patients regarding the documents was not part of the intervention in any group.

Three months after the intervention, charts were audited for presence of advance directives. No charts in any group contained advance directives. We interpreted this to mean that a simple distribution of information without discussion by a health care worker, even when accompanied by literature written in lay terms, has no effect on increasing the number of advance directives presented to the physician or office for the medical record. Like Richter et al, we are unsure if patient education elicited any positive effects such as prompting discussion among patients and significant others or other positive effects.

These studies, however, do underline the importance of personal discussion in the facilitation of behavioral changes, including the completion of advance directives.

Mary Thoesen Coleman, MD, PhD
Randy Jernecjic
Department of Family Medicine
The Ohio State University
Columbus

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In reply

Following passage of the Patient Self-Determination Act,[1] hospitals and other health care entities created a plethora of forms and informational materials. Yet it is not at all clear that information alone increases completion and filing of advance directives among the general public. Coleman and Jernecjic's experience is likely the rule among those who have sought to increase the use of advance directives.

Pearlman[2] suggested that we "identify the optimal circumstances for advance care planning: where and when (inpatient, outpatient, health promotion screening visits), who should be involved, and how often advance directives should be discussed and reviewed." For some ethnic groups, information or discussions about end-of-life decision making may be anathema. Carrese and Rhodes[3] found that discussing negative information conflicts with traditional Navajo values and may be viewed as potentially harmful by Navajo patients. Likewise, Blackhall and colleagues[4] found that Korean American patients preferred that their families handle end-of-life treatment decisions.

Two studies have demonstrated that mailed forms and information increase use of advance directives by older adults.[5,6] Older adults daily face the passing of family, friends, and even public figures that they have known and loved. Natural consequences, such as reduced anxiety for spouses or relatives, may reinforce decisions to adopt advance directives. It may be that for certain populations, who have already had multiple exposures to end-of-life decision making, mailed or hand-delivered materials are sufficient prompts for increasing use.

To summarize, there are likely a vast number of conditions that would increase the use of advance directives, or the use of other procedures to enhance patient autonomy in end-of-life decision making. These conditions will likely vary according to race, ethnicity, age, and health status of groups within the general population. The challenge lies in identifying those conditions and identifying types of advance directives that mesh with individual belief systems.

We could take one more step toward true patient autonomy by providing resources for grassroots development of advance directives. Perhaps community-based mini-grants to religious, health advocacy, and ethnic groups would facilitate the development of culturally appropriate procedures for increasing patient autonomy. Grantmakers could encourage collaboration with health and legal professionals and provide technical assistance in adapting procedures for advance directives to diverse groups. Particularly effective procedures might then be disseminated at the state or national level. Such strategies may enhance opportunities for all to engage in meaningful end-of-life decision making.

Kimber P. Richter, MA
Stephen B. Fawcett, PhD
Adrienne Paine-Andrews, PhD
University of Kansas
Lawrence
Sondra Langel
Kansas Health Ethics
Wichita
Lucia Biehler, RN
Wichita Medical Practice Association
Robert Manning, MD
University of Kansas School of Medicine
Wichita

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Addiction to Benzodiazepines—How Common?

In his article,[1] Dr Piper states "the literature provides no support for the notion that benzodiazepines are often used recklessly, in escalating dosage, or inappropriately" and "the belief that benzodiazepines are frequently consumed despite harmful medical effects and adverse social consequences, as required by the definition of addiction used . . . is not supported by the available literature." With regard to at least 1 large group of patients frequently seen by family physicians, these statements are untrue.

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It has been shown that many patients with chronic pain conditions receive benzodiazepines despite evidence that they provide little benefit in these patients and may, in fact, be detrimental.[2-4] These medications may impair functioning, the improvement of which is the usual goal in the management of chronic pain, and may even exacerbate pain by lowering the pain threshold. In my own experience with the patients with chronic pain whom I treat, who are functioning poorly and taking benzodiazepines, I have found that many refuse to consider withdrawing these medications. This is despite the fact that many of these patients state that they are seeking any relief they can from their pain and would even be willing to consider painful invasive procedures if they might help alleviate their suffering. Yet the one thing many will not consider is discontinuing the benzodiazepine.

Benzodiazepines are useful medications for many patients. However, the belief that there is little misuse of these medications is contradicted by the literature.

Steven A. King, MD, MS
Director, Division of Pain Medicine
Temple University School of Medicine
Philadelphia, Pa

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In a recent article[1] on addiction to benzodiazepines, the author reported the absence of data linking this drug class to "significant tissue or organ morbidity" and cited a 1983 article as his first reference. Although earlier literature may have suggested that benzodiazepines are relatively safe drugs (as compared with the barbiturates), there is now a body of observational research suggesting that safety is an important problem for subgroups such as elderly patients. For example, an association between benzodiazepines and adverse events such as falls, hip fracture, cognitive impairment, and motor vehicle crash has been demonstrated in elderly patients.[2-10]

I agree with the author's comment that it may be difficult to weigh the benefits and risks of drug therapy and that such analyses involve value judgments. However, to promote informed decision making, clinicians should be aware that certain subgroups of patients, such as elderly users of benzodiazepines, may be exposed to an increased risk of injury.

Roland Grad, MD
McGill University
Montreal, Quebec

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Clinical Pearl

Stearic acid, a saturated fatty acid, was associated with a 37% increase in the risk of stroke, and alpha linolenic acid, an unsaturated fatty acid, was associated with a 28% decrease in the risk of stroke. (*Stroke.* 1995;26:778-782.)

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