Advice on lifestyle dilutes important smoking message

EDITOR,—The debate about the benefits of changes in lifestyle in the prevention of coronary heart disease[1-3] seems to ignore a potentially important issue—that is, the extent to which patients' compliance with advice to stop smoking is influenced by the advice they receive about making other changes to their lifestyle. I knew a cardiologist who sometimes avoided discussing issues such as physical exercise and diet with smokers, not because these issues were unimportant but because he believed that to do so would reduce the chance that the smokers would heed his advice to stop smoking. Like others,[1-3] he recognised smoking to be by far the most important risk factor for ischaemic heart disease.

Advising smokers to change their lifestyle beyond stopping smoking may be counterproductive. Firstly, it dilutes the most important piece of advice with recommendations that may be of dubious value. Secondly, it may be perceived by the patient as evidence that stopping smoking by itself provides limited benefit; to stop smoking, patients may need to view the potential gain as total. Thirdly, it allows the patient to trade off failure of compliance in one area against compliance in another: smokers may be more likely to continue with their habit if they can appease feelings of guilt by making extra effort in other areas.

Given the overwhelming importance of smoking as a risk factor for coronary heart disease,[1-3] the crucial test of any preventive strategy is whether and to what extent it decreases the probability that patients will stop smoking. Compliance with drug treatment diminishes when additional drugs are prescribed,[4,5] why should compliance with advice about lifestyle changes be any different?

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Asking patients to write lists

Randomised controlled trials support it

EDITOR,—Despite increasing evidence supporting the relation between effective clinician-patient communication and improvement in patients' health, communication problems in clinical encounters are still extremely common.[1]

Strategies to improve communication between patients and clinicians can target history taking or the discussion of the management plan, or both. They can be simple and cheap or require expensive technology. John F Middleton found he could ask his own patients to write lists of their concerns and that it led to consultations which were perceived as more efficient.[2] Given that the study was non-randomised and unmasked and was conducted only on his own patients, he called for randomised studies with larger size, including more than one doctor, and designed to measure patient's and doctor's satisfaction, patients' compliance, and subsequent consultation rates.

A search of Medline (1966 to July 1995), CINAHL (1982 to June 1995), and HEALTH (1975 to July 1995) with the key words "lists," "physician-patient relationship," and "communication" identified two randomised studies that could answer some of the questions raised by Middleton. In one study mutual (clinician and patient) recognition of problems occurred more often when patients (seen by 13 clinicians) had written lists ($P \geq 0.05$); the duration of the encounter time or patient satisfaction did not increase significantly.[3] In the second study, women who listed at least three issues while at the waiting room asked more questions, reported less anxiety, had greater feelings of control, and were more satisfied with the visit and with the information received than patients who did not write a list.[4]

The real challenge for future research efforts is to show whether or not writing lists could affect symptoms and physiologic outcomes. During a great portion of this century, clinicians have regarded note writing by patients as an annoyance and as a sign of emotional disorders. It has been described as "la maladie du petit papier."[5] Empirical evidence to date indicates that, rather than being part of a disease, lists of problems written by patients and presented to the clinicians could be a simple, cheap, and effective intervention which could be part of the treatment to improve the quality of care.

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Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

Clinic audit supports it

EDITOR,—The value of patients completing forms to express their problems before being seen by a general practitioner, as detailed by John F Middleton,[1] is also of value in a hospital outpatient clinic.

Following the success of such a system in the breast diagnostic clinic held at the Parapet Clinic, King Edward VII Hospital, Windsor, I introduced two questionnaires at my oncology clinic at the same hospital in 1990. Patients were asked to complete them on arrival at the clinic. The first, for new patients, was for them to give details of their medical history and a list of drugs being taken; the second was for follow up visits and to obtain information on any problems occurring since the last visit. In particular, patients were asked to report any pain, including its severity and site; other symptoms, including changes in bowel or bladder habits; undue stress and any need for additional help or counselling; and their current treatment.

Being able to read the responses before seeing a patient proved most helpful. In particular, being alerted to possible problems influenced my approach to the patient and was also useful in determining whether, in a very busy clinic, the patient needed to be seen by the consultant.

Audit of the questionnaires carried out in 1994 showed that in only about 10% of the cases were problems that had not been mentioned on the forms established by subsequent interview. Patient cooperation was good; very few patients declined. Most thought that the forms were designed to save the doctor's time, but many also agreed that it was helpful to them to write down their problems before being seen.

As our aim was to improve communication between patient and physician the time element was not audited. Overall we considered that the forms were of value and that similar systems would be well worth considering in other outpatient clinics.

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Faxed electronic summaries are valued by general practitioners

EDITOR,—Jane Smith's synopsis of the Audit Commission's report *Setting the Records Straight: A Study of Hospital Medical Records* highlights several timely issues.[1,2] For example, clinical contracts are settled on the basis of information derived from coded data generated without appreciable input from clinicians. This may lead to incorrect estimates of activity, with resulting contracts providing a poor reflection of clinical need. One approach to solving this problem is that adopted at Central Middlesex Hospital, where clinicians do the coding themselves.[3] Another is to use the data collected by most hospital information systems (data on the general practitioner and demographic data on the patient together with diagnostic and procedural codes), validate the clinical activity codes at regular meetings with the

coding staff, and download these data to a standard word processing package that contains a free text module. The resulting discharge summary is then sent to the family doctor.

At St Mary's Hospital we adopted the latter approach last January. Audit of 228 summaries over two separate one month periods was performed. Summaries were sent by post, with most arriving at their destination within 12 days of the patient's discharge. Use of the postal system resulted in a median delay between dispatch and receipt of five days; fax machines are therefore now used. Comments by general practitioners were favourable ("clear and concise," "timely and comprehensive"), with support being expressed by both hospital clinicians and general practitioners for the adoption of Read coding instead of the sometimes tortuous ICD-10 (international classification of diseases, 10th revision) codes currently in use. We have already seen a considerable improvement in the accuracy of clinical coding; some clinicians were unaware of the potential for damage that incorrect coding carries. The system is also being piloted as a basis for clinical audit. Finally, the presence of a summary on the hospital information system allows access to recent clinical information in those cases in which timely retrieval of notes is difficult.

This method of producing summaries addresses many of the issues raised in the Audit Commission's report, and the summaries represent a nascent electronic patient record.

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Babies' deaths linked to suboptimal care

EDITOR,—Charles D A Wolfe makes several important points in his critique of the confidential inquiries into stillbirths and deaths in infancy, not least on the issue of interobserver variability between regional panels.[1] As chairs of the regional confidential inquiry panels in the former Northern region, we wish to defend the inquiry system as currently applied to "intrapartum deaths" fulfilling the criteria for 1994 (those babies dying in utero during labour or in the first 27 completed days of life, weighing 1500 g or more at birth, and with no severe or life threatening congenital abnormality).

We have had no difficulty in recruiting members to the panels, and all have agreed to sit on second and further panels. Several clinicians have made positive statements about the educational value of membership of the panels, and others have stated an aim to change practice in their units as a result of cases and issues discussed by the panels.

The standard applied in reaching overall grades of care in our region is that of current agreed acceptable practice as based on peer opinion and existing guidelines. We do not question the need for evidence based clinical practice, and surely one of the aims of the confidential inquiry must be to identify areas in which research is needed. In the interim, however, judgment of acceptable practice will to some extent be subjective.

In a recent, fully anonymised review of overall grades of substandard care as given by the regional panel compared with local panels, we found agreement in 18 of 36 cases for which a local panel had met. Among the 18 cases in which there was disagreement the regional panel identified the same factor(s) as the local panel in 10 cases but graded them one grade lower than the local panel in four and one grade higher than the local panel in six. In the remaining eight cases the factors that seemed crucial to the regional panel either had not been identified by the local panel (three) or had not been graded as indicating suboptimal care (five). We recognise, however, that discrepancies may reflect a lack of knowledge by the regional panel of important local factors (for example, staffing levels). Anonymised feedback on these apparently missed or misinterpreted factors will be provided in the form of a regional report on the findings of the inquiry panels.

Undoubtedly, scientific criticisms can be made of inquiry panels, but the panels seem to be fulfilling an important educational role in this region.

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Late diagnosis of HIV infection in children is common and devastating

EDITOR,—J A Evans and colleagues draw attention to the late diagnosis of HIV infection in infants not previously known to be at risk of the disease, but they only hint at the potential extent of this problem.[1] In 1993, as part of a review of services for children and families with HIV infection, we undertook in depth interviews with 10 families who had a child in the care of our paediatric HIV service.[2] This study suggested that the late diagnosis of HIV infection in children is not unusual. Of the 10 children, only three were identified as having the infection antenatally; two mothers had already been diagnosed as HIV positive, and one woman's husband had been diagnosed as HIV positive while she was pregnant. For the seven other families the child's diagnosis was the first indication of HIV infection in the family.

In Evans and colleagues' study the children had had symptoms for up to six weeks before diagnosis. In our study the time to diagnosis for the seven children diagnosed late ranged from several months (four cases) to over two years (three). The seven children had been seen by their general practitioners many times for a variety of complaints and had attended a total of nine hospitals; they had often been inpatients several times before an HIV test was suggested. The cost of this process to the families in terms of emotion, time, and money was considerable, and the final diagnosis of HIV infection, combined with the anxiety over the critically ill child, was profoundly stressful and devastating.

Evans and colleagues point out that a late diagnosis means that opportunities for reducing the risk of vertical transmission of HIV are lost and that the children are denied the benefit of prophylaxis. These children's infection is diagnosed only because they have become ill; they are therefore more likely to require inpatient facilities, intensive care, complex drug treatment, and more medical and nursing time. Also, around the time of diagnosis there are greater stresses on the clinical staff, who may be dealing with a sensitive and difficult family situation.

The late diagnosis of HIV infection in infants and children is an important problem, with costs to the child, family, and NHS. For this reason we support the argument advanced by Evans and colleagues that policies on antenatal screening for HIV should be reviewed in areas where the prevalence of HIV infection is high.

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Analgesic effect of sucrose

Heel pricks were unnecessarily painful

EDITOR,—Nora Haouari and colleagues have clearly shown that oral sucrose reduces crying and tachycardia in term infants undergoing a standard painful procedure, blood sampling by heel prick, with a manual lance.[1] The fact that the effect is dose dependent suggests that oral sucrose has analgesic properties. The key messages point out that every newborn baby in Britain is subjected to painful procedures and that little is done to minimise the discomfort which these cause.

One way to minimise the discomfort is by changing the method of heel blood sampling. Automated, springloaded lances (for example, Autolet Lite Clinisafe, Owen Mumford, Oxford) cause less pain without a reduction in efficacy, and they are less operator dependent.[2,3] The manual lance has no place on the postnatal ward or neonatal unit.

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Cuddle deprivation may have confounded experiment

EDITOR,—While it is laudable that Nora Haouari and colleagues are concerned to minimise the trauma associated with a common neonatal procedure, the starting point for their investigation seems somewhat misplaced.[1]

Firstly, they report that "parents could be present but did not speak or touch the baby during the procedure." Three minutes is a long time to leave a baby without such comfort. I am surprised that it was considered ethical. My experience of community midwifery is that babies can be very well soothed during painful procedures by being put to the breast or at least being held. It is best if the health worker performing the test is sitting beside the mother or parent so that the health worker is in the right position to gently control foot movements during the procedure.

Secondly, the WHO/Unicef Baby Friendly Initiative, now endorsed in Britain,[2,3] clearly states that newborns should not be given food or drink other than breast milk unless medically indicated. Research such as Haouari and colleagues' not only ignores the valuable contribution of breastfeeding towards an infant's physical and psychological