LETTERS TO THE EDITOR

Macho rhubarb

EDITOR,—Tim Albert's editorial¹ raises some important questions about communicating through journals. I share his concerns about the purpose and process of writing and publishing scientific articles. Distorting the tortuous IMRAD structure, I express some of mine in a poem. My misgivings about the methodology of writing the text include the apparently common practice of recycling old paragraphs and papers, grafting on the issue of the day and dressing the whole in the current macho style. For the record, I wrote my poem willingly, in my leisure time and for fun.

1 Albert T. Writing for journals: a paradigm lost? *J Epidemiol Community Health* 2000;54:642-3.

Macho rhubarb

Protocol for writing a scientific paper

Abstract	In essence writing rhubarb is cathartic.
Keywords	MeSH, MaCHo, words, recycling.
Introduction	Editors choose rhubarb papers. (Doc K) Authors aim to please them. (Doc K) Most have failed. (Doc K; Doc K) We offer something new.
Aims	We aim to coax an editor to print our narrative of innovative work —a trial which fails to find a case or [cure— which would, if published, raise [awareness and, if widely cited, make us known.
Method	Madly deeply uncontrolled. [Haphazardly we take n samples from our papers; pick the rhubarb, wash it, dock it; sprinkle newer references to spice it, [(Doc K; Doc K) add a slice of topical debate. (Doc K) We stew and taste it, cut and paste until politically correct.
Results	With confidence we p the values, square the chi. Adjusting for machismo, we regress. Rhubarb, rhubarb. Rhubarb tables. Rates of rhubarb. Odds of rhubarb. Male to female ratios of rhubarb. Risk of indigestion.
Discussion	No-one even thinks of mentioning the missing custard, let alone explaining why it curdled. Justifying stringy pulp is whinging; subtle criticism slates instead our [rivals' work. Cutting words, we prune all doubt; oust seem, appear, suggest and might; extrapolate beyond the wild. Pure rhubarb.
Key points	• rhubarb is • editorially-modified • strings of tangy words
References	Doc K. Macho rhubarb. <i>Any journal</i> ; [any year: awaiting acceptance.

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Does method of distribution improve GPs' response rate in questionnaire studies?

EDITOR,—The poor response rate of GPs to postal surveys has long been a barrier to successful research. We were pleased that Stocks and Gunnell¹ systematically studied this longstanding problem.

There are a number of factors contributing to a poor response rate. Stocks and Gunnell¹ studied the influence of the characteristics of the GPs and confirmed that there are such differences between responders and non-responders. However, other factors may also influence response rates, for instance the method of distribution of the questionnaires.

We would like to share the results of a study carried out to investigate the effect of different methods of distribution on response rates. We performed a questionnaire study related to psychiatry, investigating GPs in two similar geographical areas, Solihull and Warwickshire, both in the West Midlands.

The questionnaires were posted to GPs in Warwickshire, with prepaid envelopes provided for reply. The GPs in Solihull received their questionnaires delivered by hand by one of the researchers, and replies were collected from the surgery by the same person two weeks later.

The postal response rate was 50%, while the response rate from the hand delivered area was 60.3%. These results were significant ($p=0.05$, $\chi^2 = 5.860$, Yates's correction = 5.330).

These results show that the method of delivering and collecting questionnaires by hand significantly improves response rates. It also has a number of other advantages, such as an improvement in the researcher's knowledge of the area under study, their relationship with GPs and reducing costs of the study. We would encourage others to consider this method of questionnaire distribution in the future.

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1 Stocks N, Gunnell D. What are the characteristics of general practitioners who routinely do not return postal questionnaires: a cross sectional study. *J Epidemiol Community Health* 2000;54:940-1.

Neonatal nicotine withdrawal syndrome

EDITOR,—We have been assessing the recent in utero exposure to tobacco smoke in newborns from the Barcelona cohort of the AMICS study (Asthma Multicentre Infants Cohort Study).¹ The nursing personnel reported observational symptoms suggesting a possible neonatal nicotine withdrawal syndrome in some of the newborns from smoking mothers.

The published data about this syndrome are scant and include conflicting positions. Whereas some papers admit a neonatal nicotine withdrawal syndrome,² others reject it.³ Although some investigators have shown neuroanatomic disorders in fetus and newborns exposed to smoke during pregnancy,^{4 5} we have not found any study published about the clinical consequences of the withdrawal of

nicotine in newborns from a smoke exposed mother before birth.

To achieve a statistically significant evidence on the existence of neonatal nicotine withdrawal syndrome it would be necessary to recruit a very wide cohort of newborns because of the probable very low prevalence rate of pure neonatal nicotine withdrawal syndrome.

We designed a pilot study to assess if neonatal nicotine withdrawal syndrome might exist among newborns exposed to cigarette smoke. We included all the babies born in the Hospital del Mar in Barcelona during a period of six months from mothers smoking at least in the last four weeks before delivery. A sample of urine was obtained from newborns in the first 12 hours of life. Urinary cotinine, the major nicotine metabolite, was measured in duplicate using a double antibody radioimmunoassay.¹ The Finnegan clinical score⁶ was assessed by nursing personnel three times a day for three consecutive days. This test indicates neonatal withdrawal syndrome (positive result) when two consecutive scores over 8 are obtained, whereas a zero score indicates absence of withdrawal syndrome. We excluded newborns with conditions that could change Finnegan test's results, for example, sepsis, prematurity, asphyxia, maternal consumption of substances like coffee, cola beverages, chocolate, or drugs of abuse. Informed consent was obtained in all cases and the study obtained the permission from the local ethical committee.

Thirty three newborns fulfilled all inclusion criteria. The median concentration of urinary cotinine was 195.4 ng/ml. Only six newborns from mothers who declared to smoke less than three cigarettes/day had low levels of urinary cotinine (< 50 ng/ml). In the other cases, range of concentration varied between 123.1 and 1050.2 ng/ml. We did not find any positive result of the Finnegan test. In particular, 22 newborns showed a zero score, 16 of them (72%) with urinary cotinine lower than 195.4 ng/ml. However, we recorded scores between zero and 8, especially by irritability and tremor over the first 24 hours of life, in 11 newborns. These newborns (seven with 1-4 score and four with 5-7 score) presented urinary cotinine in the higher part of the range (median concentration: 412.2 ng/ml) and were from mothers who declared to smoke at least 20 cigarettes/day.

From the results of this pilot study, we conclude that neonatal nicotine withdrawal syndrome seems to be very uncommon. However, the observation of isolated temporary symptoms in newborns from heavy smoker mothers probably suggests an association. Finally, more research on this topic is needed, especially to investigate long term health status in neonates with prenatal exposure to cigarette smoke.

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1 Pichini S, Basagaña X, Pacifici R, et al. Cord serum cotinine as a biomarker of foetal

- exposure to cigarette smoke at the end of pregnancy. *Environ Health Perspect* 2000;108:1079–83.
- 2 Wagner CL, Katikaneni LD, Cox TH, *et al*. The impact of prenatal drug exposure on the neonate. *Obstet Gynecol Clin North Am* 1998; 25:169–94.
 - 3 Hughes JR, Higgins ST, Bickel WK. Nicotine withdrawal versus other drug withdrawal syndromes: similarities and dissimilarities. *Addiction* 1994;89:1461–70.
 - 4 Slotkin TA. Fetal nicotine or cocaine exposure: which one is worse? *J Pharmacol Exp Ther* 1998;285:931–45.
 - 5 Eriksson P. Developmental neurotoxicity of environmental agents in the neonate. *Neurotoxicology* 1997;18:719–26.
 - 6 Finnegan LP. Neonatal abstinence syndrome. In: Nelson NM. *Current therapy in neonatal-perinatal medicine-2*. Toronto: BC Decker, 1990:315–20.

BOOK REVIEW

Handbook of religion and health. Harold G Koenig, Michael E McCullough, David B Larsen. New York: Oxford Press, 2001.

During the past few years there has been a resurgence in concern with the role of religion and spirituality and health. Before that there were anecdotal reports, as well as a beginning awareness of the impact of other spiritual belief systems on human illness and

growth. This can be seen in the non-Western treatment activities in a wide variety of cultures around the world.

In several instances, it takes a willingness to suspend judgement and be open to other paradigms of health. Many use the concept of balance, and a holistic multidimensional or ecological approach. Those belief systems, most familiar to me, combine much training, with the learning of a vast number of associated skills. Medicine men, healers, are now being constantly studied.

The challenge in the West, is to see how our Western belief systems have a place both for spirituality and religion. As we are Western trained hard scientists, we demand proof, using statistical analysis and concrete outcome studies. These have begun, with showing that membership in a religious organisation, as well group prayer has resulted in improved outcomes.

Many wanted a definitive overview of both the history of science and religion, but also on mental health issues and physical illness. The authors have done a very thorough overview of all we know at this time. Clearly spirituality and religion affect growth and development, the creation of pathology and the treatment of dis-ease. They have not got the total answer. However, they have laid a groundwork for understanding a complex set of issues. They review those studies that exist, critically interpret their findings, and offer new ways of “asking the question.” They hypothesise the possible mechanisms, and suggest new directions.

One of the most important developments is the emergence of psycho-neuro-immunology. These studies are showing how social situations affect psychological processes, brain function and then the immune system. How healing and faith fit in is not as yet clear.

When one is concerned about the current health care crisis, the role of churches, mosques and temples are important. Not only are they providing ancillary services, but many are giving much direct help to all kinds of groups, the elderly, disabled, minority, homebound, homeless and more. When one turns to improving the quality of life, churches offer community. Community and networks, by themselves support individuals and families, but they are shown to improve healing.

There is now a faith-health endeavour in the US, where schools of public health and schools of theology, teach and start research on these issues. The link in Berkeley with the Graduate Theological Union and the School of Public Health has many new community connections.

I encourage anyone concerned with faith and health, to get this book. More so, it will encourage us to look at the multifaceted relationships of people, their beliefs, environments and health. I call this ecological ecology. It's not done, because it's too hard.

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