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 postoperative 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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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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