may reflect less the health care policies or ideology of a particular government than the fact that society has become more polarised. Just as the NHS was born in 1948, when inequalities in income were diminishing, so the new tensions have made themselves evident at a time of increasing inequalities. It may therefore be overoptimistic to expect that the NHS can be used as a kind of institutional glue for society, symbolising mutual support, unless this is part of a wider change of direction. Similarly, it may be unrealistic to hope that future changes in policy can be negotiated rather than imposed if the present system of adversarial politics persists. If achieving change through consensus is the aim, constitutional reforms like proportional representation may be the necessary means. In short, health policies inescapably raise questions about the nature of our society and our political system.

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Family interventions in schizophrenia

An effective but underused treatment

The systematic review by Mari and Streiner of family interventions for people with schizophrenia,[1] abstracted in a recent issue of *Evidence-Based Medicine*,[2] confirms what mental health researchers have suspected for some time[3]—that such interventions reduce relapse rates, rehospitalisation, and costs of treatment and also increase compliance with medication. This is good news for schizophrenia sufferers, their families, and others involved with their care, because family interventions promise an effective strategy in schizophrenia that complements other interventions such as antipsychotic medication.[4] Despite this, acceptance of the treatment into clinical services has been slow.[5]

Mari and Streiner included 12 randomised controlled trials of family interventions in their review, selected after systematic search of the research literature by predetermined methodological criteria. The interventions all offered family psychoeducation and support, and most included some form of skills based training for relatives, although the theoretical orientation of these programmes varied considerably. The cultural backgrounds and therapeutic environments in which the studies were conducted also differed. However, the intervention trials together showed reasonably consistent, if moderate, effects. After about one year of follow up, preventing a single additional relapse in a person with schizophrenia required intervention with seven families. The number of subjects studied in these trials was small, and the results of the meta-analysis remain vulnerable to the possibility that larger trials in the future will produce negative results.[6] Nevertheless, the current evidence is clear.

The accumulation of research evidence in this field followed a classic progression.[7] An unexpected observation that people with schizophrenia relapsed more frequently after discharge from hospital if they had more contact with their families, first published over 30 years ago,[8] led to the experimental construct of family "expressed emotion."[9] People with schizophrenia living in families characterised by high levels of hostility, criticism, or emotional overinvolvement had higher relapse rates than those who did not.[10] The numerous and diverse studies that investigated this association, reviewed by Kavanagh,[11] generally replicated the original findings. Nevertheless, sufficient theoretical and methodological ambiguity remained to allow considerable divergence of conclusions in traditional, non-systematic, reviews published in the late 1980s.[12-13] Two more recent systematic reviews, using aggregated data,[14] place the association of high expressed emotion and increased rate of relapse in schizophrenia beyond doubt. But even these had limited clinical relevance until the results of trials of family intervention became available. In 1991, a traditional, non-systematic review of intervention trials was generally positive,[3] but could not produce an aggregate estimate of the effect of family intervention. It also raised methodological and theoretical concerns about the published data. Here, then, is the value of the Mari and Streiner systematic review.[1] Strict inclusion criteria allowed the reviewers to control for methodological differences between studies and, by meta-analysis, to derive aggregate effect sizes for the family interventions. Furthermore, publishing the study in the Cochrane Schizophrenia Group module of the Cochrane Database of Systematic Reviews[15] allows for regular updates of the data and cumulative meta-analyses as new studies come to hand. The current version of the database contains four studies in addition to the eight included in the original "paper" publication of the review in *Psychological Medicine* in August 1994.

Over a decade ago, Kuipers and Bebbington concluded that family intervention as a treatment modality in schizophrenia should move from the research environment to influence clinical practice.[16] The evidence to support this move has strengthened since, and this recent systematic review recapitulates it. Yet the availability of this treatment remains poor, and descriptions of its use in routine clinical settings are rare and confined to authors with a strong research interest in the field.[5 17] Perhaps this reflects resource issues—while no formal economic evaluation of family intervention for schizophrenia exists, the large number needed to treat (seven families for a year) to prevent one relapse suggests that the intervention is highly labour intensive. But this conclusion became available only with the present review and, in any case, the provision of mental health services bears little relation to research. Judged by the best available evidence from systematic reviews, psychiatry incorporates many commonly used treatments whose comparative effectiveness is equivocal at best. Among biological treatments, selective serotonin reuptake inhibitors provide a notable example,[18] while among psychosocial treatments, the implementation of case management programmes is similarly debatable.[19] It is tempting to speculate that the current status of family intervention programmes for treating people with schizophrenia might be different if they attracted the research resources and marketing prowess associated with drug treatments, or the political will associated with case management.

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Breast cancer: asking patients what they want

Makes for better decisions about treatment and research, and better outcomes

Amid the uncertainties surrounding the treatment of breast cancer, there can be important mismatches between what clinicians and local health services provide and what some women would have wanted. There are also concerns about the way research is conducted and how women come to take part in it.[1] Both in treatment and research, women sometimes conclude that they and their interests meet with scant respect.[2] So research that picks up trends in patients' views and detects new issues as professional practices or patients' expectations change is a necessary complement to professional assumptions and aspirations.

Fortunately, there is an exemplary study, rich in findings and insight, of women's views about decision making in treatment and research and about their reasons for holding them. Alderson and her colleagues compared the views of healthy women who had undergone screening, women who had been treated for breast cancer, and health professionals over a range of contentious issues.[3] For treatment, most women in both categories of patient thought that all options should be discussed with them, including the treatments' long term implications, benefits, and risks. Most patients wanted detailed information about their cancer, most thought they should be told about uncertainties in breast cancer, and most wanted to share decision making with their doctors.

Questions about taking part in research brought out the ambiguities caused by dissonance between the "objective" world of science and the inner world of feeling. So dilemmas between accepting randomisation to a treatment arm of a randomised controlled trial and wanting "the treatment that is best for me" were explored. Women's feelings of altruism ("for the sake of our daughters") may be different from (mainly) male researchers' more abstract and population focused approach. But the health professionals in the sample, and the treated women, were more likely than the screened women to say they would refuse to take part in three recent or current trials named as examples. This suggests that greater knowledge led potential participants to see some trials as methodologically or ethically flawed, however well they understood the trials' rationales. Most women thought that controls in a trial should be told they were controls. Nearly half of the treated women wanted to make their own decision, not a decision shared with their doctors, about whether to take part in research.

In essence, both screened and treated women wanted to take part in treatment or research that would fit with their moral values, their work and social circumstances, and their responsibilities towards themselves and their families. Most of the women's views on issues like information, choice, and decision making accorded with the principles that health care consumerists, who identify patients' interests as patients see them, think should guide professional practice.[4] This is important, because some professionals believe that consumerists' views are entirely different from those of "real" patients. In any case, as evidence increases that involving patients in making decisions and choices improves outcomes,[5] consumerists' views seem less radical. But patients vary. So the challenge for the health service is to develop practices that most sensitively combine keeping pace with trends in patients' generally held views with responsiveness to their personal preferences.

To this end, treatment could sometimes be better organised. Diagnoses should be made and imparted as quickly as possible.[6] Then women should have a few days to consider where they wish to be treated and what the treatment options might be.[6 7] Access to good information is needed at this stage. After treatment, continuity of care and follow up should be improved, limiting the number of junior doctors and new nurses that the women meet and ensuring that the women can sometimes see their consultant.[6]

With better organisation, it should be easier to move away from the current reticence about breast cancer towards more openness with appropriate support. Lack of time and misconceptions about what patients most want to know hinder staff from being as helpful as they would wish.[8] But at least questions should be answered: being "fobbed off" or not answered increases patients' stress.[7] Babytalk, with phrases like "nasty cells," confuses and misleads.[6] Information necessary for informed consent should be to the standard of the prudent patient, not that of the reasonable professional.[9] Women should be offered information on their pathological state (such as lymph node status); on the short, medium, and long term benefits and risks of all proposed treatments; and on their implications for the quality and practicalities of life during treatment.[3 10] They should not have to discover that choosing one treatment rather than another has trapped them into unexpected consequences.[3] Nurse counsellors often give excellent practical advice and emotional support.[6 7] Some patients find complementary therapies helpful.[1-3]

To improve research from the patients' point of view, the highest ethical standards must always be in place. Research requires informed consent from all participants; and control subjects are participants even if they are receiving a usual treatment. Psychosocial and psycho-oncological research should learn from patients, not merely study them.[6] Some clinical research methodologies may need to be refined: large scale randomised controlled