more closely. A study of awareness of the "reduce the risk" campaign in a socially deprived area in south Wales in 1994 showed that a third of 250 mothers with children born before the introduction of the campaign said that they checked their babies more often than they had done previously.⁵

For babies to endure increasingly long periods of solitude after birth is biologically unreasonable. In 1991 in Cardiff we included another factor to lower the risk of the syndrome: we encouraged mothers to have their babies in their room at night for the first six to nine months and to keep the cot in which the babies slept by day close by. To focus only on posture, heating, and smoking and not to consider where a baby sleeps could detract from other factors in the care giving environment that might be protective. Any intervention programme aiming to reduce the incidence of the sudden infant death syndrome must also consider the broad range of care practices that could reduce the risk.

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Information about initiatives that use new technology to inform patients should be shared

EDITOR,—Chris Lock's review on the role of information technology in health care focuses on hospital information support systems and highlights the need for evidence in determining the value of information technology applications in health care.¹ The many potentially useful, though small scale, systems that are being designed for use directly by patients are often overlooked.

At a time when the public is demanding more information on health care² these interactive educational packages are increasingly being developed in hospitals and academia. Health-point is a public access system produced by Glasgow University, which provides patients with information related to health that is accessed with a touch screen.³ PharmAssist, a system being developed at Lewisham Hospital NHS Trust, informs patients about how to take their medicines.⁴ HealthWise has produced a series of computer games, which educate children on the dangers of alcohol, smoking, and drug misuse.

In his editorial linked with Lock's review Liam J Donaldson notes the difficulty in evaluating computer applications owing to their increasing diversity and the lack of formal evaluation criteria.⁵ Despite these difficulties, evaluations

that include assessments of content and acceptability to patients are feasible.

The King's Fund has set up an initiative, "promoting patient choice," which supports the development and evaluation of information packages to help patients choose between different treatment options. American interactive videos known as shared decision making programs that cover topics such as benign prostatic hyperplasia, hormone replacement therapy, and breast cancer are being evaluated in both primary and secondary care in Britain. The acceptability of a video on treatment for menorrhagia and the accompanying booklet (based on the systematic review conducted for an *Effective Health Care* bulletin) will soon be evaluated in a randomised controlled trial of 600 patients. Six other sites are developing and evaluating a variety of media, from audiocassettes to CD-ROMs, on topics such as control of postoperative pain and colorectal cancer. The King's Fund is also undertaking a review of the various roles that new electronic media can have in providing information about health and illness to patients and the general public.

The locally devolved nature of the NHS has led to a lack of sharing about such initiatives. We are trying to collate information about initiatives that use current and new media technologies to enable patients to become informed participants in decisions about their care and would be interested to hear about similar projects.

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Mortality in second generation Irish people living in England and Wales

Possibility of excess smoking should be investigated

EDITOR,—S Harding and R Balarajan's paper and John Haskey's accompanying editorial highlight the important issue of excess mortality among second generation Irish people living in England and Wales.^{1,2} Somewhat surprisingly, both articles devote little discussion to the source of the main causes of the excess deaths, which are lung cancer, all cancers, and respiratory disease. None of the figures for the remaining categories of cause specific mortality are significantly different from the national averages for England and Wales. Surely excess smoking among people of Irish origin, and not ethnicity, is a prime candidate as a cause of the excess deaths. Are these data not available in the 1% longitudinal sample from the Office for National Statistics?

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Effects of social deprivation in whole population should be addressed

EDITOR,—S Harding and R Balarajan's paper on mortality in second generation Irish people living in England and Wales concludes that special consideration should be given to the health needs of this population group.¹ We wish to challenge some of the statements made, because the data presented do not support the text.

The authors state that there is "a pattern of higher mortality from most major causes," presumably because of the values of the point estimates of the standardised mortality ratios. The confidence intervals for these ratios, however, cross from below to above 100 for most of the diseases shown, so that the true ratio could lie anywhere between these values and even indicate a decreased mortality. Though the crude standardised mortality ratios for men and women for all causes of death seem to indicate a higher mortality, the difference between the second generation Irish women and all women disappears after adjustment for social class.

The authors do not mention genetics. If, however, the genetics connected with Irishness were a cause of increased mortality then it could be suggested that those people with two Irish parents would be more at risk than those with one (a dose-response relation). In fact, there was no significant difference between these two groups.

Problems with the health of second generation Irish people are not comparable with those of population groups for whom language and culture may cause difficulties with access to health care or advice. We believe that it would be wrong to direct excessive time and effort specifically to this group but that concerted efforts should be made to address the health issues connected with social deprivation in the whole population.

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- 1 Harding S, Balarajan R. Patterns of mortality in second generation Irish living in England and Wales: longitudinal study. *BMJ* 1996;312:1389-92. (1 June.)

Authors' reply

EDITOR,—J K Cruickshank raises the important issue of the likely contribution of smoking to the increased mortality from all cancers, and especially lung cancer. Mortality from respiratory disease was also raised in both men (non-significantly) and women. Unfortunately, we do not have data on smoking in the Office for National Statistics' longitudinal study.

We believe that, though testing for significance is central to the analysis, the observation of patterns that are consistent across sex, age, and time is equally important in epidemiological studies. Small numbers are often a major problem, even in studies such as the Office for National Statistics' longitudinal study, which has around 650 000 members in the cohort. With the period of follow up extended from 1971-89 to 1971-92, we are able to test the statement of H M P Fielder and colleagues that "the difference between the second generation Irish women and all women disappears after adjustment for social class." Table 1 shows that the increased mortality among women is significant at the 5% level after adjustment for social class.

We were careful not to speculate on the genetic component of "Irishness." This is because we believe that a gradient in mortality across having