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?

DAVID CUMMINS
Consultant haematologist

Harefield Hospital,
Harefield,
Middlesex UB9 6JH

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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.

ALEJANDRO R JADAD
Postdoctoral fellow

Department of Clinical Epidemiology and Biostatistics,
McMaster University,
Hamilton, Ontario,
Canada L8N 3Z5

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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.

HANNAH LAMBERT
Honorary consultant clinical oncologist

Hammersmith Hospital,
London W12 0HI

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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