particularly those with erectile impotence, is similar to that reported by Milne¹ in a comparable clinic. There is no evidence that this is associated with a longer duration of the problem in the couples with a male presenter, and this raises the possibility that different aetiological factors, related in some way to aging, are operating among men. Categorisation on the basis of the type of sexual dysfunction, though traditional, is probably of limited value as it may exclude patient characteristics, such as the degree of performance anxiety or the amount of resentment in the relationship, which are more relevant to assessing the response to treatment. The high proportion of people rejecting or not being considered suitable for counselling indicates the complex nature of and the high degree of ambivalence associated with many of these interpersonal problems. Any treatment which requires a high degree of commitment from both partners should be expected to meet with a high rejection rate in such a clinic population.

Substantial benefits for two-thirds of those receiving treatment is an encouraging outcome, given that much of the treatment was given by therapists using the treatment method for the first or second time. With greater therapeutic experience this outcome should be improved further. The treatment approach has also proved to be both readily accepted by most therapists and easily taught and supervised. While the behavioural component is relatively straightforward, however, the psychotherapeutic element does require therapist skill and will

be more important in those cases in which complex interpersonal or attitudinal factors are operating.

The negative association between the number of sessions and outcome suggests that those who do well with this method do so with relatively few sessions. Those who drop out of treatment usually do so after three or four sessions. This stage of treatment is generally a good time to appraise the likely outcome, and in those cases in which the prognosis is uncertain a limited contract of three or four sessions can be made in the first instance.

We hope that our experience with this clinic will encourage health authorities in other areas to establish such a service, which would demand only limited resources and yet help to solve problems that have widespread and long-term repercussions on family health.

We thank Judy Bancroft, Tony Carney, Keith Hawton, and Anne Young for their help in the clinic.

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Clinical Topics

Attitudes and advice after myocardial infarction

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British Medical Journal, 1976, 1, 1577-1579

Summary

While medical opinion increasingly favours an active approach to rehabilitation after myocardial infarction, interviews with 40 patients and their relatives showed a low degree of understanding of medical advice and information. There was general satisfaction with treatment, but communication was seen as often being inadequate, vague, and conflicting.

Introduction

Medical opinion increasingly favours an active approach to convalescence from myocardial infarction, and current textbooks and reviews¹ emphasise the value of initiating such treatment from the earliest stages. The problems in communicating information to patients² and the cautious and pessimistic lay

views of heart disease lead to the expectation that it will be difficult to convey positive views about convalescence and exercise. It is important, therefore, to take into account the beliefs and attitudes of patients and their families. While their descriptions cannot be taken as valid accounts of what actually happened, presumably the patients' understanding and interpretation of information and advice, rather than what was actually said, determine their attitudes, satisfaction, and behaviour.

Methods

During the pilot and early stages of a larger study 40 patients (aged 34-69) were interviewed using a semi-structured schedule during the first week after myocardial infarction and again at home a month after discharge from hospital. Spouses were similarly interviewed at home at the time of the hospital admission and separately at follow-up. Interviews were tape-recorded. Medical notes were scrutinised.

Results

PATIENTS

Patients (see table) found it difficult to recall the early stages of illness. At the initial interview most were satisfied and indeed very grateful for the quality of their care, in both the coronary care unit and the general wards, but seemed to have very little understanding of diagnosis, the nature of hospital treatment, or longer-term implications. Most accepted this, saying, "The doctor will tell me if there is

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Patients' and relatives' views about treatment and information given at various stages after myocardial infarction

Patients' views	No (%) of patients	Relatives' views	No (%) of spouses*
<i>Views when patient was in coronary care unit</i>			
Favourable	31 (78)	Relatives present in casualty department	29 (78)
Mixed view	6 (14)	Relatives not present	8 (22)
Negative	3 (8)		
		Information given to relatives	30 (81)
Understood treatment	10 (24)	No information given	7 (19)
Did not understand treatment	30 (76)		
		Satisfied	23 (62)
		Not satisfied	14 (38)
<i>Views when patient was in medical ward</i>			
Information and advice:		Spoken to doctor	30 (81)
Good	7 (18)	Not spoken to doctor	7 (19)
Some	29 (72)		
None	4 (10)	Interview with doctor arranged:	
		By doctor	4 (11)
Intends to ask questions	12 (30)	By relative	6 (16)
Will not ask	28 (70)	By patient	3 (8)
		Casually	16 (43)
Satisfied with care	30 (75)	Given advice about future	25 (68)
Partially satisfied	6 (15)		
Not satisfied	4 (10)	Satisfied	24 (65)
		Partially satisfied	7 (19)
		Not satisfied	6 (16)
<i>Views after discharge</i>			
Hospital advice:		Advice given by hospital	13 (35)
Good	14 (35)	No advice given	24 (65)
Little	22 (55)		
None	4 (10)	Satisfied	17 (46)
		Not satisfied	20 (54)
Satisfied	29 (73)		
Partially satisfied	7 (17)		
Not satisfied	4 (10)		

*Three patients in the study were single.

anything I need to know." Some had asked questions, but two thought, "It is better not to know too much," and others said they would not try to find out more because "the doctors are all so busy." Other comments were: "I wouldn't know who to speak to or what to ask," or "Nothing ever comes of it; it's all one-way information, you have to wangle things out of them." Several mentioned worries about their treatment or progress which they had not dared to discuss with doctors. Doctors were reported as the main source of information with a few mentioning nurses, particularly in the coronary care unit, and five having seen dietitians. Only two patients, who had been discharged to convalescent homes, had had any contact with social workers.

When interviewed after discharge patients still seemed to have little understanding of the possible implications of their illness and recalled very little medical advice. None could give any clear account of their medication (even though this often included anticoagulants and glyceryl trinitrate), and diets were a source of confusion; several would have liked written instructions, especially about graded activity. It was often felt that advice was conflicting, inadequate, too vague, or inappropriate to their circumstances: "I think before I left they should have had a talk with me, 'we can advise you to do this and that'—maybe to take a short walk each day and extend it. I can't blame them; they want to get people out; they just hadn't got the time."

RELATIVES

Relatives (see table) had had much less contact with medical and nursing staff, but most were satisfied at first interview. They reported particular difficulty, however, about the practical aspects of the admission to hospital such as uncertainty about visiting hours, difficulty in getting home after arriving in the ambulance, and uncertainty about the seriousness and consequences of the infarct.

Relatives found the hospital much more intimidating than the patients; thus the coronary care unit "seemed alarming because of all the gadgets and things." "I don't know whether it makes it look worse than it is. When you don't know anything you think something has gone wrong." Particular anxiety was expressed about what were thought (often wrongly) to be complications or setbacks in treatment. Many families were diffident about approaching the doctor, either because they were frightened about what he might say or more often because they felt anxious and overawed.

After discharge families remained mainly satisfied with hospital care but criticised specifically the inadequacy of the information, its vagueness, and discrepancies. There was considerable uncertainty over how much the patient should be doing, "You don't know what the limitations are. Do individuals differ? It depends on how determined they are. I wonder if he's going too far; probably I worry too much." Several commented that they would have liked written instructions about diet, exertion, and so on.

CARE AFTER DISCHARGE

After discharge some family doctors visited the home as soon as they had been notified by the hospital or by the patient; others waited for the patient to attend the surgery or, in some instances, sent someone else to obtain a certificate. General practitioners were much more likely to speak to husband and wife and were viewed as more approachable than hospital staff, and two had visited patients while they were still in hospital. As with hospital advice, patients and their families were able to give only vague accounts of the information and advice they had received. This varied from a planned programme of increasing activity and a careful check on physical progress and medication to merely repeat prescriptions or certificates.¹

The outpatient follow-up visit was often looked forward to not only as an important stage in recovery but also as an opportunity to ask questions and clear up problems that had become evident during convalescence. Often it proved a disappointment, as they were confronted after a long wait with a doctor whom they had not seen on the ward and who had little time to talk. None the less, discharge from hospital care was usually viewed as an encouraging confirmation of good progress.

Hospital notes, summaries, and discharge letters, which are usually written by several doctors, gave little detail about significant psychosocial factors or about advice given to the patient or his family on work, diet, or activity. Outpatient notes and letters were brief, often mentioning return to work, but with little other reference to activity or social aspects or to how long medication should be continued.

Discussion

Accounts of patients and their relatives should not be regarded as more than an incomplete version of the actual communication of information. Our findings were not unexpected in view of similar reports in various hospital studies²⁻⁵ that even in the most favourable circumstances recall of information and advice is low. There are several probable reasons for the low understanding of illness by patients and families.

Administration—The overcrowded and inadequate hospital facilities impose severe restrictions: the lack of waiting or interview rooms, the severe shortage of beds, and the many practical hindrances to effective medicine. Many people are necessarily concerned in treatment, and it is often not clear who is responsible for giving advice.

Physical and mental state of the patient—Organic confusion, anxiety, the psychological denial often noted after infarct, and the strange surroundings all militate against understanding. Also inevitably after a serious and threatening illness frustration will sometimes lead to unjustified hostility towards the doctor.

Difficulties in communication—Good communication² depends on the methods of conveying information as well as the attitudes of the patient.

Uncertainty about appropriate advice—Doctors may be unaware of the practical needs of patients and sometimes may not be sure about precisely what advice they should give, especially when they are inexperienced or when, as with myocardial infarction, medical opinion has changed considerably over a few years.⁶

There seem to be significant differences in the initial requirements of patients and relatives. Patients often deny worries when they are removed and protected from everyday concerns, and only on returning home are they confronted with the implications of the heart attack and of having to decide exactly how much they should do and how to behave throughout the day. Only then do many patients become aware of the decisions that confront them and their lack of relevant information. Families, on the other hand, are from the outset presented not only with worry about an extremely serious illness but also with substantially increased physical demands, and many require con-

siderable emotional and practical support at this time.^{6,7} After discharge they are, like the patient, uncertain about how to behave, how protective they should be, and the long-term implications.

Relatively simple measures will probably be of substantial benefit in increasing understanding and reducing unnecessary social morbidity, and more complex rehabilitation should be reserved for the few who remain unnecessarily disabled. Awareness of the needs of patients and families, allocation of the responsibility for giving information, written guidance, and improved communication with the general practitioner should all be possible without making overwhelming demands on hospital staff.¹ There is a need for evaluation both of such measures and of exercise programmes and perhaps the use of nurses to supervise and co-ordinate convalescence.

The research was financed by a grant from the British Heart Foundation. We thank the physicians, staff, and patients of the Radcliffe Infirmary for their co-operation.

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Hospital Topics

Hepatitis B in retreat from dialysis units in United Kingdom in 1973

Public Health Laboratory Service Survey*

British Medical Journal, 1976, **1**, 1579-1581

Summary

A prospective study of hepatitis in over two-thirds of the dialysis units in the United Kingdom has continued since 1968. After the introduction of a control and preventive programme in 1970 there was a sustained decline in the incidence of hepatitis B to the low level of 0.3% among patients and 0.1% among staff in 1973—a greater than tenfold decrease in four years. Comparisons with data from other countries suggest that the almost complete elimination of hepatitis B from dialysis units in the UK was due to the preventive programme.

Introduction

A prospective survey of the incidence of hepatitis in haemodialysis units that began in 1968 was combined in January 1970 with a hepatitis B prevention programme, based on regular tests for hepatitis B surface antigen (HBsAg) of sera from patients and staff before entry to the units and at regular intervals afterwards, dialysis in isolation of infected patients, and appropriate cross-infection precautions. The study results showed a threefold decrease in the incidence of hepatitis B infections among patients and staff from 1970 to 1972. The results of the survey in 1973 are reported here.

Method

The method has been described elsewhere.^{1,2} In addition, in 1973 records were completed for all patients who had been treated in the

units and who were being maintained by dialysis at home or by transplants.

Results

In 1973, 33 of the 48 haemodialysis and transplant units in the United Kingdom were included in the survey. Formerly records had not been returned for staff concerned with transplantation, and, although it was planned that this staff group would be included in 1973, few units returned the relevant records, so transplant staff continued to be excluded from estimates of incidence.

Hepatitis B outbreaks—There were no new outbreaks of hepatitis B in 1973, and hepatitis B infections developed in only three patients, who were all in one unit in which a hepatitis B outbreak had been in progress since 1970. This outbreak ended in the unit in mid-1973. Six months after the last HBsAg carrier was dialysed in the unit it was cleared of patients and equipment, thoroughly cleaned, disinfected, and re-equipped before patients, known to be HBsAg-negative, were admitted. In the associated transplant unit, however, HBsAg carriers continued to undergo transplantation, and, in contrast to the absence of infection among the staff of the haemodialysis unit, two nurses in the transplant unit developed hepatitis B infections in 1973. No hepatitis B infections of patients or staff in either the haemodialysis or the transplant unit were reported in the following year.

Introduction of HBsAg to units—HBsAg was not detected in the serum of any patient in the 32 units without outbreaks of hepatitis B. HBsAg was, however, introduced into a unit by a doctor who began duty without undergoing a HBsAg screening test; he worked in the unit for 12 weeks before he was identified as a symptomless HBsAg carrier and transferred to another department. No evidence of hepatitis B infection of patients or other staff of the unit was found then or later. This finding is in keeping with the outcome of two similar incidents in 1971, in each of which a nurse who was a HBsAg carrier worked in a unit for about three months without transmitting infection.

Incidence of hepatitis B—The incidence of hepatitis B infection in the survey units as a whole decreased to 0.3 per 100 patients, compared with 1.4 in 1972, 3.5 in 1971, and 4.9 in 1970 (table I). Among the staff of haemodialysis units the incidence rate, which rested solely on the HBsAg carrier doctor described above, was 0.1 per 100 persons, compared with 0.4 in 1972, 0.8 in 1971, and 1.3 in 1970.

*The survey was co-ordinated and the report prepared by Sheila Polakoff, MD, MFCM, consultant epidemiologist, Epidemiological Research Laboratory, Central Public Health Laboratory, London NW9 5HT. The collaborators in the study are listed in the appendix.