

Thomas C. Psychosocial needs in cancer patients related to religious belief. *Palliat Med* 2003;17:49-54.

THE AUTHORS REPLY: The findings of our observational study cannot be used to predict the effects of an intervention. Consequently, our article had little to say about the implications of our findings; in it, we suggest that parents seeking advice might benefit from the finding that none of the parents we questioned regretted having talked about death with their child. We also emphasize the responsibility of health care workers to help parents respond to the needs and wants of their terminally ill child.

To intervene when parents do not seek advice is more problematic. As highlighted by Dr. Davies, the finding that 189 parents in our study did not regret not having talked about death indicates that we cannot conclude that every parent with a terminally ill child should talk with the child about death. As stated by Dr. Tanvetyanon, our data do not support an intervention in which parents are asked to talk about death despite their belief that silence is in the child's best interest. Such unjustifiable implications can harm some parents and children. We have no indication that nontalkers constitute a subgroup of parents who also would have regretted talking, as

suggested by Dr. Tanvetyanon. We found that no religious parent regretted having talked about death and that 35 percent of the religious parents regretted not having talked about death with their terminally ill child.

As Dr. Tanvetyanon points out, the child's needs and wants are central. Our initial interviews with parents and their free comments during the main survey indicate that parents sensed the child's unmet needs and thereby regretted not having talked. We found that the child's age, as noted by Dr. Tanvetyanon, is related to the child's awareness of impending death and possibly also to predictors of the child's need to talk. Yet we cannot be certain when talking, or when not talking, about death is in the best interest of an individual child. Whether or not to intervene, when we sense that a child might benefit from talking, remains a matter of personal sensitivity, communication skills, and clinical experience.

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Risk Stratification for Prophylactic Ablation in Asymptomatic Wolff–Parkinson–White Syndrome

TO THE EDITOR: The most surprising finding in the article by Pappone et al. (Sept. 16 issue)¹ is not that prophylactic ablation results in a low risk of life-threatening arrhythmias. It is that their control group had an extraordinarily high rate of such events. The authors enrolled asymptomatic children and considered them to be at high risk if they had inducible atrial fibrillation or atrioventricular reciprocating tachycardia. Neither criterion is widely accepted as a feature that defines a high risk for sudden death. Indeed, Pappone et al. did not consider pathway refractory periods or preexcited RR intervals among their inclusion criteria, making a comparison with published data impossible. After randomization, 3 of 27 control patients (11 percent) had life-threatening events — a very high rate. This finding is inconsistent with published observations² and our experience.

How do the authors account for the high rate of attacks in the control group? The question is crit-

ical to their conclusions and has serious implications for the assessment of young patients with the Wolff–Parkinson–White syndrome. If the risks for the untreated patient are overstated, then the study is misleading, and the authors' conclusions might result in the unnecessary application of ablation in many asymptomatic children.

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1. Pappone C, Manguso F, Santinelli R, et al. Radiofrequency ablation in children with asymptomatic Wolff–Parkinson–White syndrome. *N Engl J Med* 2004;351:1197-205.

2. Munger TM, Packer DL, Hammill SC, et al. A population study of the natural history of Wolff–Parkinson–White syndrome in Olmsted County, Minnesota, 1953–1989. *Circulation* 1993;87:866-73.

THE AUTHORS REPLY: We thank Dr. Triedman and colleagues for raising fundamental questions about risk stratification for the accurate selection of asymptomatic persons with the Wolff–Parkinson–White syndrome who might benefit from prophylactic ablation. We understand that for many years, the identification of high-risk patients relied mainly on the finding of pathway refractory periods, pre-excited RR intervals, or both — features that unfortunately are associated with very low specificity, despite a high negative predictive value. We empirically attempted to find other criteria to identify high-risk patients by using a specific protocol for inducibility, which demonstrated not only sensitivity but also specificity.^{1,2} Accurate risk stratification among asymptomatic persons with the Wolff–Parkinson–White syndrome is undoubtedly necessary³ and must be validated prospectively in a large cohort of untreated persons.

By preliminary analysis of pooled data from 477

untreated, asymptomatic persons with the Wolff–Parkinson–White syndrome, we found that inducibility, multiple pathways, and younger age predict future life-threatening events, including syncope, cardiac arrest, and sudden death. On the basis of these three variables, we propose a scheme for risk stratification into low-risk (<20 percent), intermediate-risk (20 to 50 percent), and high-risk (>50 percent) categories with possible implications for decisions concerning prophylactic ablation.

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2. Pappone C, Santinelli V, Manguso F, et al. A randomized study of prophylactic catheter ablation in asymptomatic patients with the Wolff–Parkinson–White syndrome. *N Engl J Med* 2003;349:1803-11.
3. Wellens HJJ. Catheter ablation for cardiac arrhythmias. *N Engl J Med* 2004;351:1172-4.

Attracting Students to Primary Care

TO THE EDITOR: Whitcomb and Cohen¹ and Fincher² (Aug. 12 issue) call for changing the training settings for students and residents in primary care to reflect the types of environments in which high-quality primary care can best be provided, with use of “models of efficient, interdisciplinary, patient-friendly care in academic medical centers and exemplary community-based practices.” Although I agree with these sentiments, if these training settings do not reflect practice in the real world, we run the risk of alienating potential future primary care trainees with “bait and switch” tactics. Unfortunately, although the chronic care model, for example, provides a reasonable blueprint for how such care could be structured,³ implementation is precluded by the current health insurance and health care systems in the United States. A recent article on the Pursuing Perfection initiative suggests that, even with substantial grant funding, such exemplary practices are not financially sustainable.⁴ It seems unlikely that anything short of complete reform of the U.S. health care system will make primary care attractive to large numbers of medical students.

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3. Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH. Improving the quality of health care for chronic conditions. *Qual Saf Health Care* 2004;13:299-305.
4. Kolata G. Health plan that cuts costs raises doctors' ire. *New York Times*. August 11, 2004:A1.

TO THE EDITOR: Students shun primary care because primary care today is unattractive. We are trapped in a catch-22. Insurers, both commercial and governmental, try to reduce payments for medical care whenever possible. When they reduce their payments per visit, we increase the number of visits. So they cut payments again. If more patients are to be seen, visits must be shorter, and problems simple and discrete. Indeed, the coding system rewards us for seeing new patients with acute problems. Peo-