Evidence-based language

Editor—Chooi and colleagues\(^1\) have once again drawn our attention to the noxious power of ill-chosen words.\(^2\) Our speciality is beginning to realize that sophisticated anaesthetic techniques can be sabotaged by simple, thoughtless errors in communication. We now believe that there is an opportunity for the Royal College of Anaesthetists to embrace the current evidence and thus catalyse two desirable developments.

First, widespread adoption of ‘evidence based language’ has the capacity to attenuate the distress of invasive medical procedures. Lang and Laser’s\(^3\) excellent textbook catalogues a wide range of linguistic and behavioural approaches (supported by data) with the potential to alleviate pain and anxiety. It remains depressingly common to hear anaesthetists using expressions such as ‘bee sting’ and ‘sharp scratch’. These clumsy verbal relics from the 1970s were asserted, without evidence, to be beneficial. Dutt-Gupta and colleagues\(^4\) demonstrated that the opposite was true. We are concerned that trainees are still being taught to use these obsolete language rituals.

Secondly, we should consider the implications of careless language for informed consent on the day of surgery. In the weeks preceding elective surgery, it is entirely sensible for patients to receive as much balanced information as possible. However, we suggest that the day of surgery should be handled differently. For decades, anaesthetists have acquiesced under constant threat from our friends in the legal profession. In consequence, one hears ever more exhaustive lists of complications being discussed in the minutes before induction of anaesthesia. Patients are naturally tuned in to hear the worrying bits. And so, ironically, in an era when anaesthesia has never been safer, patients have never been more convinced that they are doomed! Officious recital of endless lurid complications on the day of surgery is, in our opinion, both professionally clumsy and ethically questionable. We feel that our College is ideally placed to confront the lawyers and to spell out the deleterious effects of legalistic defensiveness on our patients.

Language matters to patients. Rarely does an opportunity to alleviate distress with zero cost present itself. It is time to follow the evidence.


declaration of interest

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J. G. Allen*
E. Cervi
King’s Lynn, UK
‘E-mail: jon.allen1@virgin.net


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Intravenous or perineural dexamethasone for interscalene brachial plexus block: the equivalence not yet proven

Editor—We read with interest the article by Desmet and colleagues\(^5\) comparing i.v. and perineural dexamethasone. The results of the study suggest that both i.v. and perineural dexamethasone are equivalent in increasing the analgesic duration of single-shot interscalene block (ISB). Although the results of the study are important to clinical practice, especially with the recent evidence of neurotoxicity in animal studies on peri-neural dexamethasone,\(^2\) a few methodological issues of the study need clarification.

The hypothesis of the study was that dexamethasone prolongs the duration of single-shot ISB regardless of the route of administration. Based on their hypothesis, the study is appropriate for an equivalence design. The inclusion of a ropivacaine-only group is not necessary for hypothesis testing, as i.v. dexamethasone has been shown to have analgesia effect in the postoperative period.\(^3\)

There is no indication in the article specifying that the dexamethasone used during the study was preservative-free or not, since the preservatives may have neurotoxic properties.\(^4\)

The authors have tested motor blockade of fingers to define block success rate along with pain scores. This cannot be considered as a valid method of testing ISB as a recent study has shown that only 15% (95% confidence interval, 6–33%) of individuals receiving ISB had surgical block of the hand and forearm.\(^5\)

The authors have used 30 ml of 0.5% ropivacaine for the block. This certainly is not the standard of care in our practice since the use of lower volume of local anaesthetic under...