Patients in pain: Who should be responsible?

Michael Gross, MD

It is not an unusual situation in modern surgical practice to go to either the recovery room or the floor to review postoperative patients and see other specialists in attendance. However, it is now time to question some of the more recent changes in practice that are being presented and enacted upon surgical patients.

Pain management

The advance of surgery as a specialty was enabled by the development of anesthesia as a practice and then as a specialty. The dichotomy of surgery is that we operate to relieve pain and in doing so we cause pain. The continued advance in surgical outcomes has been dependent upon improvements in both specialties. We are now seeing the development and institution of hospital-based pain services for both acute and chronic pain, run by anesthesiologists. It has become practice in my institution for patients in postoperative pain to have the acute pain service called by the nurses before the resident on call.

I have reservations about these changes and the scientific underpinnings that purport to support them. I would like open with a discussion of the belief that all pain is bad and must be eliminated. I believe that pain should be seen as a management problem, something to be assessed and treated, but something that can be understood only through close attendance, both pre- and postoperative, upon patients in pain. As such, we are now changing the education and experience that our residents need to function as practicing surgeons. It is important to understand through observation how various patients react to pain in many different ways, even though they have had the same condition or operation. Nurses sending for a pain specialist directly impedes that learning experience. How then is the resident to learn what is normal postoperative pain and what is abnormal? If the pain is increasing and the need for stronger pain medication continues, who is responsible for the assessment of the patient to determine whether there is a complication manifesting itself through pain and pain alone?

A constructive dialogue with our colleagues is clearly needed, but in addition I propose that we need to define the lines of responsibility along 2 principles.

First, the management of postoperative pain has to remain the responsibility of the treating surgeon or staff. It is appropriate for us as professionals to learn optimum treatment protocols for postoperative pain, including drug type, dosage, delivery route and complications. It is for us to assimilate that information into our daily practice, or to be part of trials to determine what those parameters are.

An example of potential complications relate to the use of nonsteroidal anti-inflammatory drugs (NSAIDs) for postoperative pain relief. Inflammation is a necessary part of wound and bone healing, and recently NSAIDs have been clearly shown to interfere with wound and tendon healing. Without a dialogue between our 2 groups of professionals, one group’s well-intentioned plans for pain relief will interfere with the other’s treatment plan. It is essential that postoperative pain control be coordinated to prevent conflicts at the patient’s bedside.

Second, new techniques or changes in practice should be driven by an institutional committee of representative specialties, funded and charged with the responsibility of educating all staff about the changes, introducing them, and monitoring and evaluating the outcomes of those changes. This group could also be responsible for conducting trials, reviewing practice and publishing the manuals that would guide surgical teams in the treatment of postoperative pain. I do not yet know if this level of coordination and cooperation has been achieved in any Canadian hospital, but I would strongly
support such a program to address these issues.

**Use of data that does not meet scientific criteria**

I shall use an example of a review article published in the pain literature. The difficulty with review articles is that data from the papers quoted within the article are often open to interpretation. The review article is the one often quoted when repeating the conclusions drawn from those papers, yet the accuracy of the data and conclusions drawn cannot be examined. The table reproduced here from the review article mentioned (Table 1) purports to quantify the amount of chronic pain associated with common surgical procedures.

It is inappropriate to infer that these rates of chronic pain are generalizable to all of these surgical procedures. My difficulty is that the authors of this review are making a case for the provision of pain services to the level suggested by the incidence of chronic pain quoted. It is obvious that we need to continue to collect data on outcomes if we are to refute this type of aggregate data, and indeed we have data that suggest that the level of unmet need is very high in certain areas, and that the pain suffered by patients is also chronic and disabling.

As surgeons we are also specialists who treat pain, and therefore have a distinct understanding of it. We have always sought to relieve pain surgically where appropriate, so we must be seen as treaters of pain, not just the cause of a lot of chronic pain.

**Treatment of non-cancerous chronic conditions with opiates**

Opiates are additive and addictive in nature. Patients with cancer pain require increasing doses, yet have a finite lifespan; in their declining days, large doses are not unusual. With chronic pain such as osteoarthritis, however, this is not the case. Surgeons must deal with the complication of postoperative management by withdrawal from opiates previously prescribed and the need for a pain management program continuing long after the surgical procedure. Treatment of chronic conditions with opiates should be seen as a necessity only for urgent admissions for an operative procedure. Using addictive drugs when a surgical solution exists that results in a drug-free way of life for over 90% of those patients is a deferral to a suboptimal treatment plan.

I also believe that patients with subjective diagnoses such as fibromyalgia and chronic fatigue syndrome, for which there are no diagnostic tests, should never be placed on opiates. Most papers indicate that treatment for depression is a more successful management plan.

In summary, the surgical community should strive to work with our colleagues in other specialties, but we should not allow our unique perspectives on and understanding of pain to be overruled by exclusion. An objection may be made that it is hard to get surgeons to the table to discuss such issues; but if a priority is set that surgeons must be involved as laid out above, then surgeons will be there.

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**Table 1**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Surgeries performed</th>
<th>Range of estimated incidence/prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% Chronic pain, no.</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>55 404</td>
<td>16–50</td>
</tr>
<tr>
<td>Cholecystectomy*</td>
<td>&gt;50 000</td>
<td>21–27</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>19 853</td>
<td>3–35</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>21 649</td>
<td>30†</td>
</tr>
<tr>
<td>Breast surgery</td>
<td>14 438†</td>
<td>13–49</td>
</tr>
<tr>
<td>Thoracotomy</td>
<td>16 305†</td>
<td>7–67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>&gt;177 649</strong></td>
<td><strong>3–67</strong></td>
</tr>
</tbody>
</table>


* Data from Quebec, Manitoba and Alberta were excluded because of differences in reporting.
†,‡ According to 2000-01 surgical procedure codes 197.12–97.28 (excludes mammoplasty) and 146.01–46.5
§ The only datum available.