

Empowerment of patients—fact or fiction?

EDITOR—Empowerment of patients is a key element of the *NHS Plan*.¹ However, the current obsession with performance indicators may pressurise managers to interfere with clinical services with little regard to the opinions of patients.

Our unit has a busy orthopaedic outpatient clinic that deals with complex hip problems, many of which are tertiary referrals with patients travelling a considerable distance for their consultations. New patients are routinely given 20 minutes, but some consultations take much longer so that the clinic often runs behind schedule.

Hospital managers asked us to reorganise the clinic to minimise waiting room times and maximise patient throughput. Each patient's consultation was to be strictly limited to the allocated time to improve the "performance" of the clinic. We thought it crucial to survey our patients before the clinic was reorganised. Accordingly, 172 patients were asked which statement represented their views—(a) I prefer a clinic that allows me the possibility of a longer consultation, even if this means I may have to wait longer in the waiting room, or (b) I prefer a clinic that runs to time, even if this means my consultation is strictly limited to the allocated time.

Sixty eight per cent of patients preferred the present system (option a), whereas 28% preferred the alternative suggestion (option b) and 4% did not know. During the survey only 38% of patients were seen within 30 minutes of their appointment time; the average wait was 55 minutes.

Our survey shows that the desire to influence performance indicators could result in changes that are unpopular with patients. Being slaves to crude measures of performance, such as waiting times, risks a negative effect on what is not measured, such as the quality of the consultation. We as doctors must defend attempts to erode aspects of clinical services that are important to patients but do not feature on hospital league tables. Empowerment of patients,

while laudable in principle, seems to be nothing more than politician's hot air when hospital performance stars are at stake.

Ben Squires orthopaedic specialist registrar
bensquires@tiscali.co.uk

Ian Learmonth professor of orthopaedic surgery
University Department of Orthopaedic Surgery,
Bristol Royal Infirmary, Bristol BS2 8HW

1 Secretary of State for Health. *The NHS plan. A plan for investment, a plan for reform*. London: Stationery Office, 2000.

Men and older people are less likely to use NHS Direct

EDITOR—Last year George discussed the underuse of NHS Direct by certain groups in society.¹ Other investigators have also identified variations in the use and awareness of the service.^{2,3} We examined this issue by conducting a survey of people in general practice waiting rooms at two surgeries in Southwark, London. We surveyed 207 people aged 13-90 (a response rate of 79.6%).

A significantly greater proportion of women than men had heard of NHS Direct ($P=0.04$). Among those aware of the service, we found no sex based difference in use. Use of the service declined significantly with age ($P=0.014$). Among those aware of the service, however, older people were still less likely to use it ($P=0.0021$). We found no differences in this study when making comparisons with respect to social class or ethnic group.

We asked participants who had heard of NHS Direct but had never used it their reasons for never having done so. The most commonly cited reason was that the respondent had never needed to. Among those older than 50, however, it was that the respondent would rather see their general practitioner.

These findings indicate that among people attending general practice, sex and age are determining factors in the awareness and use of NHS Direct. The finding of an equivalent level of use among men and women aware of it implies that simply increasing awareness will increase the use of the service among men particularly. With regard to age related differences however, the relative underuse by older people remains even among those aware of NHS Direct. Our results indicate that in older

people a significant barrier to the use of the service exists, aside from a lack of awareness, and that this barrier may be a preference for seeing their general practitioner.

Waqas Ullah medical student
waqas.ullah@kcl.ac.uk

Andrew Theivendra medical student
Vaneeta Sood medical student
Aswinkumar Vasireddy medical student
Alan Maryon-Davis senior lecturer in public health sciences
Guy's, King's, and St Thomas's School of Medicine,
London SE1 3QD

1 George S. NHS Direct audited. *BMJ* 2002;324:560-59.

2 McInerney J, Chillala S, Read C, Evans A. Target communities show poor awareness of NHS Direct. *BMJ* 2000;321:1077.

3 The Comptroller and Auditor General. *NHS Direct in England*. London: Stationery Office, 2002.

Breast self examination

Breast self examination provides entry strategy

EDITOR—Given what is now known about the long subclinical growth phase of human breast cancers, the finding of a recent study from Shanghai, that teaching breast self examination did not detectably improve survival, is not surprising.¹ None the less, Austoker's related editorial, proclaiming the death of breast self examination, should not go unchallenged.²

Many studies have reported a reduction in primary tumour size dependent on breast self examination, which may in turn enable more conservative surgery.³ The editorial's implication that all such end points are rendered illusory by the Shanghai study is overstated; as if to acknowledge this, Austoker concedes that prompt symptomatic presentation ("breast awareness") remains important. But is the timely presentation of breast symptoms—of which palpation of a lump is the commonest—so different from what most people understand by breast self examination?

False positive and false negative "costs" are attached to breast self examination and to any preventive diagnostic interventions. However, an individual who is informed of both the negative randomised data and of the inverse association of tumour stage with survival might still reasonably opt for the potential costs of a biopsy dependent on breast self examination, rather than for the implied comfort of ignorance or uncertainty.

In Asia, where high rates of late presentation persist owing to cultural and economic factors,⁴ there seems little reason to

bmj.com

Letters appearing here are an edited selection of rapid responses originally posted on bmj.com

We ask for all letters to the editor to be submitted as rapid responses via bmj.com

For advice see: bmj.com/rapidresponses

be cheered by the debunking of breast self examination. As one facet of an expanding spectrum of patient empowering initiatives, breast self examination at least provides an entry strategy towards the gradual improvement of cancer awareness and outcomes.

Kline has proposed that the rhetoric of breast self examination should be modified so that healthcare consumers are accurately informed and thus empowered, rather than misled or inadvertently coerced.⁵ Surely this is the insight that public health in the 21st century should be striving to attain.

Richard J Epstein *professor*
Division of Haematology and Oncology,
Department of Medicine, University of Hong Kong,
Queen Mary Hospital, Pokfulam Road, Hong Kong
Special Administrative Region, China
rpestein@hku.hk

- 1 Thomas DB, Gao DL, Ray RM, Wang WW, Allison CJ, Chen FL, et al. Randomized trial of breast self-examination in Shanghai: final results. *J Natl Cancer Inst* 2002;94:1445-57.
- 2 Austoker J. Breast self examination. *BMJ* 2003;326:1-2. (4 January)
- 3 Koibuchi Y, Iino Y, Takei H, Maemura M, Horiguchi J, Yokoe T, et al. The effect of mass screening by physical examination combined with regular breast self examination on clinical stage and course of Japanese women with breast cancer. *Oncol Rep* 1998;5:151-5.
- 4 Alagaratnam T. The presentation of breast cancer in an oriental community. *Aust N Z J Surg* 1995;65:634-6.
- 5 Kline KN. Reading and reforming breast self-examination discourse: claiming missed opportunities for empowerment. *J Health Commun* 1999;4:119-41.

Editorial misses central point

EDITOR—Instead of clarifying the “confusion of the past decade,” Austoker fuels a debate that misses the central point.¹ No single screening procedure is foolproof. Self examination can miss tumours, as can other methods. The issue is not whether breast self examination alone can save lives, but how many lives it can save in conjunction with other screening procedures. Women need to know that screening is multifaceted—that if they are concerned they should not rely on simply one test. Only then can they be assured of detecting breast cancer earlier or eliminating the possibility of having the disease.

Furthermore, Austoker’s cited Thomas et al study was a trial of the teaching of breast self examination, not the practice of it.² The possible impact of cultural values in the adherence to breast self examination and hence on results is overlooked.^{3,4} Instead, Austoker posits that since there is no single agreed method, or it engenders anxiety, breast self examination fails to be effective. Breast cancer survivors can assure women that a positive diagnosis is far more distressing than the trepidation experienced through self examination.

The message is clear. Breast cancer can, and does, induce anxiety in women. However, to discount breast self examination as a detection tool because it results in more biopsies or creates temporary stress, or because guidelines are inconsistent, is unconscionable. Women have been “taught” that early detection of smaller tumours is their best chance for survival. For many women in the trial reported by Thomas et al, breast self examination resulted in the iden-

tification of smaller tumours; more in situ cases and 81.9% of tumours were discovered directly through self examination.² These figures alone speak volumes about the efficacy and effectiveness of breast self examination as part of an overall, multi-pronged approach to detecting breast cancer.

Rosetta Manasciewicz *steering committee member*
Breast Cancer Action Group, PO Box 381, Fairfield,
Victoria 3078, Australia
rmanasz@optushome.com.au

- 1 Austoker J. Breast self examination. *BMJ* 2003;326:1-2. (4 January)
- 2 Thomas DB, Gao DL, Ray RM, Wang WW. Randomized trial of breast self-examination in Shanghai: final results. *J Natl Cancer Inst* 2002;94:1445-57.
- 3 Tang TS, Solomon LJ, McCracken LM. Cultural barriers to mammography, clinical breast exam, and breast self exam among Chinese-American women 60 and older. *Prev Med* 2000;31:575-83.
- 4 Sadler GM, Wang K, Wang M, Ko M. Chinese women: behaviors and attitudes toward breast cancer education and screening. *Women's Health Issues* 2000;10:20-6.

Readability of British and American medical prose

Why are unreadable articles still being written?

EDITOR—The article by Weeks and Wallace is yet another of many articles over the past 20 years showing that medical information (such as journal articles, informed consent forms) is written in an “unreadable” writing style.¹ Although such articles are interesting, no more research on the topic is needed as any future studies will come to the same conclusion.

The issue that should be studied is why, after so many years of so much readability research, so many articles are still so badly written. Readability findings seem to have no impact on physicians-researchers-writers.

Why are journal articles written at a “very difficult” level on the Flesch reading ease score? Why can’t authors write at a more understandable level? How are researchers trained to write—how many and what kind of writing courses did they take in college? Are researchers writing articles that are hard to read because such articles have always been written that way, or because they just don’t know how to write any other way?

Mark Hochhauser *readability consultant*
3344 Scott Avenue North, Golden Valley, MN
55422, USA
MarkH38514@aol.com

Competing interests: None declared.

- 1 Weeks WB, Wallace AE. Readability of British and American medical prose at the start of the 21st century. *BMJ* 2002;325:1451-2. (21 December.)

Transatlantic writing differences are probably exaggerated

EDITOR—Weeks and Wallace have come up with an excellent idea, which is to compare texts in *BMJ* and *JAMA* by using two

“readability” scores.¹ Unfortunately, the differences between the two journals, while statistically significant, are disappointingly slight when you look at what the tests actually measure.

The FOG score, for example, creates an index by counting long words and long sentences. When we looked at practice leaflets they ranged from 8.4 (the style of a tabloid newspaper) to 17.2.² In the study by Weeks and Wallace, the respective scores are 16.9 and 17.8, a difference of about one point, which can be explained by an extra three words of three syllables per 100 words. This does not seem to be sufficient to warrant a conclusion that one is more readable than the other.

However, this should not detract from the main finding, which is that the prose in both journals is very dense, and we should do something about making it more accessible. In my experience, the problem is that most people who write and edit journals still believe that this is the “proper” way to write.

Tim Albert *principal*
Tim Albert Training, Dorking, Surrey RH14 1QT
tatrain@compuserve.com

Competing interests: TA runs courses in effective writing.

- 1 Weeks WB, Wallace AE. Readability of British and American medical prose at the start of the 21st century. *BMJ* 2002;325:1451-2. (21 December.)
- 2 Albert T, Chadwick S. How readable are practice leaflets? *BMJ* 1992;305:1266-8.

Misclassification, long words, and errors may obscure real differences

EDITOR—I have three comments on the paper by Weeks and Wallace.¹

Firstly, an error seems to have crept in as the FOG scores shown in the figure are about half the values of those described in the text. I assume that the text is correct and the figure is wrong, given the authors’ conclusions about the poor readability of the articles, but it would be nice if this could be confirmed.

Secondly, I have my doubts about the relevance of the Flesch and FOG scores for grading articles in medical journals. Both scores are influenced by long words, but in medical articles, long words are probably inevitable and do not necessarily make an article hard to read if their meaning is clear. Consider, for example, the challenge of writing a paper about the link between hypercholesterolaemia and atherosclerosis without using any words of more than two syllables. It could undoubtedly be done and would probably end up with a better readability score, but would not necessarily be any more readable than one that used the long words.

Finally, I suspect that they may have underestimated the difference between British and American authors as a result of misclassification of authorship. The analysis by

