The chronic need to improve the management of pain

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In this issue, Drs Morley-Forster, Clark, Speechley and Moulin report on their survey conducted by Ipsos-Reid in June 2001 (pages 189-194). Only physicians who met the eligibility criteria of having written 20 or more prescriptions for moderate to severe pain in the preceding four weeks or having devoted 20% of their time to palliative care were eligible to participate. Sixty-eight per cent of the respondents thought that moderate to severe chronic pain was not well managed in Canada. Despite this opinion, 23% of physicians in palliative care practice and 34% of primary care doctors stated that they would not use opioids to treat moderate to severe chronic noncancer pain even as a third-line treatment after two previous medications had failed. One-quarter to one-third were concerned about the potential for addiction, and a smaller percentage reported concern about the potential for patient abuse and/or misuse, and side effects. Fear of a College audit resulting in the loss of their medical licence was cited by 10% of primary care physicians. When asked what obstacle hindered their use of strong opioid analgesics, an unexplained 10% of palliative care doctors and 14% of primary care doctors answered "nothing in particular".

If these attitudes are translated into physician behaviour and patient outcomes, it could well result in inferior pain relief for a substantial proportion of patients who suffer from pain. Given the last 20 years of significant changes in the approaches to management of chronic pain – promoted by continuing medical education programs, publications of treatment guidelines by professional associations, promotion by industry manufacturers of opioids and adoption by provincial colleges of recommendations regarding treatment of nonmalignant pain – one would have hoped that the attitudinal barriers to opioid prescription would have vanished.

What is needed to fundamentally improve these attitudes and bring them into line with the opinions of practice leaders in pain management and accumulating evidence that opioids are an appropriate option in the management of chronic nonmalignant pain?

The findings of this study should not be altogether surprising, although they are discouraging. Carr (1) reviewed recent research regarding the impact of national guidelines for pain control. He noted that because "adequate pain control usually can be achieved by means of low-technology approaches, the technical means to control pain has existed for decades prior to the call to promote pain control through guidelines and standards". The evidence is that the guidelines by themselves do little to alter clinician behaviour, which is influenced importantly by medical colleagues, prevailing practice, opinion leaders and other factors. Even evidence-based guidelines are not consistently followed unless the recommendations are coupled with positive incentives for compliance and negative ones for noncompliance.

Variables that most increase the adoption of guidelines, as measured by physician performance or health outcomes, include reminder systems, academic detailing and multiple interventions. Moderate efficacy has been demonstrated for audits and feedback targeted to specific providers and delivered by peers or opinion leaders, but weak efficacy has been shown for the traditional strategies of didactic presentation, and traditional continuing medical education and mailings (2).

In recent years, systematic reviews and clinical trials have been conducted to define the possible efficacy of various strategies for continuing medical education. Greater efficacy has been demonstrated for multiple interventions, two-way communication, printed and graphic materials, and use of locally respected health personnel as educators (3). Interactive workshops result in moderately large changes in professional practice, while didactic sessions do not (4). Local opinion leaders seem to have an effect on clinical practice, although the impact on patient outcomes has been harder to demonstrate (5).

The problem is not the inadequacy of guidelines. When guidelines are implemented, at least in the field of cancer pain relief, pain outcomes can be improved. A treatment algorithm based on Agency for Health Care Policy and Research guidelines was employed in a randomized controlled trial, with comparison to standard community practice, and using patient outcome measures. Those cancer pain patients who were not on chemotherapy and who were randomly assigned to the pain algorithm treatment group achieved a statistically significant reduction in usual pain intensity when compared with the reference group (6). A two-year uncontrolled longitudinal study of cancer patients treated by a pain service following World

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Health Organization guidelines for cancer pain relief found that patients had a significant reduction in a wide variety of physical and psychological symptoms, with only a minor number of side effects contributed by the pain treatment regimens; efficacy of pain treatment was rated as good in 70%, satisfactory in 16% and inadequate in 14% (7). A prospective randomized study of patients with cancer pain used a pain education program to enable patients to understand the principles of pain relief, to learn how to use a pain diary and to communicate with health professionals regarding their symptoms. Patients randomly assigned to the patient education group had significantly lower rates of inadequately treated pain up to eight weeks postdischarge, compared with the reference group with no patient education (8).

Although to date there are no studies on the effect of fee-for-service versus global funding influences on the adequacy of pain management practices, it is likely that the current fee-for-service structure, combined with busy primary care practices, is also a barrier to the adoption of pain relief strategies by some primary care practices; unless this is redressed, professional motivation will not swing toward spending more time with patients with chronic pain, or those with pain and psychological comorbidity, who require more time and effort, and nonbillable or poorly billable time.

The above discussion suggests that improvements can be made, but the improvements do not depend on single initiatives or unilateral actions. It certainly must involve efforts by opinion leaders to influence the training of new doctors at the undergraduate level, by participation in the teaching program and contributing to the curriculum. It must involve community-based continuing medical education efforts at local hospitals and medical groups, but using more effective strategies such as interactive learning and one-on-one mentorships and feedback-based learning. It must involve an active incorporation of guidelines at local levels such as academies of medicine and hospital medical staff organizations. Government-mandated jurisdictions, such as hospital associations and provincial colleges of physicians and nurses, can do more to promote guideline applications and establish compliance monitoring. Each of us as pain clinicians needs to have the attitude that “it is my job” and not “someone ought to do something about this”.

REFERENCES
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