observed after anesthesia for nonabdominal procedures.[5] The anesthesia literature has only a few relevant articles discussing the occurrence of pancreatitis in association with the administration of narcotics[6] and occasionally with cardiopulmonary bypass procedures.[7,8] Continued study and monitoring of anesthesia patients will be necessary to better understand the causes of this serious postoperative event. As in the past, Zeneca will continue to monitor adverse events reported in temporal relationship with the administration of Diprivan, including reports of pancreatitis.

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Payment for Routine Postoperative Patient-controlled Analgesia

To the Editor:—Recently Mackey *et al.*[1] faulted the Health-Care Financing Administration (HCFA) Policy for not reimbursing anesthesiologists for postoperative patient-controlled analgesia (PCA), thereby impeding optimum postoperative pain management.

Their comment suggesting that postoperative pain management has been poorly managed in the past seems correct. Their equating the risks of postoperative epidural analgesia with PCA seems to be exaggeration. However, that is incidental.

Looked at from the perspective of HCFA and the public, who ultimately pay health-care costs, routinely reimbursing anesthesiologists for PCA postoperative pain management adds another level of costs to health care. Additionally, it tends to add to the fragmentation of individuals; patients are too often seen as collections of anatomic parts or functions. It would be better for surgeons and patients if routine postoperative pain were not seen as a separate symptom needing treatment by an anesthesiologist.

We anesthesiologists must become more efficient and work more closely with our surgical colleagues. Health-care money spent on our inefficiency will not be available in the future for higher priorities, such as research and new technology.

Patients deserve empathetic and compassionate relief of postoperative pain. It may not need to be optimum, but it should be safe and effective. PCA can be a valuable tool for this; we can help by giving our surgical colleagues practical information on using and monitoring the safety and effectiveness of PCA. Once we have done this, we will have a reasonable defense for our charges, as consultants in the special circumstances that Mackey *et al.* refer to, that the HCFA policy allows.

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