have no relevance in the ordinary world of medical practice.

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SIR,—May I strongly support the views put forward by Dr Anthony Hopkins (9 June, p 1733). For some years now I have been emphasising the importance of the well trained general physician with a special interest,¹⁻³ and there are compelling practical reasons why neurology should be included as a special interest.

Most acute neurological problems are seen and managed initially by non-neurological consultants. In the South East Thames region 61% of referrals for admission to the regional neurosciences centre originate from general physicians, general surgeons, paediatricians, and geriatricians, and only 5% from consultant neurologists.⁴

A strong case can be made for referral of outpatients to neurologists to be secondary rather than primary, initial screening being done by general physicians (with an interest). Such a procedure would free the neurologist from many of the trivial problems currently responsible for crowded outpatient clinics and long waiting lists. The question of over-specialisation was eloquently analysed by Professor Brian Jennett: he mentioned in particular the problems facing neurology saying, "Everyone would benefit from the interposition of a well trained general physician between the family doctor and the neurologist."⁴ I am well aware of the opinion of the neurology committee of the Royal College of Physicians but would hope that this committee and the Association of British Neurologists would take note of the views of their consultant colleagues. I am equally conscious of the reliance we place on the expertise of our neurologists, but the development of a general physician with an interest in neurology would raise the standard of clinical practice in the district general hospital. Furthermore, it would relieve the burden on many overworked neurologists and would do nothing to minimise the high regard in which they are held by their more generalist colleagues.

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¹ King RC. The general physician. *World Medicine* 1979;14:111.

² King RC. General physicians. *World Medicine* 1980;15:62.

³ King RC. Cardiac tamponade. *Br Med J* 1980;280:865.

⁴ Jennett B. *Lancet* 1979;i:594.

SIR,—Dr Anthony Hopkins's study on different types of neurologist is of much wider importance than its title implies (9 June, p 1733). Similar arguments could doubtless be obtained from within and without every specialty. While no one can deny that specialisation has contributed enormously to advances in medical knowledge, it has led to the development of two opposite trends—"not my pigeonitis" on the one hand and "keep off the grassitis" on the other.

The former is characterised by advising other doctors that the patient's problem does not fall within his or her responsibility without any constructive suggestion to help either the patient or the referring doctor, and the latter by taking umbrage if other doctors locally assume responsibility for treating

conditions for which they regard themselves as having proprietorial rights.

It is clearly impossible, as Dr Hopkins indicates, to provide complete specialist cover throughout the entire country—so some patients must be treated by non-specialist consultants and some specialists must treat some patients outside their own specialty. In other words all specialists, in my view, should make an attempt to keep up with matters just beyond their specialty, and non-specialists should try and keep up with advances in the specialties.

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Letters from hospitals to general practitioners

SIR,—We have recently undertaken a similar survey to that of Mr William Bado and Dr Christopher J Williams (16 June, p 1813) on the usefulness of letters from hospitals to general practitioners. Ours was on patients with myocardial infarction. We asked 56 general practitioners in the Dales of Yorkshire "What information in discharge summaries do you find of value in the future management of patients who have a myocardial infarction?"

Like Mr Bado and Dr Williams we have backed up a questionnaire survey with evaluative studies of over 100 patients, documenting the management of each patient from the time at which he or she first presented with acute chest pain. Like Mr Bado and Dr Williams's study, our data indicate that technical topics are of interest in the discharge summary and that the general practitioner's interest and needs are relatively well catered for. Moreover, our data confirm the findings that "social topics" are perceived as valuable by general practitioners yet are relatively poorly catered for in discharge summaries.

Our data differ, however, in one interesting respect. In attempting to be more precise about "social topics" we listed three different categories, and we found that only 18% of general practitioners wanted information on social background and problems but that 93% wanted to know the information given to the patients and that 89% wanted to know the arrangements for follow up.

Our studies clearly indicate that (whatever else a hospital discharge summary should contain) it should inform the general practitioner what the patient has been told and what the hospital intends to do.

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SIR,—The article by Mr William Bado and Dr Christopher J Williams (16 June, p 1813) is a timely reminder to hospitals to look at the information they give to general practitioners. I recently carried out a survey among GPs in our area, in which I tried to answer two questions: (a) is it important for the GP to have a choice of the contents of a summary letter written immediately after the patient's discharge from our unit (a general surgical

unit)? (b) if so, what information does he consider essential?

Diagnoses were classified into five groups depending on the complexity of the clinical problem and on whether previous letters to the GP had given details of preliminary management. Five standard summaries were also provided: the first brief, and each of the others with more information so that the fifth contained full details. Each GP was asked to indicate the summary preferred for each diagnosis.

Questionnaires were sent to 105 GPs, and 82 (78%) replied. Of these 76 (92%) said it was helpful for them to have a choice of discharge letter. The choices varied widely, but in almost all cases GPs selected those summaries which contained details of information given to the patients and their relatives and plans for the patients' further management.

The findings support those of Mr Bado and Dr Williams—namely, that GPs considered social information given to patients and their relatives as important. More interesting, however, was the finding that the type of summary preferred for a given clinical problem varied between GPs, and this should be borne in mind by hospital doctors when they write summary letters. Long letters which merely relate information already in the case notes in a neater format help the hospital doctor during the patient's subsequent visits but were not considered by many GPs to be helpful. The classification of diagnoses and summaries has enabled us to encode each GP's choice of discharge letter in a computer program which generates "personalised" summaries. If a computer is not used several standard printed forms can be produced and the appropriate information put into one that has been chosen by the GP.

I thank all the GPs who took part in this survey.

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Radiotherapy in small cell cancer of the lung

SIR,—The failure to detect a statistically significant difference between their two groups of patients does not necessarily mean that "this dose of radiotherapy 40 Gy (4000 rad) ... does not improve survival in patients with ... small cell cancer of the lung treated with chemotherapy who have stable or responding disease" as Dr R L Souhami and others claim (2 June, p 1643). To have found no improvement is quite a different matter from showing that one does not exist. Indeed, all that such studies can hope to show is the likelihood (conventionally taken as 95%) of the difference between two treatments being within certain limits. If, as in this study, these limits are not quoted readers cannot assess the possibility that a clinically-important difference has failed to be detected. Haybittle has elaborated this point.¹

As the authors rightly point out, their study is the largest of its kind yet reported, but the confusing way in which the results are presented tends to obscure the fact that the number of patients who might reasonably be hoped to benefit from irradiation is still small. The abstract informs us that of 371 patients altogether only 279 patients continued with the treatment allocated by randomisation. The

untreated patients have not been excluded from the groups analysed in fig 4 (survival of patients with limited disease not responding to chemotherapy) or in fig 6 (non-responding patients with extensive disease.) These two groups therefore each contain patients in both arms who did not receive radiotherapy, and so clearly cannot possibly provide any useful data on the actual value of irradiation.

Incidentally, it also follows that the titles of these two figures are incorrect—they should point out that the arms differ not by virtue of having received radiotherapy or not but by intention or not of giving radiotherapy to patients whose disease did not progress. Analysis by "intended treatment" is not helpful in assessing the value of a form of treatment when many patients (in this case the non-responders) are considered a priori unlikely to benefit from it.

What then of the 158 patients who did respond to chemotherapy? In order to assess the value of thoracic irradiation in conjunction with chemotherapy in such patients surely what is of interest is whether the addition of radiotherapy increases the number of long term survivors, rather than whether it has an impact on median survival (although it is interesting that for patients with both limited and extensive disease the irradiated patients have the longer median survival times: no statistical analysis is given of these observations).

Quite what time interval one should choose for assessing long term survival is open to discussion, but the two years taken as an example above serves as a useful "bench mark." At this point, taking all responding patients, it appears that there are only 13 survivors. If only patients with limited disease are considered (the group most likely to obtain an advantage from irradiation), there seem to be only seven survivors from 65. The 95% confidence limits of survival rates for such small numbers must be very wide; without more detail than is provided in the paper they cannot be accurately estimated, but it seems unlikely that even a substantial benefit for one treatment would have been detected.

This paper certainly lends no support to the hypothesis that thoracic irradiation might confer a benefit for patients with small cell lung cancer treated by chemotherapy, but nor does it seriously refute it.

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¹ Haybittle JL. The reporting of non-significant results in clinical trials. In: Scheuren HR, Seckessen G, Armbruster I, eds. *Clinical trials in early breast cancer*. Heidelberg: Springer-Verlag, 1979:28-38.

* * Dr Souhami and others reply below.—ED, BMJ.

SIR,—Because only a small proportion of patients survived two years the confidence intervals are very large, and it is true that the conclusion can only be that no survival advantage has been shown in favour of thoracic radiotherapy. If we follow Dr Morgan's assumption (with which we agree) that the benefit of radiotherapy is likely to be restricted to patients with limited disease responding to chemotherapy, then if a 15% improvement in survival (over the present 10%) at two years is to be observed with 95% power we should need to enter 1100 such patients into the study. A difference of 15% may itself be

overoptimistic considering the limitations of current staging methods in defining limited disease. So many patients would be hard to muster, and Dr Morgan's criticisms will apply to all smaller studies (whether positive or negative in result).

We can say that our study accords with other smaller studies in failing to show a beneficial effect of radiotherapy. Furthermore, the dose of radiotherapy in our study (40 Gy (4000 rad) in 20 fractions) did not prevent local relapse, which implies that the negative result is not a chance effect.

We preferred to randomise patients to a policy of giving radiotherapy and to analyse all patients whether responding or not. Dr Morgan appears to advocate randomising after 12 weeks when the response to chemotherapy has been obtained and then analyse the data from these groups. This is a matter of trial design, and there are advantages and disadvantages in both methods. In the procedure that we adopted all patients should be included in the analysis. Analysis of survival from the 12 week point does not alter the findings in our study, but this analysis is inappropriate when an early randomisation has been carried out.

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SIR,—The inability of the moderate dose radiation to eradicate residual intrathoracic disease after chemotherapy in patients with small cell cancer of the lung is the major result of the trial reported by Dr R L Souhami and others, which deserves further comment.

Small cell cancer of the lung may be more radiosensitive than other types of lung cancer and respond with prompt tumour shrinkage, but it is certainly not as sensitive as Hodgkin's disease or seminoma, which are eradicated in bulk by 40Gy (4000 rad) tumour dose in 2Gy (20 rad) fractions. Of the 139 patients with small cell cancer of the lung given radiotherapy, 93% responded to induction chemotherapy with a partial remission or less; in these patients sheer bulk of tumour is the most important determinant of curability.

The only data reporting good local control rates with tumour doses equivalent to 30-40Gy (3000-4000 rad) are associated with concomitant, not sequential, chemotherapy.¹ Good radiation dose response data are hard to come by, but raising the tumour dose to 55-65Gy (5500-6500 rad) in 2Gy (20 rad) fractions using shrinking field techniques does increase local control rates. Whether this would help the patient in the long term depends on whether intrathoracic disease can be a limiting factor in the cure of small cell cancer of the lung. It certainly can be; radiotherapy alone was associated with three out of 70 (5%) 10 year survivors in patients with limited disease treated 20 years ago in the original Medical Research Council trial of treatment of small cell

cancer of the lung.² Today's selection of patients with limited disease treated with high dose megavoltage radiotherapy alone might do appreciably better than this.

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¹ Cox JD, Byhardt R, Komaki R, Wilson JF, Libnoch JA, Hansen R. Interaction of thoracic irradiation and chemotherapy on local control and survival in small cell carcinoma of the lung. *Cancer Treatment Reports* 1979;63:1251-5.

² Fox W, Scadding JG. Medical Research Council comparative trial of surgery and radiotherapy for primary treatment of small-celled or oat-celled carcinoma of bronchus—10-year follow-up. *Lancet* 1973;ii:63-5.

Breaking bad news

SIR,—There are several reasons why communication is poor in addition to those that Dr Robert Buckman mentions (26 May, p 1597). Firstly, interviewing seriously ill patients or their relatives is often left to the most junior medical staff—often a newly qualified house officer. This is fair to neither patients, relatives, nor staff. Dr Trisha Greenhalgh illustrates this point (2 June, p 1689). Her registrar would perhaps have been even more clear sighted had he interviewed the relatives of the "ventilated cadaver" in the presence of his junior colleague in what would then have been a doubly educative and sympathetic procedure.

Secondly, patients are often interviewed by several doctors, particularly in hospitals. Even if all the doctors tell the patient what they believe to be the truth there will inevitably be variations in the story, which may be misinterpreted by the patient as an attempt to hide the truth. Thirdly, if patients feel that information is being withheld they will attack what they perceive to be the weakest link in the chain, usually the nurses. Most nurses to whom I have spoken about breaking bad news say that as student nurses on night duty they have been approached by patients asking "I haven't got cancer, have I nurse?" or "What do the doctors think it is?"

I suggest that patients or their relatives should be interviewed as far as is possible by one doctor, who should be as senior as is practically possible. The nurses should be involved in the discussion since they will know which patients are anxious or fearful and they are usually aware of how much the patients want to know. Junior staff or medical students should be encouraged to observe the interviews.

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SIR,—I enjoyed Dr Robert Buckman's article very much (26 May, p 1597), but he has omitted a most important element of the subject. Surely we should want our patients to find peace of mind following bad news, and I feel that it is important that the doctor is able to help the spiritual needs of the patient. Either he should point to someone who could counsel or be able to discuss these issues with the patient himself. We should not abrogate responsibility of helping a patient's inner turmoil after bad news is broken and let others pick up the pieces.

I am glad to say that there are such counselling services arising, and the bringing in of