and will only see cases referred from other consultants. As a result there is considerable detachment of the neurological services as far as general practitioners are concerned.

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SIR,—Dr Anthony Hopkins (9 June, p 1733) has drawn attention to the progressive isolation of neurologists that has followed the decision to stop advertising for physicians "with an interest." Another consequence is that a registrar who moves into the specialty and remains for more than a year is likely to have difficulty in getting back into the mainstream of clinical medicine. Nevertheless, it takes about three years of concentrated clinical experience for a post-membership trainee to become competent in clinical neurology. One of the difficulties for physicians with an interest who had less training was that they attracted progressively more neurological cases and had neither the experience nor the facilities to deal with them.

The location of beds is important. Beds in a general hospital are always in demand for emergencies, and patients needing inpatient investigation tend to be kept waiting or squeezed out. When the beds are in a small hospital which does not take emergencies the patients are isolated from facilities for investigation.

While there may be a case for physicians with adequate training doing part time neurology, there is surely an even greater need for neurologists to deal with emergencies in their own specialty. To do this they must have beds in the general hospital for cases of stroke, status epilepticus, subarachnoid haemorrhage, and other acute conditions. In this they can usefully collaborate with neurosurgeons as well as other physicians. Cases of this type form a considerable component of medical emergencies, and a neurologist would be better used in this way than in managing cases that properly belong to other specialists.

Neurological symptoms account for about a fifth of medical outpatients. The neurologist is in the best position to select those who require special tests, but this means seeing many patients who do not require investigation at all.

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SIR,—We have reviewed the diagnoses of 265 patients admitted to a general medical ward, which does not admit cardiac patients, from 19 March to 14 June 1984. Patients being observed after drug overdoses accounted for 71 admissions. Of the remainder 57 (30%) were neurological admissions. The reasons for admission were: epilepsy (17), investigation of headache (13), stroke (11), subarachnoid haemorrhage (5), multiple sclerosis (3), transient ischaemic attack (2), cerebral neoplasm (2), and miscellaneous (3).

These figures exclude acute admissions to our geriatric medical unit, although a survey of all such admissions during 1982 showed that a similar proportion of patients (188 out of 613 (31%)) had active neurological problems on admission. There were more cases of strokes—101 (54% of the neurological cases).

Obviously not all of these patients require assessment by a neurologist. The hospital has excellent neurological backup: a consultant neurologist has monthly clinics, seeing both outpatients and inpatients, and we have access to regional neurosurgical opinion. We feel, however, that the general medical workload would support a physician with an interest in neurology.

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Hidden dangers of sliced bread

SIR,—I was pleased to read Mr N J Bundred's article concerning the dangers of ingested bread wrapper clips, but I think he understates the dangers. I have been interested in bread clips since November 1983 when I performed emergency right hemicolectomy for an ileocolic intussusception. A bread clip was firmly attached to the bowel wall at the apex of the intussusception. The patient, who had presented in a very unkempt state, was a respiratory cripple and unfortunately died of respiratory failure six weeks after surgery.

I thought his death was partly due to the need for surgery immediately after the ingestion of the bread clip. I contacted the Federation of Master Bakers, which informed me that after a letter in the *Lancet* it had set up a committee to look into ways of making clips safer.¹ It later said that the problem must be rare as it had heard of no other cases, despite the sale of at least 10m clips each day.

I thought the problem was more extensive than this but I was surprised to find two further cases at Swindon. One, a 60 year old woman who later died, was first operated on in June 1982 for an unexplained intra-abdominal abscess. This operation was complicated by the development of small bowel fistulas. At a second laparotomy a bread clip was found lying free in the peritoneal cavity. The fistulas, however, persisted and pancreatitis supervened. The patient died after a protracted illness of four months. The second case was a 49 year old woman who presented with dysphagia and had a clip removed from the middle third of the oesophagus endoscopically. Her recovery was uneventful.

The lodging of clips in the oesophagus is, however, not without danger. I have been informed of a case where the clip caused dysphagia and a barium swallow suggested a carcinoma. At thoracotomy, after excision of the oesophageal mass (later found to be inflammatory), a mediastinal abscess was found containing a bread clip which had presumably eroded through the oesophageal wall. The patient unfortunately died later of complications of the major surgery.

These clips represent avoidable danger to life, and I hope that in reporting these three fatal cases I can influence the Federation of Master Bakers. Perhaps simply enlarging the clips would be sufficient to prevent their accidental ingestion?

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¹ Rivron RP, Jones DRB. A hazard of modern life. *Lancet* 1983;iii:334.

Conservative management of pregnancy in diabetic women

SIR,—Both Dr J Murphy and others (21 April, p 1203) and Dr John M Stronge and Dr M I Drury (19 May, p 1539) advocate conservative management of pregnancy in diabetic women and quote excellent results. While it is true that the widespread use of home glucose monitoring and stricter attention to diabetic control in pregnancy now make it unnecessary to admit most diabetic women to hospital, it is important to recognise that even very close control of diabetes does not achieve the even pattern of blood glucose concentrations seen in the non-diabetic pregnant woman. Furthermore, it does not guarantee that pregnancy complications will not develop or that the fetus will be unaffected.

The delivery of a baby typically affected by diabetes at the end of a pregnancy in which the diabetes is impeccably controlled is well described¹ and accords with our own experience. Fetal macrosomy (> 90th centile) was present in 30% of 100 women whose diabetes was well controlled at King's College Hospital from 1982 to 1984, indicating that the fetus had been affected by the maternal diabetes in spite of good control. Why one woman with well controlled disease gives birth to a macrosomic baby and another apparently similar woman has a normal sized baby is not clear. It would seem that a macrosomia factor operates in some pregnancies where the diabetes is well controlled.

Developing macrosomia can be detected by serial ultrasound scanning, and we believe it is prudent to consider delivery before full term in these women, generally at or about 38 weeks. To allow a macrosomic fetus to continue to grow disproportionately even larger in the last two weeks of pregnancy is to invite a difficult delivery and perhaps to risk an unexplained late intrauterine death. The need is to individualise management, which in our hands has produced a reasonably low perinatal mortality rate of 3.2% in 463 consecutive diabetic pregnancies (1971-83).

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¹ Knight G, Worth RC, Ward JD. Macrosomy despite a well controlled diabetic pregnancy. *Lancet* 1983;iii:1431.

Breaking bad news

SIR,—Dr Robert Buckman (26 May, p 1597) made some valid points, especially concerning the fears that some doctors have of performing badly and creating a problem that they cannot handle while bad news is being broken. I take issue, however, with his conclusions that teaching of such skills would need only minor alteration in the curriculum and that such a skill can be taught.

There have been many studies looking at the reactions of patients to bad news, and although Dr Buckman quotes his own experience many studies have pointed to the fact that doctors are appallingly bad at giving bad news. Much of this blame is, of course, related to the news itself rather than the performance of the doctor. The teaching about physical disease is based on each disease having at least something

in common from patient to patient to make it recognisable and that symptoms or signs can often be elicited to a certain extent objectively. This can certainly not be said, however, about the reaction of patients to bad news. The way to approach such patients can only be a matter of experience, as surely judging a patient's personality comes more from experience than lectures. I do not condone the present lack of time in the curriculum for such discussion, but I believe it is facile to think that students will be any better at such a difficult job with the occasional role play or lecture.

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SIR,—Dr Robert Buckman (26 May, p 1597) has done extremely well to evaluate the fears that a doctor may have when dealing with patients who have a terminal disease. One such fear is the basic one of hurting the patient in an emotional, if not a physical, way. It goes against the grain to do anything that does the patient harm. This is surely why the paternalistic attitude has developed theoretically to save the patient any hurt.

Treating the patient in the humane way that is necessary for good communication is also painful for the doctor—painful for him to see at close quarters the emotional turmoil. Dr Buckman is quite right that more should be done to expose medical students and young doctors to training in counselling and talking to dying patients and that role play can be extremely valuable. The working party on the care of the dying for Basingstoke and North Hampshire Health Authority has found twice yearly multidisciplinary symposiums extremely valuable, and these are based on role play and workshop groups exploring the interaction with seriously ill and dying patients. Understanding our own emotional reactions—and that they exist—is the first step in helping these patients.

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SIR,—As a father of a 17 year old boy who died of osteosarcoma two years ago after being ill for 19 months, I recognise the patterns of doctors' reactions that Dr Robert Buckman describes. In our experience as parents communication about the poor prognosis for our son was difficult, almost impossible. Emphasis was placed on the supposedly bright side, and this had great impact on our participation in therapeutic decision making. Expectations were presented as hopeful until two months before our son died, and cytotoxic drugs were used until then. At that moment the disease had been disseminated through the lungs for more than a year and metastasectomy had been rejected six months before.

I do not blame the doctors personally. Dr Buckman gives a clear analysis of the complicated situation in which doctors find themselves. I agree with him that developing skills in talking to seriously ill patients and their families should be part of the medical curriculum. Indeed, this is one of the suggestions I made in a paper based on our experience.¹ The central theme was where the bounds became blurred between truth and reality. Publication was followed by an extensive and intensive

discussion to which many doctors contributed. The wide variation in their opinions underscored the need for open communication about these matters as well as the enormous uncertainties.

Dealing with the issues raised by Dr Buckman is important for improving not only the patient-doctor relationship but also the quality of medical care. Not adequately coping with bad news leads to a flight in the line of the least resistance, which does more harm than good to patients.

Conversation with seriously ill children and their parents needs special consideration. Where lie the responsibilities, and how can we both involve children in decision making and not provide suggestible children with coloured information?

Talking implies providing information about the chances one has with or without specific treatments. This information is based on reported results. May reports be biased by the involvement of authors in their own evidence or by the selection for publication? I suggested the founding of an independent institution for the critical appraisal of research results in cancer treatment.

Conversation about bad news is also a matter of discussing the costs and benefits of treatment. What quantity and quality of life is gained or lost? This cost benefit approach is unexplored in the treatment of cancer but nevertheless crucial.²

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¹ Knottnerus BJ. Gewetensvragen aan artsen. *Medisch Contact* 1983;38:429-30.

² Fayers PM, Jones DR. Measuring and analysing quality of life in cancer clinical trials: a review. *Statistics in Medicine* 1983;2:429-46.

Hospices

SIR,—Dr D C Hogg (12 May, p 1453) is right to question the relation between general practice and hospices. This practice is probably typical of many others and the following figures will bring a perspective to the debate.

From our list of 14 271 we had 143 deaths in 1983; 33 patients died of cancer. A total of 103 of the patients died in the care of the practice: 60 at home; 14 in rest homes or part three accommodation; eight in nursing homes; and 21 in the cottage hospital. Of the rest, 35 died in hospital, two in hospices, and three elsewhere.

We have had tremendous support from our local hospice, and as a centre of excellence its influence helps all those who are caring for the dying at home. Like Dr Hogg, however, I would like to think that most of my patients will need admission to a hospice only for assessment and stabilisation of particularly resistant and difficult symptoms.

The hospice movement seems very aware of its sometimes delicate relation with general practice, and there is undoubtedly some danger that their policies of excellence will be misconstrued by many doctors, and also by an interested and concerned public, as representing the "ideal" management for terminal illness. That this is already something of a problem was brought home to me when a local medical registrar on discharging home a terminally ill patient with an uncomplicated carcinoma of the bronchus contacted the hospice domiciliary team as a

matter of routine. In addition, the emotive forces behind the movement will maintain a ready supply of funds, and it will require wisdom and foresight to see that such funds are distributed to take account of the actual workload (see above figures) and to ensure that the recent improvements in the district nursing service, such as night nurses, continue and expand.

A charge of arrogance would be easy here, but like most general practitioners I believe that care of the dying is very much part of our job and we should look to the hospices to help us do this better—not to do it for us.

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***This correspondence is now closed.—ED, *BMJ*.

Adjuvant questions

SIR,—At last there is common sense expressed by a person with such standing as Dr Diana Brinkley (9 June, p 1709), who has extensive experience with trials for breast cancer. She cautiously expresses considerable doubts and very rightly states: "There is no consensus on how patients with early breast cancer should be treated and no consensus on when adjuvant hormone therapy or chemotherapy should be prescribed."

Surely this is the moment for British oncologists to state that more consideration should be given to our patients with regard to possible harmful and unpleasant chemotherapy until such time as properly controlled, confirmed international clinical trials have at least shown that no harm has accrued.

These columns have not been wanting for suggestions regarding methods of minimising damage by, for instance, one day cyclical monthly treatments to avoid repeated bone marrow damage and intra-arterial chemotherapy direct to the tumour with antidotes timed to the venous circulation to block damage on exit from the tumour circulation. Our immunity is a most precious possession which should be guarded from possible damage at all times, especially when it is planned in treatment.

Indeed, I would go further in stating that some treatments given today may be actionable in law.

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Planned and unplanned deliveries at home

SIR,—Mrs Marjorie Tew's letter (2 June, p 1691) is interesting but unfortunately contains many factual mistakes. She writes of her "conclusions about the obstetricians' perinatal surveys of 1958 and 1970." They were not obstetricians' surveys, though there were obstetricians on the various committees. The directors of the surveys were Neville Butler and Roma Chamberlain, both of whom were paediatricians. The initial working party for the 1970 survey had only one obstetrician in its 10 members, and the staff of 10 members of the survey equally had only one obstetrician. Paediatricians, physicians, a community midwife, and statisticians formed the bulk of the committee—so there was no bias in favour of obstetricians, or self assessment.