outcome but the one that produces the outcome that the patient favours. When patients are mentally incompetent an advance directive may express their wishes. Having ascertained that the directive was made in the light of knowledge of the medical facts and a clear understanding of the implications, doctors should be morally and legally obliged to respect the patient's wishes.

The concern that developments in treatment will not be accommodated is unrealistic. Sudden cures for incurable diseases are regrettably rare. If a previously untreatable disease became treatable, however, I believe that the courts would support a doctor who disregarded an advance directive drawn up before the treatment was available.

A more regular occurrence in my practice is that I wish to know an unconscious patient's views on what is an acceptable quality of life, given that he or she is now critically ill in an intensive care unit. Often the best we can achieve is survival with severe neurological damage or other impairment. Once we have ensured survival with aggressive, unpleasant, and costly treatment and have delivered a quality of life that is unacceptable to the patient neither we nor the patient can undo the harm.

An increasing number of patients express their wishes about limitation of treatment before their admission to our unit. Often they are former patients who found the quality of life on discharge barely acceptable and cannot contemplate survival with additional physical or mental impairment. I am happy to respect those wishes, as I would like my wishes to be respected were I in that position. I see no difference between this scenario and that of a Jehovah's Witness who refuses a blood transfusion—a situation in which the law and medical ethics are quite clear.[2] When a patient's wishes require a doctor to act contrary to his or her conscience the doctor must refer the patient to another practitioner. The alternative, of doctors carrying out treatments contrary to the patient's stated wishes and getting away with it because the patient is not mentally or physically competent to resist, is something that no doctor or the BMA could sanction.

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Coffee intake and death from coronary heart disease

Coffee may have both short and long term effects

EDITOR,—I Stensvold and colleagues found that a previously reported association between coffee consumption and mortality from coronary heart disease had been weakened by six more years of follow up, and they suggest that this could be due to a decreased intake of boiled coffee.[1] When, however, they excluded subjects who were referred to a doctor because of their coronary risk, and when they analysed more than 23 000 subjects included some years later in an identical study (thus using a more recent evaluation of the distribution of risk factors), the coefficient for coffee drinking was slightly higher.

Between 1990 and 1992 we performed two case-control studies in patients with first confirmed acute myocardial infarction and ischaemic stroke confirmed by computed tomography; these were conducted in parallel and with the same operational characteristics (same hospitals, interviewers, etc) in Abruzzo (southern Italy). Altogether 513 patients with acute myocardial infarction (median age 58) and 237 with ischaemic stroke (median age 63) were recruited along with hospital controls (matched by five year age group and sex) with acute diseases not related to cardiovascular risk factors. Our results (table 1) accord with those of a recent meta-analysis[2] and with the first six years of follow up in Stensvold and colleagues' cohort study and support the existence of a short term effect of coffee intake. No clear relation could be found between coffee intake and ischaemic stroke, possibly because of the low number of subjects with high levels of coffee consumption who were older. In Greenland's meta-analysis recent cohort studies had more positive results than older ones, while a fairly homogeneous increased risk was found in case-control studies.[2]

Table 1—*Odds ratio of myocardial infarction and ischaemic stroke according to daily coffee intake*

Daily coffee intake (cups)	Myocardial infarction: Cases/controls	Myocardial infarction: Odds ratio* (95% confidence interval)	Ischaemic stroke: Cases/controls	Ischaemic stroke: Odds ratio* (95% confidence interval)
0	56/97	1.0	57/57	1.0
1	91/134	1.0	61/80	0.6 (0.3 to 1.2)
2	121/156	1.1 (0.6 to 1.8)	63/59	1.4 (0.7 to 2.8)
3	90/59	1.9 (1.0 to 3.4)	30/25	0.7 (0.3 to 1.7)
4	66/32	2.9 (1.3 to 6.5)	10/14	0.6 (0.2 to 1.7)
≥5	89/35	3.8 (1.8 to 7.9)	16/2	15.3 (2.4 to 97.5)

*Conditional multiple logistic model adjusted for social class, education, alcoholic beverages, smoking habit, diabetes mellitus, hypertension, blood cholesterol concentration, body mass index, physical activity, and family history of myocardial infarction and stroke.

Cohort studies cannot easily allow for the changes in lifestyle habits that occur during follow up: coffee intake peaks between ages 40 to 49 and then declines,[3] and assessment of coffee consumption 10 or more years before death from coronary heart disease may be a poor indicator of more recent consumption.[4] In addition, non-fatal cardiovascular events (for example, acute myocardial infarction, angina pectoris, revascularisation procedures) could result in patients stopping smoking as well as reducing their coffee intake. The effect of coffee intake in Stensvold and colleagues' study (this information was collected at baseline) could therefore have been weakened as follow up was prolonged.

In summary, the existence of a short term effect of coffee intake in addition to a long term one (on atherosclerosis) cannot be easily dismissed. Negative results of cohort studies could be associated with a modification of lifestyle habits (including stopping drinking coffee and lowering intake in addition to changing the type of coffee consumed), due either to aging of the cohort or a worsening health status during follow up.

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Coffee drinking was compared with tea drinking in monozygotic twins in 18th century

EDITOR,—One of the more peculiar attempts to throw light on the question of whether drinking coffee is bad for one's health[1] was carried out in the 18th century by King Gustaf III of Sweden. He is better known for instituting the Swedish Academy, the august body of 18 (18 because the king liked the sound of the Swedish word for that number, *ardeton*) whom Alfred Nobel later selected to award his prize in literature.

A pair of monozygotic twins had been sentenced to death for murder. Gustaf III commuted their death sentences to life imprisonment on the condition that one twin drank a large bowl of tea three times a day and that the other twin drank coffee. The twin who drank tea died first, aged 83—a remarkable age for the time. Thus the case was settled: coffee was the less dangerous of the two beverages. The king, on the other hand, was murdered at a masked ball in 1792 at the age of 45 and became the subject of an opera by Verdi.

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Care management

Care programme approach constitutes good management

EDITOR,—Max Marshall is correct in distinguishing between "standard" case management and "assertive community treatment."[1] Clearly, the benefits suggested by research on assertive community teams cannot be expected for routine community teams, which have lower ratios of staff to patients. This does not mean, however, that the care programme approach offers no benefits to patients and their relatives. It is hard to see how the components of the care programme approach can be regarded as anything but good practice for people with a mental illness. Surely patients should have their needs assessed and care plans recorded. And, surely, any care that is instigated should be reviewed and there should be one professional