EDITORIAL

PAIN AFTER SURGERY

It is well known that pain after surgery is not treated adequately in the majority of hospitals either in the United Kingdom or elsewhere in the world. Over the past few decades, many publications have attested to this fact; some articles have described the harrowing personal experiences of doctors who have undergone surgery [1, 2]; several editorials have been published in both specialized anaesthetic journals [3] and general medical journals [4, 5] lamenting this state of affairs, and attention has been drawn to inadequacy of pain relief after surgery by the majority of review articles on this subject [6, 7]. In the 1980s, surveys of patients' subjective well-being revealed an incidence of moderate or severe pain after surgery of 31–75% [8, 9]. What is so surprising is that this deplorable state of affairs has persisted and continues to persist in many hospitals, despite considerable advances in the pharmacology of analgesic drugs, and descriptions of new and improved methods of relieving pain.

Only in a few centres, populated by enthusiastic anaesthetists (and occasionally surgeons) has there been substantial improvement in the quality of postoperative pain relief in recent years. This trend has been most noticeable in the U.S.A., where acute pain teams have evolved at a remarkable rate since the first description of such a service was published in 1988 [10]. The reasons for this progress in North America, coupled with relative inactivity elsewhere, undoubtedly relate to the economics of health care delivery. In the United Kingdom and other countries which do not embrace a "fee for item of service" system, creation of an acute pain service has not commanded a high priority in relationship to other medical innovations and, consequently, progress has been hampered by inadequate funding of the resources required.

In this issue of the Journal, we report the first year's experience of an acute pain service which has been developed in a district general hospital in the U.K. [11]. Of particular interest is that the only major additional staffing requirement was the appointment of a nursing sister to spearhead development of the service. This is probably the minimal additional resource requirement in addition to equipment and increased input from the pharmacy, and reflects the particular workload, case mix, hospital layout and anaesthetic staffing of the unit described. It is certain that greater resources would be necessary in the absence of such a favourable conjunction of circumstances.

The general failure of the medical profession in the United Kingdom to achieve progress (despite good evidence that improvements in analgesia were attainable) stimulated the Royal College of Surgeons of England and the College of Anaesthetists to establish a working party to commission a report on pain after surgery. The Report was published in September 1990 and distributed to all Fellows of the Royal College of Surgeons of England and Fellows of the College of Anaesthetists in November 1990 [12]. The Report may be unfamiliar to other subscribers to this Journal and it may be valuable to summarize its contents.

The Working Party comprised representatives of the anaesthetic, nursing, surgical and pharmacy professions. The Report describes the extent of the problem of postoperative analgesia and reviews the well known reasons for failure of conventional parenteral administration of opioids to achieve satisfactory pain relief. It outlines all the methods which are available for treatment of acute pain and draws attention particularly to pain relief in children, noting that in children many of the traditional attitudes which exist towards pain in adults are exaggerated because of reluctance to prescribe adequate doses of opioids. The Report also draws attention to the role of an acute pain service, the problems of safety and monitoring, and the role of the high dependency unit.

The Report makes several important recom-
mendations to improve education in analgesia, systematically record pain regularly after operation and establish acute pain teams in all major hospitals. It also makes important recommendations on the provision of staff, resources and facilities for the provision of adequate postoperative pain relief. It is composed in a style designed to be comprehensible to non-medically qualified administrators and other lay-persons. Although there may be very little new for the consultant anaesthetist within the United Kingdom, this Report nonetheless provides an extremely important and authoritative document which may be used by the profession to support a stated case of need for establishment of acute pain services and provision of other resources which are necessary.

We commend the Report of the Joint Colleges’ Commission not only as a useful educational document for nursing, pharmacy, physiotherapy and other non-medical healthcare staff, but also to anaesthetists and surgeons for whom it should provide valuable ammunition in their fight for a share of resources. This Report should be useful, therefore, not only to anaesthetists within the United Kingdom, but also to those in other countries where resource allocation in health care delivery is similar to that in the U.K.

Graham Smith

REFERENCES