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%.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 surgery² 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

patients' satisfaction but, more importantly, outcome. Indeed, anaesthetists and surgeons may also attach greater importance to pain relief and, in particular, regional anaesthesia if the promising results of recent research are borne out by larger controlled studies.⁵ If a combination of new surgical techniques, high quality analgesia, and aggressive rehabilitation can reduce the mean length of stay after major surgery by half, then both providers and purchasers should be interested in the role of regional analgesia in the outcome of surgery. This will require a great change in clinicians' attitudes to postoperative care and an injection of new moneys in the short term. Whether either of these developments occurs remains to be seen.

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Low expectations of pain relief encourage persistence of poor standards

EDITOR,—M Harmer and colleagues report the slow pace of development and lack of funding for acute pain services in Britain since a report on postoperative pain by the Royal College of Surgeons of England and the College of Anaesthetists.² Their paper makes for depressing though familiar reading for those working to secure universally applied humanitarian standards of postoperative analgesic care for surgical patients.

Like most units in the authors' survey, my hospital uses patient controlled analgesia for postoperative pain relief in some patients. As there is no acute pain service to supervise the use of this expensive technology it is implemented by untrained and inexperienced staff. This results in a lack of effectiveness even in comparison with discredited conventional administration of intramuscular narcotic on request but no more frequently than every four hours (audit data on file). Yet despite this wasted expenditure, repeated submissions for funding for an acute pain service, which could improve the effectiveness of patient controlled analgesia or substitute it with safer and more effective protocols for treating pain at lower cost,^{3,4} have failed. Our most recent audit found that over 90% of 107 randomly surveyed postoperative patients had severe or unbearable pain after their surgery regardless of the modality of analgesic treatment (visual analogue pain score ≥ 6) and, furthermore, that most patients and staff expected such poor pain control.

Prevalent public attitudes characterised by low expectations of postoperative pain relief encourage the persistence of poor standards of delivery of analgesia,⁵ and government guidelines largely ignore the treatment of acute pain as a criterion of quality. Managers consequently fail to address the issue when deciding funding priorities. Until the public and government as well as purchasers and providers begin to treat freedom from postoperative pain as a fundamental human right and a measure of quality of medical care, the current confused and unstructured management of post-

operative pain will continue to be both therapeutically ineffective and a costly waste of resources.

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Anaesthetics training in the United States

America offers far less experience than Britain

EDITOR,—The American system of anaesthetics training certainly has several strengths, as Geoffrey N Morris points out.¹ The training is structured and highly supervised, and residents undergo constant appraisal and assessment by their seniors. I agree that after the three year scheme the trainees are as competent and experienced as any senior house officer in Britain. The problem is that that is where the training ends.

Morris emphasises the level of supervision: residents are supervised totally, "whether the case is an arthroscopy or open heart surgery." But what happens when this supervision stops abruptly? It is currently fashionable to think that the only training that is worth anything is directly supervised, one to one teaching. Yet I have learnt my most important lessons from working alone, making my own decisions and dealing with the consequences. The beauty of the supervision that British doctors receive is that, as a senior registrar, I do not have to get a consultant to hold my hand if I do a dilatation and curettage in the middle of the night, but someone is available for telephone advice or to come in and help if necessary. A service commitment is an essential part of any worthwhile training scheme, and we should not allow ourselves to be fooled into thinking otherwise.

American training provides a fraction of the experience available in Britain. I have met final year residents who have never given anaesthesia for a tonsillectomy or have never seen a laryngeal mask airway. If the graduating residents are "confident" they are inappropriately so. Morris's most surprising comment is that "confidence in the quality of the training is reflected in the fact that it is not obligatory to pass the 'board' exams." That reflects a total lack of interest in maintaining any kind of standard. What is the point of having board exams if they are not compulsory?

Another question is, Where are the attending anaesthesiologists between induction and recovery? Are they doing their own cases? No. What proportion of the time of an average "attending" is spent giving anaesthesia? Very little. Whom do American surgeons see giving anaesthesia? Residents or nurses.

Consultants in Britain teach, supervise, and carry out research, but, above all, they do the work. They maintain a senior presence in theatre. They are in control of preoperative preparation and critical care. All of this is to the patient's advantage. To suggest that the quality of consultant training in Britain could be maintained with an

abbreviated course is nonsense and plays into the hands of the "trained monkey" brigade, which British anaesthesia has done so much to combat. I suspect that Morris's comments are motivated more by impatience to become a consultant than by objective comparison of the output of each system.

Morris's residents will not become consultants before he does: they will not become consultants at all.

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- 1 Morris GN. Anaesthetics training in the United States. *BMJ* 1995;311:332. (29 July.)

Three year residency produces equivalent of competent middle grade registrar

EDITOR,—Geoffrey N Morris is fortunate in experiencing what may be the best training programme for anaesthetic residents provided in the United States.¹ We have worked in a similar capacity to him in Texas and Colorado and have spoken to many other British anaesthetists who have worked elsewhere in the United States. Our assessment of the training received during the three years of an anaesthetic residency is that it can produce a practitioner equivalent to a safe, competent middle grade registrar in the British system. As in any other profession, however, some people stand out as excellent exponents of their "trade," and those residents who go on to complete a fellowship are, of course, well trained in that subspecialty. For most residents, however, three years is not long enough to provide enough experience and judgment to deal with all of the patients when a non-specialist may have to anaesthetise. Furthermore, residents are not compelled to sit their "board" exams, and there is little independent control on the quality of anaesthetists leaving the residency programmes.

We do not agree that the supervision of trainees is "vastly superior." Although residents are supervised for most procedures, the supervising practitioner may be responsible for several residents in several rooms. In cases in subspecialties the ratio of residents to staff (or attending) anaesthetists may often be one to one. At night or in more general cases, however, the ratio may increase. The number of cases that one staff anaesthetist may supervise is often limited by restraints on remuneration. (Government sponsored schemes such as Medicare and Medicaid will remunerate only staff who are supervising two or fewer rooms.)

The training in the United States achieves its aims—to produce in a short period large numbers of anaesthetists who are capable of independent practice for the majority of cases. That system could not, however, be easily imported to Britain. We do not believe that most trainees in the United States, after completing the three years of residency, would be suitable for appointment to consultant posts in Britain.

There are obvious humanitarian and safety advantages in the reduction in junior doctors' hours. There is also a need for planned training schemes in which the educational content is ensured. These aims are to be applauded. We need to decide, however, what we want our training schemes to achieve. Perhaps trainees need to experience a large and varied number of clinical cases, with appropriate supervision, so that they may truly be "consulted" and not simply be providers of care at the end of their training.

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