

Preventing teenagers from starting smoking <i>Lionel Jacobson, et al</i>	629	Acute myocardial infarction <i>Philip C Hannaford</i>	632	Membership of the RCGP by assessment <i>S J Tiley</i>	633
Homoeopathy and immunization <i>E Ernst and A R White</i>	629	Putting research into practice <i>Dougal Jeffries</i>	633	MRCGP examination 1996 <i>A C E Stacey</i>	633
Cancer patients' place of death <i>Craig Gannon; D A Seamark, et al</i>	630	Future of general practice: despair or hope? <i>V M Drury and R J P Godlee</i>	633		
Videotaped consultations <i>L M Campbell and T Stuart Murray; Tim Coleman</i>	631				

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Preventing teenagers from starting smoking

Sir,
Teenage health is of increasing interest.¹ The United Kingdom government has specified teenage health in its population targets, including an aim to reduce teenage smoking.^{2,3} Recent evidence suggests that existing measures to reduce smoking have been unsuccessful.⁴

A study has suggested that intensive discussion with teenagers in a primary care clinic about smoking could potentially reduce smoking.⁵ This contrasts with school lessons about smoking which achieved no overt benefit.⁶ Thus teenage smoking should be considered from the perspective of individuals as well as populations; the most appropriate place to receive individual advice is primary care.

Health education in the consultation may help to reduce the overall number of smokers, although research has shown that talking to adult smokers achieves only relatively small benefits.⁷ These data may be improved by using methods developed from the field of addictions research using the concept of readiness to change.^{8,9} This concept was adapted for a pilot study to test an intervention for assessing an individual's vulnerability to start smoking, or readiness to start.

The study was undertaken in one general practice in a deprived area of Cardiff in late 1994. Teenagers consulting L J during routine surgery (and their parents if present) were asked permission to discuss smoking and to help with the research; confidentiality was guaranteed. Thirty five teenagers aged 12 to 18 years were invited opportunistically and were asked to mark a cross on a visual analogue scale where one end of the scale indicated that the teenager was not thinking of starting smoking and where the other end indicated that the teenager was thinking of starting smoking or had friends trying to persuade the teenager to start smoking.

All 35 teenagers were willing to take part. Each discussion took less than five minutes. Eleven (31%) were current smokers and were unsuitable for the study; they were counselled regarding smoking. Of the remaining 24, 15 indicated

that they were not thinking of starting smoking and received support for this action. However, nine of the 35 teenagers (26%) were contemplating starting to smoke, four indicating on the scale and in discussion that they were actively thinking of starting soon; all accepted counselling based on their responses.

The 24 teenagers eligible to use the scale described the technique as acceptable, easy to understand and felt that it could be helpful in their decisions on smoking. In particular, the nine who were thinking of starting to smoke reported that they would think more about their decision over whether or not to start smoking although they recognized that they may still start to smoke in the future.

Further development is needed to assess the feasibility of this method for generalized use in primary care. Several issues are apparent, such as: how to advise in a patient-centred manner; how to use the strategy based on teenagers' relatively infrequent visits to the doctor; and how to match advice to teenagers' readiness-to-start responses. Nonetheless, this strategy may be helpful and could be used for smoking and potentially for other areas of health behaviour such as drug use and sexuality.

LIONEL JACOBSON
STEPHEN ROLLNICK
PAUL HACKETT

Department of General Practice
University of Wales College of Medicine
Llanedeyrn Health Centre
Cardiff CF3 7PN

References

1. Jacobson LD, Wilkinson CE. Review of teenage health: time for a new direction. *Br J Gen Pract* 1994; **44**: 420-424.
2. Department of Health. *The health of the nation: a strategy for health in England* (Cm 1986). London: HMSO, 1992.
3. Welsh Health Planning Forum. *Protocol for investment in health gain: healthy living*. Cardiff: Welsh Office, 1993.
4. Office of Population Censuses and Surveys. *Smoking among secondary schoolchildren in England in 1993*. London: HMSO, 1994.
5. Townsend J, Wilkes H, Haines A, Jarvis M. Adolescent smokers seen in general practice: health, lifestyle, physical measurements and response to anti-smoking advice. *BMJ* 1991; **303**: 447-450.

6. Nutbeam D, Macaskill P, Smith C, *et al*. Evaluation of two school smoking education programmes under normal classroom conditions. *BMJ* 1993; **306**: 102-107.
7. Russell M, Wilson C, Baker C, Taylor C. Effect of general practitioners' advice against smoking. *BMJ* 1979; **279**: 231-235.
8. Prochaska J, DiClemente C, Norcross J. In search of how people change; applications to addictive behaviours. *Am Psychol* 1992; **47**: 1102-1114.
9. Rollnick S, Kinnersley P, Stott N. Methods of helping patients with behaviour change. *BMJ* 1993; **307**: 188-190.

Homoeopathy and immunization

Sir,
Homoeopathic remedies are believed by doctors and patients to be almost totally safe. Is homoeopathic advice safe, for example on the subject of immunization? In order to answer this question, a questionnaire survey was undertaken in 1995 of all 45 homoeopaths listed in the Exeter 'yellow pages' business directory. A total of 23 replies (51%) were received, 10 from medically qualified and 13 from non-medically qualified homoeopaths.

The homoeopaths were asked to suggest which conditions they perceived as being most responsive to homoeopathy. The three most frequently cited conditions were allergies (suggested by 10 respondents), gynaecological problems (seven) and bowel problems (five). They were then asked to estimate the proportion of patients that were referred to them by orthodox doctors and the proportion that they referred to orthodox doctors. The mean estimated percentages were 11% and 8%, respectively. The 23 respondents estimated that they spent a mean of 73 minutes on the first consultation.

The homoeopaths were asked whether they used or recommended orthodox immunization for children and whether they only used and recommended homoeopathic immunization. Seven of the 10 homoeopaths who were medically qualified recommended orthodox immunization but none of the 13 non-medically qualified homoeopaths did. One non-medically qualified homoeopath only used and recommended homoeopathic immunization.

Homoeopaths have been reported as being against orthodox immunization¹ and advocating homoeopathic immunization² for which no evidence of effectiveness exists.³ As yet there has been no attempt in the United Kingdom to monitor homoeopaths' attitudes in this respect. The above findings imply that there may be a problem.

The British homoeopathic doctors' organization (the Faculty of Homoeopathy) has distanced itself from the polemic of other homoeopaths against orthodox immunization, and editorials in the *British Homoeopathic Journal* call the abandonment of mass immunization 'criminally irresponsible'³ and 'most unfortunate, in that it will be seen by most people as irresponsible and poorly based'.⁴ Homoeopathic remedies may be safe, but do all homoeopaths merit this attribute?

E ERNST
A R WHITE

Postgraduate Medical School and
Centre for Complementary Health Studies
University of Exeter
25 Victoria Park Road
Exeter EX2 4NT

References

1. Burgess M. Homoeopathy and vaccination [letter]. *Lancet* 1994; **344**: 1168.
2. Sulfaro F, Fasher B, Burgess MA. Homoeopathic vaccination, what does it mean? *Med J Aust* 1994; **161**: 305-307.
3. English P. The issue of immunisation [editorial]. *Br Homoeopathic J* 1992; **81**: 161-163.
4. Fisher P. Enough nonsense on immunisation [editorial]. *Br Homoeopathic J* 1990; **79**: 198-200.

Cancer patients' place of death

Sir,

I was interested to read the study by Seamark and colleagues (*July Journal*, p.359) examining general practitioners' and hospital doctors' views of the appropriate place of death for cancer patients. It raised many important issues that surround the management of patients with terminal cancer. Unfortunately, it failed to address the complexity of palliative care that can necessitate cancer deaths occurring in particular locations.

The appropriate place of death remains the subjective decision of the patient, possibly in light of medical advice and social circumstances. It is never an objective decision to be made by medical staff. Therefore this study of doctors' opinions has doubtful significance. The method

used in the study also has to be questioned. In asking doctors to self-appraise retrospectively their patient management, especially with regard to such an emotive issue, the study is open to marked bias, be it covert or overt. Such reporting is not sufficiently objective to lend itself to the statistical analysis used in the paper.

The studies quoted by Seamark and colleagues, showing that more than three quarters of cancer patients expressing a preference wished to die at home or in a hospice^{1,2} and that over half die in hospital,³ could mislead as they confer too simplistic a view. A more recent prospective study of the preferred place of death of cancer patients referred to home care shows that as patients deteriorate in their final months, many change their minds and no longer want to die at home (from around 75% of patients to about 50% in the last week before death).⁴ This shows that there may not even be a perceived problem of inappropriately placed cancer deaths, as only a small percentage of cancer patients did not die in the preferred location they expressed in their last week.

Equally the hospital admission of patients who subsequently die away from home, even though appearing to be against their expressed wishes, should not necessarily be seen as inappropriate. This decision would have had to be made without the firm knowledge that death would be the outcome and has to reflect many changing factors, with each patient's individual needs having to be assessed at that particular time. For example: the patient's wish for continuing treatment or investigation despite his or her poor condition; the need to obtain satisfactory symptom relief via interventional methods, such as tapping ascites; the lack or inability of social support to cope at home; the lack of community care resources to manage patients at home; insufficient domiciliary palliative medicine input; limited availability of beds at hospices or community hospitals; and the need to exclude or treat possible reversible pathology.

Even in the hospice setting, predicting death can prove surprisingly difficult and therefore such predictions should not be expected of doctors to ensure an appropriate place of death for their patients. Similarly, once a patient has been admitted to hospital for appropriate reasons, it may not be appropriate to pursue discharge home or transfer to a hospice, even though death may have become imminent, again for the reasons given above, or perhaps if the patient has become too ill to move. Fortunately, hospital-based palliative care services are now rapidly expanding to provide excellent symptom control, with certain additional practical benefits

that hospitals can offer (the flexibility of a large number of beds; access to other specialist opinions and diagnostic services; 24-hour nursing and medical cover by staff to whom the patient may already be known; appropriate medical notes on site; and it may be nearer for visitors than hospice facilities).

Palliative medicine is patient centred and, as such, conforms poorly to generalizations. It is essential to remember that patients, their diseases and their circumstances are different and patients are entitled to individual attention. There is no fixed ideal or an appropriate place of death for any cancer patient; rather the aim should be a holistic approach considering all the patient factors at any given time, including whether death may be imminent, in order to take the appropriate action.

CRAIG GANNON

Myton Hamlet Hospice
Myton Lane
Myton Road
Warwick CV34 6PX

References

1. Dunlop RJ, Davies RJ, Hockley JM. Preferred versus actual place of death: a hospital palliative care support team experience. *Palliat Med* 1989; **3**: 197-201.
2. Townsend J, Frank AO, Ferment D, et al. Terminal cancer care and patients' preference for place of death: a prospective study. *BMJ* 1990; **301**: 415-417.
3. Hospice information service. *Where people die and hospice provision 1974-1991. Fact sheet 7*. London: St Christophers Hospice, 1992.
4. Hinton J. Which patients with terminal cancer are admitted from home care? *Palliat Med* 1994; **8**: 197-210.

Sir,

Dr Gannon's letter raises points regarding our research paper (*July Journal*, p.359) that require a response. It may well be that doctors' opinions on the appropriate place of death of their cancer patients can never be objective, but the reality is that doctors have an important influence on the final place of death of their patients. Our paper analysing the place of death of cancer patients whose general practitioners had access to community hospital beds showed that fewer patients died at home or in a district general hospital compared with patients whose general practitioners did not have access to community hospital beds.¹

It is generally acknowledged that obtaining cancer patients' views on their care is a difficult task and that their expressed preferences may change with time. However, there is evidence that proxy opinions carry some credence and that the view of the medical carer, rather than that