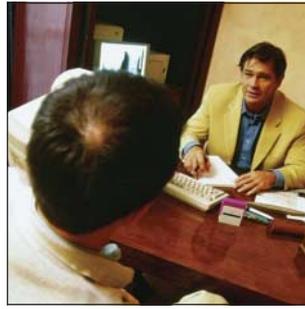


Patient involvement in healthcare decisions is hard on doctors

Doctors are encouraged to involve patients in making treatment decisions, but this poses challenges for doctors. In a clinical review article, Say and Thomson (p 542) discuss these challenges, which include the extra time and effort required to elicit patients' perspectives and the negotiations needed when the preferences of the doctor and the patient differ.



Doctors often do not have the interpersonal skills to sufficiently communicate risk. A dearth of appropriate information to support patients' treatment decisions is also a problem, say the authors.

POEM*

Warming diphtheria-tetanus vaccines doesn't reduce pain

Question Does warming diphtheria-tetanus vaccine reduce the discomfort of the injection?

Synopsis Many healthcare providers warm the phials containing diphtheria-tetanus vaccine before injection to reduce pain and side effects. A convenience sample of 150 patients aged 16 years or older cared for in an emergency department who required a diphtheria-tetanus booster vaccination was identified. Subjects were randomly assigned in a double blind fashion (concealed allocation assignment) to receive a vaccine that had been given no deliberate warming ("cold"); rubbed for one minute between a nurse's hands ("rubbed"); or placed in a 37°C warming cupboard for five minutes ("warmed"). The temperature of the liquid in the syringe was measured with a flux wire temperature probe immediately before injection. All outcomes were assessed five minutes after injection and at 24 and 48 hours by individuals blind to treatment group assignment. A total of 92% of the patients were available for complete follow up. With intention to treat analysis, no significant differences between the vaccine groups in the incidence of pain or the number of adverse reactions after injection were noted at any of the follow up evaluations. Interestingly, the temperature of the vaccines immediately before injection approached ambient temperature in all three groups, most likely secondary to the large surface area of the syringe relative to the small amount of fluid (0.5 ml). I would have liked the authors to have evaluated the pain immediately after injection to see if there was any difference between the groups.

Bottom line Warming the adult diphtheria-tetanus vaccine either by rubbing in the hands or with a warmer does not reduce the incidence of pain or adverse reactions after injection. Although the study was done only on adults, there is no reason to assume that warming is beneficial for children.

Level of evidence 1b (see www.infoPOEMs.com/resources/levels.html); individual randomised controlled trials (with narrow confidence interval).

Maiden MJ, Benton GN, Bourne RA. Effect of warming adult diphtheria-tetanus vaccine on discomfort after injection: a randomised controlled trial. *Med J Aust* 2003;178:433-6.

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

Editor's choice Be bold and be sensible

"Fortune assists the bold," wrote Virgil, thinking of the Trojan wars not of medicine. But there is room for boldness in medicine, and I see examples in this *BMJ*.

The Global Initiative on Chronic Obstructive Lung Disease—a pretentiously named outfit that must have slavered over its acronym GOLD and which is backed by the National Institutes of Health and the World Health Organization—warns against using opioids in managing patients with dyspnoea and chronic obstructive pulmonary disease (p 523). We all know that opioids are respiratory depressants and that such patients have almost no respiratory reserve. Yet some experienced doctors believe that morphine can help patients with refractory dyspnoea. A bold group from Australia has now conducted an adequately powered crossover trial of oral morphine against placebo in patients with refractory dyspnoea in whom the underlying aetiology is maximally treated (p 523). The morphine produced important improvements. The authors think that the results are generalisable to primary, respiratory, and palliative care settings but warn that a bigger study is needed to evaluate safety.

Louis Lasagna, the man who "created clinical pharmacology," was clearly bold. His obituary describes how 50 years ago he injected saline subcutaneously into surgical patients with steady, severe wound pain and found that roughly a third reported satisfactory relief of pain (p 565). It was essential, he argued, to consider the placebo response in clinical trials.

England's National Institute of Clinical Excellence (NICE) seems to be getting bolder, perhaps because its chairman, Mike Rawlins, is also getting bolder. For years he was chairman of the Committee on Safety of Medicines, but at a recent meeting he was dismissive of what he described as its traditional method of a lot of old boys sitting round a table and issuing instructions. It's too paternalistic. A better method might be to give people clear information and let them make up their own minds.

NICE has now decided that in vitro fertilisation works and should be available on the National Health Service (p 511). We didn't need NICE to tell us that in vitro fertilisation works, but the idea that it should be available to all subfertile couples is bold. Most such couples have had to go to the private sector to get treatment. The cost of treating all couples would be hundreds of millions of pounds each year, meaning that treatments for other patients would have to be denied.

Unfortunately it's not NICE's job to tell the NHS what should be ditched to free up the millions needed, but it does offer some guidance on treatments that shouldn't be used—strictly on the evidence. Thus it last week advised against the use of thiazolidinediones (glitazones) in patients with type 2 diabetes except in narrow circumstances (p 520). Diabetes UK immediately leapt in and condemned the advice as "rationing." NICE should be bold enough never to fear "the r word" that politicians don't dare to speak.

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