Correspondence

Structural aspects of anaesthetic care

To the Editor:
I was very interested in the Editorial (CJA 1994, 41: 661–6) by Davies and Priddy. Anaesthetists should be aware that hospital accreditation as carried out by the Canadian Council on Health Facilities Accreditation (CCHFA) is changing its focus from "paper" standards towards a concern for the "client." The client includes the patient, the family, all types of hospital staff including physicians, and often the community.

The process is mainly carried out by the hospital before the survey and includes responses to questions related to qualifications, physician resources, physical resources including equipment, patient documentation, aspects of continuous quality improvement, etc., etc. The Chief of the Anaesthesia department will be involved in the completion of the questionnaire. It is here that the peer review programme exemplified by ASPENS in Nova Scotia would provide a very useful addendum to the facility comments part of the questionnaire. Each hospital knows when the CCHFA survey will occur and it would be useful for peer review of the anaesthetic department to occur about six months before this.

The CCHFA survey team, which includes one physician, spends between three and five days in the large acute care hospital. That physician is almost never an anaesthetist but he/she will meet with the chief of anaesthesia and tour the OR suite and PACU for about one hour. It should be stressed at that time by the chief that the department follows the CAS guidelines and the equipment meets CSA standards. However, the new standard being developed for use in 1995 is generic and does not specify anaesthesia equipment under resources management. I suspect that if CCHFA tried to specify each type of equipment in its presurvey questionnaire, the amount of paper required would be excessive.

There is no doubt that the anaesthesia department can improve the level of accreditation award for a hospital by being prepared with a peer review done before the CCHFA survey. Deficiencies noted and presented during the accreditation process will "stimulate" the hospital administration to rectify them either before the survey or following receipt of a recommendation from CCHFA.

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REPLY

We thank Dr. Sellery for his interest in our editorial and his comments. We are in agreement with him (as we suggested) that an ASPENS-like review precede the CCHFA site visit. As Dr. Sellery mentions, such a link would promote the identification and correction of any deficiencies. However, we have concerns about the promotion of the CCHFA's "focus away from paper standards towards a concern for the client." Should not the concern for a patient's well-being start with ensuring that all standards are met? We would prefer that all anaesthetic machines conformed to a Canadian Standards Association standards, and that anaesthetists practiced in a manner compatible with the Guidelines to the Practice of Anaesthesia as Recommended by the Canadian Anaesthetists' Society, before we were granted "ways in which personal choice is encouraged and supported."[1]

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1 A Client-Centred Accreditation Program. Acute Care Proposed Standards for 1995 (Second Draft). Canadian Council on Health Facilities Accreditation. Ottawa, Ontario, 1994.

The prevention of postoperative pain: shouldn't it begin at medical school?

To the Editor:
I read Dr. Moote's article[1] with interest. I have heard it said that "patients expect to be in pain after surgery, and the doctors and nurses who care for them see to it that they are not disappointed"! Whilst this may be facetious, it does underscore the main problem which is one of attitudes rather than lack of technology. Implicit in her approach is the assumption that postoperative pain

is predictable and indeed inevitable, and that is pure self-deception on the anaesthetist's part to image that patients will not experience it if a "wait and see" approach is adopted with respect to the use of analgesics. The consequence of this is that the onus is shifted from the patient (who until now has had to declare his pain to his hospital attendants in order to receive acknowledgment and treatment for it) to the physician, who should now be taking all possible steps to prevent that pain from occurring in the first place. Although Dr. Moote referred to the interaction between nurse and patient in determining exactly how the anaesthetist's prescription is interpreted, she made no mention of the rôle played by the surgical resident in the management of postoperative pain. In the United Kingdom, although the anaesthetist usually writes the prescription for postoperative pain relief, if the regimen is inadequate or not to the nurses' liking, it is the house officer who is consulted about the problem, and the responsibility for managing the patient's pain is shifted yet again. This newly qualified doctor is expected to be knowledgeable in such matters, but has probably received little formal training in this important topic. Once more, the relief of postoperative pain has become "someone else's problem."

A recent English study[2] used a questionnaire to assess the knowledge of newly qualified house officers about the management of postoperative pain, and found that many of their responses were inappropriate, if not somewhat hazardous. We have seen for ourselves how effective such simple measures as writing up oral analgesics regularly instead of "as required" can be. We have learned how widely opioid requirements vary by seeing how our patients use their PCA machines, just as they have benefited from being able to tailor the analgesic to their pain. Surely it is time to include doctors in training, who are still liberal and receptive, in this new, humanitarian revolution? And surely it is anaesthetists who should be leading the way?

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REFERENCES

1 *Moote CA.* The prevention of postoperative pain. Can J Anaesth 1994; 41: 527–33.

2 *Gould TH, Upton PM, Collins P.* A survey of the intended management of acute postoperative pain by newly qualified doctors in the South West Region of England in August 1992. Anaesthesia 1994; 49: 807–10.

REPLY

I would like to thank Dr. Smith for his interest in my article on the prevention of postoperative pain. As stated by Dr. Smith, simple measures as oral analgesics given at regularly scheduled round-the-clock (not prn., or as required), can profoundly improve the management of postoperative pain. Also, opioid requirements vary tremendously and we observe this daily in patients using PCA. Analgesic protocols must allow for variability in dosing schedules. This can be accomplished by providing a "rescue" dose of analgesia.

Another very important tool is a pain "flow sheet," which can be used to document the efficacy of the analgesic dose and any side effects or complications. In this manner, opioid analgesia may be titrated to patient's need while identifying side effects such as nausea or respiratory depression which require treatment. Finally, it is important to involve the patient in this process to give the patient control of their analgesia, whether or not they have a pump at their bedside, or a button in their hand. Patients, nurses and physicians must learn to talk opening about pain and use common language such as verbal rating scales or visual analogue scores. The flow sheet is used to document these pain scores, in addition to analgesic agents and side effects. This bedside information is essential to monitor and mold the analgesic regimen to fit the individual needs of each patient.

Numerous guidelines for acute pain management agree that NSAIDs have a fundamental role to play in the management of acute postoperative pain. The paper by Gould[1] reveals a poor theoretical and practical knowledge of analgesic agents, where NSAIDs were often used inappropriately. While there has been much published on the use of NSAIDs for postoperative pain, the appropriate application of this knowledge in routine clinical practice has been slow and sporadic.

I agree that knowledge regarding pain management is inadequate and that more education is essential. In Canada, the management of both acute and chronic pain is an integral and required component of the residency training programme for anaesthesia. Changing attitudes about pain is an extremely important element of undergraduate medical education and may have an important impact on future practice patterns.[2] Anaesthetists have much to offer medical schools in providing these programmes. The International Association for the Study of Pain has developed such a curriculum for pain management.[3] The issue of medical education and pain management has been addressed repeatedly in the literature, but the haunting questions remains: "Is education enough?"[4,5] Perhaps education alone is not enough, since a recent editorial calls for national initiatives to improve the management of patients in pain.[6] This returns us to the root of the problem of inadequate analgesia which was so eloquently summarized by Bonica,[7] "for nearly 30 years I have studied the reasons for inadequate management of postoperative pain, and they remain the same ... inadequate or improper application of available information and therapies is certainly the most important reason for inadequate postoperative pain relief."

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REFERENCES

1 *Gould TH, Upton PM, Collins P.* A survey of the intended management of acute postoperative pain by newly qualified