

more closely. A study of awareness of the "reduce the risk" campaign in a socially deprived area in south Wales in 1994 showed that a third of 250 mothers with children born before the introduction of the campaign said that they checked their babies more often than they had done previously.⁵

For babies to endure increasingly long periods of solitude after birth is biologically unreasonable. In 1991 in Cardiff we included another factor to lower the risk of the syndrome: we encouraged mothers to have their babies in their room at night for the first six to nine months and to keep the cot in which the babies slept by day close by. To focus only on posture, heating, and smoking and not to consider where a baby sleeps could detract from other factors in the care giving environment that might be protective. Any intervention programme aiming to reduce the incidence of the sudden infant death syndrome must also consider the broad range of care practices that could reduce the risk.

D P DAVIES
Professor

Department of Child Health,
University of Wales College of Medicine,
Cardiff CF4 4XN

B M ANSARI
Professor
I E L EVANS
Registrar

Department of Child Health,
East Glamorgan Hospital,
Church Village,
Pontypridd CF38 1AB

- 1 Hiley CMH, Morley CJ. Risk factors for sudden infant death syndrome: further changes in 1992-3. *BMJ* 1996;312:1397-8. (1 June.)
- 2 Douglas AS, Aslan TM, Helms PJ. Seasonality and the sudden infant death syndrome during 1987-9 and 1992-3 in Australia and Britain. *BMJ* 1996;312:1381-4. (1 June.)
- 3 Davies DP. Ethnicity and SIDS: what have we learnt? *Early Hum Dev* 1994;38:215-20.
- 4 McKenna JJ. Evolution and sudden infant death syndrome (SIDS). Part II. Why human infants? *Human Nature* 1990;1:179-206.
- 5 Evans IE, Ansari BM, Davies DP. Awareness of risk-reducing measures relating to sudden infant death syndrome in Rhondda and Taff Ely. *Proceedings of the annual British Paediatric Association meeting 1995*. London: BPA, 1995.

Information about initiatives that use new technology to inform patients should be shared

EDITOR,—Chris Lock's review on the role of information technology in health care focuses on hospital information support systems and highlights the need for evidence in determining the value of information technology applications in health care.¹ The many potentially useful, though small scale, systems that are being designed for use directly by patients are often overlooked.

At a time when the public is demanding more information on health care² these interactive educational packages are increasingly being developed in hospitals and academia. Health-point is a public access system produced by Glasgow University, which provides patients with information related to health that is accessed with a touch screen.³ PharmAssist, a system being developed at Lewisham Hospital NHS Trust, informs patients about how to take their medicines.⁴ HealthWise has produced a series of computer games, which educate children on the dangers of alcohol, smoking, and drug misuse.

In his editorial linked with Lock's review Liam J Donaldson notes the difficulty in evaluating computer applications owing to their increasing diversity and the lack of formal evaluation criteria.⁵ Despite these difficulties, evaluations

that include assessments of content and acceptability to patients are feasible.

The King's Fund has set up an initiative, "promoting patient choice," which supports the development and evaluation of information packages to help patients choose between different treatment options. American interactive videos known as shared decision making programs that cover topics such as benign prostatic hyperplasia, hormone replacement therapy, and breast cancer are being evaluated in both primary and secondary care in Britain. The acceptability of a video on treatment for menorrhagia and the accompanying booklet (based on the systematic review conducted for an *Effective Health Care* bulletin) will soon be evaluated in a randomised controlled trial of 600 patients. Six other sites are developing and evaluating a variety of media, from audiocassettes to CD-ROMs, on topics such as control of postoperative pain and colorectal cancer. The King's Fund is also undertaking a review of the various roles that new electronic media can have in providing information about health and illness to patients and the general public.

The locally devolved nature of the NHS has led to a lack of sharing about such initiatives. We are trying to collate information about initiatives that use current and new media technologies to enable patients to become informed participants in decisions about their care and would be interested to hear about similar projects.

MARK DUMAN
Project officer, "promoting patient choice"
SIMON WALLACE
Senior registrar in public health medicine

King's Fund Development Centre,
London W1M 0AN

- 1 Lock C. What value do computers provide to NHS hospitals? *BMJ* 1996;312:1407-10. (1 June.)
- 2 Consumers' Association. The NHS: what's the verdict? *Which? Way to Health* 1995 Jun:80-3.
- 3 Jones RB, Navin LM, Murray, KJ. Use of a community-based touch-screen public-access health information system. *Health Bull* 1993;51:34-42.
- 4 Duman MB. New multimedia patient counselling system. *Br J Healthcare Computing and Information Management* 1995;12(8):30-2.
- 5 Donaldson LJ. From black bag to black box: will computers improve the NHS? *BMJ* 1996;312:1371-2. (1 June.)

Mortality in second generation Irish people living in England and Wales

Possibility of excess smoking should be investigated

EDITOR,—S Harding and R Balarajan's paper and John Haskey's accompanying editorial highlight the important issue of excess mortality among second generation Irish people living in England and Wales.^{1,2} Somewhat surprisingly, both articles devote little discussion to the source of the main causes of the excess deaths, which are lung cancer, all cancers, and respiratory disease. None of the figures for the remaining categories of cause specific mortality are significantly different from the national averages for England and Wales. Surely excess smoking among people of Irish origin, and not ethnicity, is a prime candidate as a cause of the excess deaths. Are these data not available in the 1% longitudinal sample from the Office for National Statistics?

J K CRUICKSHANK
Senior lecturer in clinical epidemiology

Clinical Epidemiology Unit,
University of Manchester Medical School,
Manchester M13 9PT

- 1 Harding S, Balarajan R. Patterns of mortality in second generation Irish living in England and Wales: longitudinal study. *BMJ* 1996;312:1389-92. (1 June.)
- 2 Haskey J. Mortality among second generation Irish in England and Wales. *BMJ* 1996;312:1373-4. (1 June.)

Effects of social deprivation in whole population should be addressed

EDITOR,—S Harding and R Balarajan's paper on mortality in second generation Irish people living in England and Wales concludes that special consideration should be given to the health needs of this population group.¹ We wish to challenge some of the statements made, because the data presented do not support the text.

The authors state that there is "a pattern of higher mortality from most major causes," presumably because of the values of the point estimates of the standardised mortality ratios. The confidence intervals for these ratios, however, cross from below to above 100 for most of the diseases shown, so that the true ratio could lie anywhere between these values and even indicate a decreased mortality. Though the crude standardised mortality ratios for men and women for all causes of death seem to indicate a higher mortality, the difference between the second generation Irish women and all women disappears after adjustment for social class.

The authors do not mention genetics. If, however, the genetics connected with Irishness were a cause of increased mortality then it could be suggested that those people with two Irish parents would be more at risk than those with one (a dose-response relation). In fact, there was no significant difference between these two groups.

Problems with the health of second generation Irish people are not comparable with those of population groups for whom language and culture may cause difficulties with access to health care or advice. We believe that it would be wrong to direct excessive time and effort specifically to this group but that concerted efforts should be made to address the health issues connected with social deprivation in the whole population.

H M P FIELDER
Senior registrar in public health medicine
J G AVERY
Consultant in public health medicine
D WRIGHT
Deputy director of public health

Iechyd Morgannwg Health,
Swansea SA1 1LT

- 1 Harding S, Balarajan R. Patterns of mortality in second generation Irish living in England and Wales: longitudinal study. *BMJ* 1996;312:1389-92. (1 June.)

Authors' reply

EDITOR,—J K Cruickshank raises the important issue of the likely contribution of smoking to the increased mortality from all cancers, and especially lung cancer. Mortality from respiratory disease was also raised in both men (non-significantly) and women. Unfortunately, we do not have data on smoking in the Office for National Statistics' longitudinal study.

We believe that, though testing for significance is central to the analysis, the observation of patterns that are consistent across sex, age, and time is equally important in epidemiological studies. Small numbers are often a major problem, even in studies such as the Office for National Statistics' longitudinal study, which has around 650 000 members in the cohort. With the period of follow up extended from 1971-89 to 1971-92, we are able to test the statement of H M P Fielder and colleagues that "the difference between the second generation Irish women and all women disappears after adjustment for social class." Table 1 shows that the increased mortality among women is significant at the 5% level after adjustment for social class.

We were careful not to speculate on the genetic component of "Irishness." This is because we believe that a gradient in mortality across having

Table 1—All cause mortality ratios* (95% confidence intervals) adjusted for socioeconomic status among second generation Irish people in England and Wales at working ages† during extended period of follow up (1971-92)

	Women		Men	
	Standardised mortality ratio	No of deaths	Standardised mortality ratio	No of deaths
Mortality adjusted for:				
Age	126 (103 to 152)‡	104	124 (110 to 140)‡	267
Age and social class I-IV§	134 (103 to 170)‡	67	129 (111 to 149)‡	184
Age, housing tenure, and access to car	126 (102 to 152)‡	102	122 (107 to 138)‡	247

*Relative to all men or all women (standardised mortality ratio = 100).
 †Ages 15-64 for men, 15-59 for women.
 ‡Standardised mortality ratio significantly different from 100 at 5% level.
 §First five years of follow up were excluded to allow for health selection.²

one or both parents born in the Republic of Ireland represents not only a possible genetic contribution but, importantly, the effect of lifestyle and cultural factors ("ethnic features") that could persist across generations. We consider variation in lifestyle factors to be an integral part of ethnic analysis and likely to be a major contributor in this case.

While we agree with Fielder and colleagues that health problems of second generation Irish people are not comparable with those of population groups for whom language and culture may cause difficulties in access to health care, this does not rule out the fact that Irish people may have problems different from those of the majority population. This would apply not only to second generation but also to first generation Irish people.¹ How can it be wrong to direct time and effort to this group when an opportunity to achieve considerable health gains exists?

We disagree with Fielder and colleagues that if concerted efforts were made to address health problems connected with socioeconomic deprivation in the whole population then the issue of the health of Irish people would be addressed. Though socioeconomic status is important, it cannot explain the excess mortality shown in table 1.

S HARDING
 Senior research analyst

Longitudinal Study,
 Office for National Statistics,
 London WC2B 6JP

R BALARAJAN
 Professor

Institute of Public Health,
 University of Surrey,
 Guildford GU2 5YL

- 1 Adelstein AM, Marmot MG, Dean G, Bradshaw JS. Comparison of mortality of Irish immigrants in England and Wales with that of Irish and British nationals. *Ir Med J* 1986;79:185-9.
- 2 Fox J, Goldblatt P, Jones D. Social class mortality differentials: artefact, selection or life circumstances? In: Goldblatt P, ed. *1971-81 Longitudinal study. Mortality and social organisation*. London: HMSO, 1990.

Going home after a heart attack

Patients should visit their general practitioner, not vice versa

EDITOR,—Doubtless H J N Bethell is correct in stating that there is much that can be done in primary care for patients recently discharged after having a myocardial infarction.¹ Nevertheless, in the context of current efforts to delegate some of the average general practitioner's ever increasing workload and to encourage patients to attend the surgery rather than expect a visit, Bethell's assertion that general practitioners should visit these patients soon after discharge is disappointing.

There is no reason why a suitably trained nurse practitioner could not undertake all the

tasks that Bethell outlines. Nor is there any reason why, in most cases, the patient could not attend the general practitioner's surgery. Ironically, expecting the general practitioner to visit runs counter to the rehabilitation process. Surely a patient who is fit enough for sex within a week or two of arriving home ("unless it is with an unfamiliar partner"¹) is fit enough to consult at the surgery (unless, perhaps, it is with an unfamiliar doctor).

KEITH HOPCROFT
 General practitioner

26 Froden Brook,
 Great Burstead,
 Billericay,
 Essex CM11 2TW

- 1 Bethell HJN. Going home. *BMJ* 1996;312:1372-3. (1 June.)

Depression is also a risk factor

EDITOR,—H J N Bethell's editorial on care after myocardial infarction omits to mention depression, particularly in the list of factors that increase risk.¹ This is surprising, as depression is known to be an "independent risk factor for mortality at six months. Its impact is at least equivalent to that of left ventricular dysfunction ... and history of previous myocardial infarction,"² its effects being at least partly mediated through further myocardial ischaemia.³

Depression after myocardial infarction is often chronic⁴ and associated with non-compliance with treatment and with refusal of rehabilitation programmes. It is diagnosed and treated much less frequently than would be the case if the patients were free of physical illness.⁵ This is probably because doctors perceive a lack of effective treatments. It is likely, however, that rehabilitation is effective, at least partly through an effect on psychological symptoms, and psychological treatments should be used if available. Few trials of antidepressant drugs have been carried out in these patients, but the risks of using such drugs have probably been exaggerated.⁵ High quality trials of these treatments are urgently needed.

DAVID GILL
 MRC/NHS research and development health services research fellow

University of Oxford,
 Institute of Health Sciences,
 Oxford OX3 7LF

- 1 Bethell HJN. Going home. *BMJ* 1996;312:1372-3. (1 June.)
- 2 Frasure Smith N, Lesperance F, Talajic M. Depression following MI: impact on 6 month survival. *JAMA* 1993;270:1819-25.
- 3 Jian W, Babyak M, Krantz DS, Waugh RA, Coleman RE, Hanson MM, et al. Mental stress-induced myocardial ischemia and cardiac events. *JAMA* 1996;275:1651-6.
- 4 Perez-Stable EJ, Miranda J, Munoz R, Ying Y. Depression in medical outpatients: underrecognition and misdiagnosis. *Arch Intern Med* 1990;150:1083-8.
- 5 Roose SP, Dalack GW. Treating the depressed patient with cardiovascular problems. *J Clin Psychiatry* 1992;53(suppl):25-31.

Women with urinary incontinence should be referred to a specialist

EDITOR,—Arnfinn Seim and colleagues give some useful reminders about improvements that can be achieved by treating urinary incontinence in women in general practice.¹ At the end of their study, however, 80% of the women were still incontinent to some extent. It is interesting that only 16% of the patients were referred for specialist opinion. In the long term it may be better for patients to be referred for expert diagnosis and treatment, to avoid some of the long term financial and social burdens of prolonged incontinence.² When the prospect is many years of incontinence (the youngest patient was only 20 years old)³ a referral to a specialist—who can perform urodynamic tests, make an accurate diagnosis, and devise a management plan—is preferable to making an unsupported diagnosis and providing treatment that may be inappropriate. Obtaining a good clinical history of bladder disorders is known to be difficult, so if treatment is to be based on the history alone then treatments that are effective in both common forms of incontinence (genuine stress incontinence and detrusor instability) are probably more appropriate—for example, pelvic floor exercises.³

The trial was undoubtedly performed by a team interested in this subject and method of treatment, and I suspect that the results would not be as good if the trial was repeated by a less enthusiastic set of practitioners. Although, as a hospital urogynaecologist, I would not like to see my urodynamic clinics overrun, I would like more than 20% of patients to become fully continent.

JONATHAN R A DUCKETT
 Specialist registrar

Department of Obstetrics and Gynaecology,
 Good Hope Hospital,
 Sutton Coldfield B75 7RR

- 1 Seim A, Sivertsen B, Eriksen BC, Hunnskaar S. Treatment of urinary incontinence in women in general practice: observational study. *BMJ* 1996;312:1459-62. (8 June.)
- 2 Lee PS, Reid DW, Saltmarche A, Linton L. Measuring the psychosocial impact of urinary incontinence: the York incontinence perceptions scale (YIPS). *J Am Geriatr Soc* 1995;43:1275-8.
- 3 Nygaard IE, Kreder KJ, Lepic MM, Fountain KA, Rhombert AT. Efficacy of pelvic floor muscle exercises in women with stress, urge, and mixed urinary incontinence. *Am J Obstet Gynecol* 1996;174:120-5.

Interventions in childbirth

Medical intervention is not synonymous with loss of dignity

EDITOR,—In her effort to empathise and share the experience of childbirth with her daughter in law, Ann Oakley (a professor of social science) offers a one sided view of care in labour.¹ I can assume only that her personal involvement has caused her to be unable to appraise the event with objectivity or professionalism.

Although, as a sociologist, Oakley has witnessed many labours, she repeatedly misinterprets the best of professional intentions. Obstetric practice may well have had—and probably still has—shortcomings. But in describing former practices that were attempts to minimise the incidence of puerperal sepsis as "dehumanising" Oakley does not sufficiently consider the reasons for the practices and implies intent to take away the dignity of the labouring mother. The idea of doctors "hovering with their forceps outside the door" having to be overcome by midwives brings images of bizarre behaviour to mind. Does Oakley really believe that obstetricians would choose to lose sleep rather than lose