Training doctors did not improve careseeking in mothers

JEREMY HORNBERG

Training doctors to counsel mothers about when to seek care for their sick children did not improve mothers' careseeking behaviour, but it did affect their appreciation of the need to seek care. Mohan and colleagues trained a group of doctors from 12 primary care centres in rural India on how to educate mothers to detect signs of serious illness and seek medical attention (p 266). Although doctors' performance improved after training, six months later it had declined substantially.

POEM*

Open hernia repair better than laparoscopic

Question Is an open or laparoscopic approach better for inguinal hernia repair?

Synopsis Open surgical repair of inguinal hernias involves use of a prosthetic mesh and the possibility of local anaesthesia, and the patient is often discharged within a few hours of the procedure. A laparoscopic procedure has been introduced that requires general anaesthesia but claims to reduce postoperative pain and allow earlier return to usual activities. Which is better? The authors randomised (allocation concealed) 2164 patients at 14 Veteran's Affairs medical centres to receive either the open or laparoscopic procedure. Of the 2164 initially randomised, 1983 actually had surgery. The surgical protocol was standardised for each type of procedure, and surgeons must have performed at least 25 of their chosen procedure to qualify for the study. Patients were followed up for two years, and 1696 (86%) completed the follow up. Crossover from laparoscopic to open repair occurred in 9.8% of patients, compared with only 1.6% crossing over in the other direction. Patients were analysed by the group to which they were originally assigned, which is appropriate. Patients who had laparoscopic repair experienced less pain after surgery and returned to work sooner (4 v 5 days; 95% confidence interval for difference 1.1 to 1.3). However, the difference in pain was generally minor, between 6 and 10 on a 100 point visual scale (in general, differences less than 15 points are unlikely to be clinically important). There were more complications with laparoscopic repair, including more life threatening complications (0.1% v 1.1%; odds ratio 11.2, 1.3 to 95.3). The recurrence rate at two years was also lower in the open repair group (4.9% v 10.1%; absolute risk reduction 5.2%; number needed to treat = 20).

Bottom line Although laparoscopic repair is associated with a small reduction in pain and gets your patient back to work a day sooner, it carries a greater risk of serious complications and recurrence.

Level of evidence 1b (see www.infopoems.com/levels.html). Individual randomised controlled trials (with narrow confidence interval).

Neumayer L, Giobbie-Hurder A, Jonasson O, et al. Open mesh versus laparoscopic mesh repair of inguinal hernia. *N Engl J Med* 2004;350:1819-27.

©infoPOEMs 1992-2003 www.infoPOEMs.com/informationmastery.cfm

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

My last choice

Do you need approval from an ethics committee to ring up chief executives of hospitals and ask them questions? As a journalist, a member of parliament, or a confidence trickster you wouldn't, but if you are a researcher who has drawn up a protocol you might. Ethics committees, which were devised to protect vulnerable patients from some abuse, have forgotten why they were created and have begun to equate chief executives with the unconscious or the mentally incompetent. They have, in other words, spun out of control.

No fewer than five sets of researchers describe a series of Kafkaesque experiences with ethics committees that have made research difficult or impossible (p 277, p 280, p 282, p 286, and p 288), and an editorial analyses other barriers to research (p 241). We commissioned only the editorial; the other pieces arrived spontaneously, reflecting frustration, anger, and even despair among researchers. There must, of course, be a balance between the needs of research and the interests of patients—but, as healthcare workers lack evidence for much of what they do, research is important. It is unlikely to be in the public interest to make it more difficult to do research.

And that is almost it. I have 280 words before I get off the *BMJ* stage. I end my time as editor on 30 July, and I go not alone but with Sir Anthony Grabham, the chairman of the BMJ Publishing Group's board and the holder of a great restoration comedy name. I've been around for only a quarter of a century, whereas Tony has done 50 years with the BMA, moving smoothly from young firebrand through steady hand at the tiller to elder statesman. He became chairman of the council of the BMA at a time when membership threatened to fall below 50% and the finances were distinctly shaky. He turned things round, and profits of the BMJ Publishing Group have also grown since he became chairman of the board. We, the staff, are grateful to him for his stewardship.

Editors of the *BMJ* are, my predecessor insisted, alternating fools and bastards. He was clear that he was a bastard rather than a fool and that his predecessor was a fool. That makes me a fool, and I accept the judgment without a murmur. But I hope that I've been a jolly fool. Even more ambitiously, I would aspire to be like the fool in *King Lear*.

It is time now for me to climb into the picture of all the past editors of the *BMJ* that hangs outside our office. They are mostly glum looking with lots of facial hair. I will look down from my space on my ex-colleagues for a few years before somebody takes down the picture, puts it on eBay, fails to get a buyer, and then throws it out. I find the thought of oblivion deeply comforting, but even more comforting is the thought of my successors doing wonderful things. And I know they will.

Richard Smith *editor* (rsmith@bmj.com)

To receive *Editor's choice* by email each week subscribe via our website: bmj.com/cgi/customalert