultice

EDITOR—Freshly washed cabbage leaves are known in European folk medicine as the poor man's poultice. There is nothing new about this ancient remedy used to help reduce all types of painful swelling. You may even find that there is a cache of cabbage in the fridge of your local maternity unit.

So there is nothing freakish or stupid about the woman pictured in Minerva who used it over her painful knee.¹

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- 1 Minerva. *BMJ* 2003;326:1406. (21 June.)

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