insinuate this. In Denmark it is good clinical practice to treat an empyema with drainage. Most of our patients treated with sinus puncture felt great relief afterwards, and no one found the treatment barbaric.

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Ensuring that guidelines are effective

Give them to the patient

EDITOR,—Richard Thomson and colleagues state that guidelines can help patients and professionals to make decisions about health care.[1] But professionals may be reluctant to offer copies of guidelines to their patients. There are at least seven potential advantages in doing so.

Firstly, it could help give patients that sense of control over their treatment and care that comes from knowing in advance what is going to happen.

Secondly, it could help patients to discuss with professionals the reasons for specific treatments and procedures and to negotiate omissions or additions to the guidelines to apply to themselves. This could enhance clinical freedom rather than restrict it, since clinical freedom to act derives from the patient's agreement to the course of action. Clinicians should be responsible to their patients, not for them.[2]

Thirdly, it could result in improvements in informed consent as a consequence of my second point. Informed consent and informed choice depend on rational discussion, as Szawarski has pointed out.[3] And the requirement for informed consent applies potentially to all procedures, not just some.

Fourthly, it could increase patients' safety because they could check that all the steps in the guidelines were being carried out.

Fifthly, it could increase compliance, since guidelines would serve as aides memoire to patients.

Sixthly, it could enhance clinical observation and thinking, for discussions with patients should lead to some matters that are taken for granted being questioned and should increase sensitivity to patients' experiences of clinical care.[4]

Finally, it could help in the dissemination of guidelines, since once patients knew that guidelines existed they would begin to expect them to be used.

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Pilot of patient held guidelines is under way

EDITOR,—Richard Thomson and colleagues rightly draw attention to the need to consider ways in which the successful implementation and use of agreed guidelines can be enhanced.[1] The need for the guidelines to be available for use at the time of contacts between patients and carers has been highlighted before.[2] Not enough thought seems to have been given, however, to ways in which this might be achieved. Attaching guidelines to the medical record limits their use to situations in which the record is available. Having guidelines on a desktop computer is not feasible in most circumstances, and unless there is a networked system this would still depend on individual clinicians ensuring that they were entered and keeping them up to date.

We are currently working with interested clinicians in Sandwell to develop local clinical guidelines for diabetic care by general practitioners and practice nurses. It occurred to us that a cheap and effective way of ensuring that guidelines were available at consultations would be to give them to patients and ask the patients to carry them at all times along with their diabetes cooperation card. Experience of patient held records in obstetrics and community child health suggests that patients can be relied on not to lose documents relating to their care. We also hope to involve patient groups in agreeing the detail of our guidelines; the guidelines will draw patients' attention to aspects of diabetic care in which the patient has to make decisions. After all, the accepted definition of guidelines is that they are systematically developed statements to assist practitioners' and patients' decisions about appropriate health care for specific clinical circumstances.

We do not know of any systematic effort to involve patients in the development, dissemination, and use of clinical guidelines on the management of a chronic condition such as diabetes. The British Diabetic Association's attempt, through information leaflets, to inform patients of the care they can expect is limited by the relatively low take up of membership of the association and by the lack of local professional ownership of the material. We believe that locally agreed guidelines, given to patients as well as to professionals, will be far more effective in informing and empowering patients. The patients know what care processes to expect at specified stages, and the clinicians can use the statements that are specifically for patients to reinforce the message that successful treatment depends as much on the patient as on the doctor.

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Acute pain services

Purchasers must be prepared to pay for a multidisciplinary team

EDITOR,—An acute pain service provides continuity in the management of acute pain by narrowing the chasm between the prescriber, the person who gives analgesia, and patient. Hence the results of the survey of acute pain services in the United Kingdom are disappointing but hardly surprising to those who manage acute pain.[1] I support the authors' recommendation that purchasers should demand optimal management of acute pain and be prepared to pay for it. More importantly, purchasers should ensure that they are paying for a service that uses reported indicators of the success of such a service.

Several of these indicators have been described. Firstly, there should be daily supervision by a consultant, with more than one consultant being involved in the service.[2,3]

Secondly, a junior doctor could be assigned to the service for a monthly rotation. He or she should have no other responsibilities to ensure rapid attendance for serious complications, which have a reported rate of 0·48-1·2%,[2,3,5] and unsatisfactory analgesia, which has a reported rate of 10%.[3,4] Such a rotation should not be considered lightly. Apart from having clinical duties, the doctor could participate in a continuing teaching programme to accommodate the rapid turnover of junior medical and nursing staff, the development or redesigning of protocols, audit, and research.

Thirdly, care after regular working hours could be provided by a dedicated team.[3]

Fourthly, an acute pain nurse could help introduce standard protocols to nursing staff,[4] pinpoint and solve nursing administrative problems,[3] and teach junior staff.

Fifthly, the pharmacy should be asked to provide premixed solutions for patient controlled and epidural analgesia. This would reduce the labour of junior doctors and nurses, allowing greater clinical commitment.

The acute pain team is a multidisciplinary team responsive to patients' needs around the clock. Purchasers must be prepared to pay for this.

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Work is needed to show that good quality analgesia improves outcome of surgery

EDITOR,—Fewer than half the hospitals in the United Kingdom that were surveyed by M Harmer and colleagues had established formal acute pain services.[1] On the other hand, before the scathing report by the Royal College of Surgeons of England and the College of Anaesthetists on pain after surgery[2] there were almost no such services. To that extent, the report has had a beneficial effect. Acute pain teams, new concepts such as pre-emptive analgesia (the reduction of pain after injury by the administration of analgesia before injury) and balanced analgesia (the concomitant use of regional anaesthesia, non-steroidal anti-inflammatory drugs, and opioids), and new techniques such as intravenous and epidural patient controlled analgesia have improved the quality of postoperative pain relief.[3]

Although good quality analgesia is a worthwhile humanitarian and ethical goal in its own right, however, it is only the means to an end: the improvement of surgical outcome. Most work published in recent years that has compared different regimens of postoperative analgesia has concentrated on the quality and the safety of the techniques and on satisfaction among patients and staff. Because so few papers have addressed the issue of outcome, little evidence exists that good quality analgesia itself greatly improves it.[4]

Harmer and colleagues wish to see purchasers "demand optimal acute pain management from provider units—and be prepared to pay for it." Purchasers are more likely to do this if they are persuaded that analgesia improves not only