Telling patients there is nothing wrong

Randomised controlled trials are needed

EDITOR,—It is still unclear from the literature whether investigative tests reassure patients with anxieties about the presence of serious disease.[1 2] Ray Fitzpatrick discusses some of the possible reasons for this, including psychiatric morbidity, poor communication, and the "wild card effects" mentioned in the study by I G McDonald and colleagues.[3]

Other psychological processes in patients are also likely to influence outcome: early childhood experiences of illness, particularly when associated with lack of parental care, are a powerful risk factor for adult somatisation, and the accuracy of patients' medical knowledge and other cognitive errors such as catastrophic thinking[4] are likely to influence the effectiveness of investigations to reassure.

The decision to investigate may also reflect a physician's obsessive fear of missing organic disease and an inability to cope with any diagnostic uncertainty, which will give patients mixed messages about their symptoms. Physicians may find it particularly difficult to communicate equivocal results to the patient because equivocal findings increase doctors' anxieties about diagnosis. Any reassurance that the patient derives from normal results of investigations may then be negated by the continued prescription of drug treatment: cardiac drugs have been prescribed for up to half of patients with normal coronary arteries despite there being no medical indication.[5]

Examination of the methodology used in the studies in this area can also explain the conflicting results in the literature. Few investigators have used objective measures of reassurance, such as patients' subsequent use of medical services or functional disability, or standardised measures of anxiety or health beliefs. The most rigorous way to test the hypothesis that a particular test does or does not reassure patients with no serious disease is a randomised controlled trial of that test. There have been few randomised controlled trials in this area even though, as Fitzpatrick points out, "reassuring patients who have unwarranted concerns that they are seriously ill is one of the commonest medical tasks."

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1 Fitzpatrick R. Telling patients there is nothing wrong. *BMJ* 1996;313:311-2. (10 August.)
2 Howard LM, Wessely S. Reappraising reassurance—the role of investigations. *J Psychosom Res* (in press).
3 McDonald IG, Daly J, Jelinek VM, Panetta F, Gutman JM. Opening Pandora's box: the unpredictability of reassurance by a normal test result. *BMJ* 1996;313:329-32. (10 August.)
4 Petrie K, Moss-Morris R, Weinman J. The impact of catastrophic beliefs on functioning in chronic fatigue syndrome. *J Psychosom Res* 1995;39:31-7.
5 Chambers J, Bass C. Chest pain with normal cardiac anatomy: a review of natural history and possible etiologic factors. *Prog Cardiovasc Dis* 1990;33:161-84.

What is said may not convey what is intended

EDITOR,—Ray Fitzpatrick's editorial on reassuring patients[1] and I G McDonald and colleagues' paper[2] remind me of an entertaining lecture given some 50 years ago by the very practical cardiologist Willie Evans. It was entitled "False reassurance" and stood me in good stead for the rest of my professional career.

Many of the points in the editorial and paper were made in that lecture, but the most impressive feature was an exhibition of extracts from consultants' letters to patients, such as "You are very well for your age"; "Your son's heart murmur is completely innocent and he can play football, but if he has any dental extractions he should be given penicillin"; and "I can find nothing wrong, but come and see me again in a year's time." The second half of each of these statements destroyed the intended effect unless it was fully explained at the patient's intellectual level.

In my experience, the most frequently used and most fatuous attempt at reassurance is the remark "Don't worry." A patient worries because he or she cannot cope adequately with distress. Telling a patient not to worry without providing a convincing explanation not only doesn't work but often increases the anxiety, because usually the patient continues to worry and therefore feels even more inadequate.

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1 Fitzpatrick R. Telling patients there is nothing wrong. *BMJ* 1996;313:311-2. (10 August.)
2 McDonald IG, Daly J, Jelinek VM, Panetta F, Gutman JM. Opening Pandora's box: the unpredictability of reassurance by a normal test result. *BMJ* 1996;313:329-32. (10 August.)

Queen should remove her crest from cigarette packets

EDITOR,—In his article on tobacco control Simon Chapman emphasises the importance of limiting advertisements for tobacco, particularly those advertisements that are attractive to young people.[1] I would like to draw attention to one form of advertising that has gone unchallenged. The Queen's crest adorns most cigarette packets sold in Britain. It is displayed on the front of packets and is in a prominent position compared with the position of the government health warning. Thus young people are given two messages: the Queen supports some brands of cigarettes while her government opposes smoking of all brands.

The decision to support certain brands of cigarettes is that of the Queen and her officials, although the Department of Health may offer advice. It seems that the queen has a choice of whether to discourage all smoking by removing her crest from cigarette packets or to feel impolite when cigarettes from packets that are not embossed with the royal coat of arms are offered to her guests. Maybe this is similar to my choice when a respected acquaintance offers me a cigarette: I have a choice between feeling impolite in refusing a gift and righteous in protecting my health.

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1 Chapman S. Tobacco control. *BMJ* 1966;313:97-100. (13 July.)

Many hospices provide care for any patient with advanced incurable disease

EDITOR,—Anne Mary Jayes rejects the idea that palliative care should be available only to people who are dying.[1] I agree with her. The principles of palliative care should be available to any patient with any illness, and palliation is often the only treatment available for common chronic diseases.

As in many other such units, Highland Hospice's criteria for acceptance extend to anybody with advanced incurable disease. Patients with malignancy are commonly admitted for control of their symptoms. We pursue an active treatment and rehabilitation policy and discharge over half of our inpatients. Thus even patients with terminal illness do not have to be dying, or even in a terminal phase, to merit admission.

We have been offering planned inpatient and outpatient respite care for patients with severe Parkinson's disease. We are restricted, however, in what we can routinely offer to patients with non-malignant conditions and indeterminate prognoses and have to approach this issue carefully. We could easily be overwhelmed by requests for respite or even long term care, which would seriously compromise our service. Most hospices could offer respite care to only a tiny proportion of patients with chronic non-malignant disease.

Care for carers is available in the community and offers some respite, but, without a considerable expansion of resources, hospices cannot realistically meet the need for inpatient care. We depend on other providers for this, particularly when long term care is required.

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1 Jayes AM. Open letter from a carer. *BMJ* 1996;313:370. (10 August.)

Cigarettes and drugs in Northern Ireland

Violent lawlessness is not mitigated by the unworthiness of victims

EDITOR,—Liam Farrell is grossly mistaken if he thinks that the beatings and generalised brutality to drug pushers in Northern Ireland are "a positive spin off of the paramilitary activity."[1] This type of activity is violent lawlessness of the worst kind and is not mitigated by the apparent unworthiness of the victims. Farrell says that some of his patients prefer his partner. I am not surprised; they are probably safer.

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1 Farrell L. Uncool, unsmooth, unhealthy. *BMJ* 1996;313:306. (3 August.)

Banning smoking would not stop people from buying cigarettes

EDITOR,—Liam Farrell writes that "if the government banned smoking tomorrow, lung cancer would largely disappear."[1] Rubbish. The government has banned lots of addictive drugs; evil men make fortunes dealing in them. The government banned driving at over 30 miles an hour in built up areas; every day, people are killed or injured by drivers exceeding the speed limit. If the government banned smoking tomorrow then Britain would be full of criminals dealing in illicit cigarettes and smokers paying over the odds for them.

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1 Farrell L. Uncool, unsmooth, unhealthy. *BMJ* 1996;313:306. (3 August.)