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The Role of the Anesthesiologist in the Management of Chronic Nonmalignant Pain: A Canadian Perspective

To the Editor:—After reading the letters by Erjavec¹ and Khan² and the accompanying response by Jacobson,³ we felt obliged to share some of our ideas regarding chronic pain management. As anesthesiologists involved in the management of chronic pain we share the points of view expressed by Jacobson *et al.*⁴ Their emphasis on a biopsychosocial model of chronic non-malignant pain that also embraces a biomedical approach when appropriate seems ideal.

We would like to comment on the "training" of anesthesiologists in the subject of chronic pain. It is our belief that we are failing our residents, our profession, and patients with the current approach used in many anesthesiology residency and chronic pain fellowship programs. We concur with Jacobson *et al.* that the focus of "current pain training is on regional anesthesia, interventional techniques, and medication management." We further agree that "anesthesiologists training in chronic pain management need more biopsychosocial instruction."

However, there are issues important to the recruitment and training of anesthesiologists in the area of chronic pain management that are just as important as the lack of "biopsychosocial training." Although physicians can be trained to communicate more effectively, it is equally likely that a physician's personality may limit his or her effectiveness as a biopsychosocial healer while allowing the physician to function appropriately in a traditional biomedical environment. Therefore, when recruiting physicians into anesthesia residency programs more attention needs to be paid to recruitment of people who are more likely to be effective and happy as biopsychosocial healers if, ultimately, we expect them to treat patients with chronic pain. This is especially true in Canada where true multidisciplinary pain clinics are few and anesthesiologists must assume multiple roles.

We agree that anesthesiologists are in an excellent position to contribute to the management of chronic pain. However, anesthesiologists graduating from "traditional" anesthesiology residencies often think that a chronic pain fellowship is simply a ticket to a job, which often leads to job dissatisfaction. Further discontent is created by the failure of traditional training programs to adequately prepare residents for their role in treating patients with chronic non-malignant pain, and which is compounded by the lack of acceptance regarding the importance of this role by anesthesiologists serving in more traditional venues. Add to this the "financial penalty" perpetuated and maintained by "traditional" fee schedules and the necessity to provide "continuity of care" (a concept foreign to most "traditional" anesthesiologists), and the discontent grows.

If "anesthesiologists" are to continue to participate in the treatment of these patients, these "problems" need to be addressed by our leaders. If not, other disciplines will quickly take on the leadership role by training their own in the science and art of biopsychosocial healing. Biomedical interventions requiring technical expertise may occasionally require the assistance of a proficient

anesthesiologist, but many of these skills can be readily learned by physicians in other disciplines (*e.g.*, interventional radiologists).

In summary, although anesthesiologists have an opportunity to make an important contribution in the management of chronic non-malignant pain, there are many obstacles hindering progress in this area.

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