

State-of-the-Art Pain Management in Singapore

Welcome Address by Dr Yeo Sow Nam Alex, Convention Organising Chairman at the 38th SMA National Medical Convention, 19 & 20 May 2007, Suntec Convention Centre

Pain is one of the most common reasons for patients to seek medical attention and one of the most prevalent medical complaints in the US. In a 1999 Gallup survey, nine out of 10 Americans aged 18 or older reported suffering pain at least once a month, and 42% of adults reported experiencing pain everyday. Women, minority groups, elderly persons (especially nursing home residents), and individuals with cancer are at appreciable risk of suboptimal pain assessment and treatment. Effective pain management presents a significant challenge for physicians, other healthcare professionals, and their patients.

In a large epidemiological survey conducted in US, Europe and Australia, chronic pain is found to afflict one in five. Some 75 million Americans experience persistent pain, and at least 9% of the US adult population is estimated to suffer from moderate to severe nonmalignant pain. Patients with persistent pain can be especially difficult to treat. In one survey conducted for the American Pain Society, 47% of those with moderate, severe, or very severe pain had changed physicians at least once since their initial visit for pain relief. When asked why, they cited continued suffering (42%), the physician's lack of knowledge (31%), not taking the pain seriously enough (29%), and unwillingness to treat it aggressively (27%) as reasons for the change.

In Singapore, we have just completed a large epidemiological survey of the prevalence and impact of chronic pain. It showed 9% of Singapore population suffering from chronic pain. The psychosocial and socioeconomic impact of this is great. Professor Jensen, the President of International Association for the Study of Pain, had elegantly delivered in the plenary lecture that chronic pain is indeed a disease entity. This year, the Singapore Medical Association's National Medical Convention's theme of "Breaking New Barriers in Pain

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Management" cannot be more timely. Together with various local and overseas experts from the fields of Pain medicine, neurology, orthopaedics surgery, rheumatology, palliative care, a very exciting array of pain conditions and their latest management approaches were discussed. Mdm Halimah Jacob, our Guest-of-Honour, had kindly graced the occasion and endorsed the Association's efforts in recognising treatments of chronic pain as vital to the maintenance of standards in our medical fraternity.

THE BARRIERS

1) Physician Barriers

- Inadequate training in pain management
- Ethnic/racial/gender biases
- Inadequate pain assessment
- Reliance on behavioural cues in assessment

Traditionally, physicians are trained to diagnose and treat disease – the likely root cause of the pain – as opposed to treating pain itself. In one survey of clinical oncologists regarding their training in pain management, 88% rated their medical school education as fair or poor, 73% rated their residency training as fair or poor, and

only 51% rated pain management in their own practices as good or very good.

Physicians and other healthcare providers may consider pain an inevitable and accepted part of life or be influenced by cultural, gender, or age biases. Ethnic biases may also occur: in a study conducted in a Los Angeles hospital, Caucasian patients were twice as likely to receive analgesia as Hispanic patients. Comparatively, low use of analgesics has been observed in cognitively impaired nursing home residents with Alzheimer's disease. There have been allegations, and some data support the notion that women are more likely than men to be undertreated or inappropriately diagnosed and treated for pain. However, determining whether gender differences in pain experiences are caused by biological or social factors is difficult.

Managing pain in special populations can be particularly challenging. For example, patients who were members of racial and ethnic minorities were found in some studies to receive less analgesia than patients who were not.

Accordingly, physicians and other healthcare providers need current, state-of-the-art education to address prevailing attitudes towards pain, because physician and patient views can present barriers to optimal pain management. Physicians and other healthcare professionals also need education to assist them in developing the skills required to evaluate and manage pain in special populations, such as racial and ethnic minorities.

The teaching in NUS and postgraduate school must involve teaching of systematic approach to proper pain assessment and management.

Current technologies and breakthrough in basic science research have unravelled an ever expanding armamentarium of pain management strategies from medications, the use of sophisticated computerised implants to the use of cognitive behavioural modifications for group therapy.

In the US, pain is often regarded as an inevitable part of daily life, and many individuals believe that admitting pain is a sign of weakness. Older patients may fail to report pain because they accept it as part of the aging process or they may fear the pain is a harbinger of a serious illness, such as cancer. Cancer patients may fear that pain, or a need for pain treatment, portends a poor prognosis or progressive disease. According to one survey, only 40% of patients with persistent pain were under a physician's care for pain relief. Those who received no treatment cited several reasons: they underestimated

their pain, they thought that they could "see it through", or they assumed that there was nothing their physician could do to alleviate the pain. Additionally, about 25% of patients with persistent pain who seek medical care wait at least six months before going to a doctor. Patients may have particular concerns about side effects of opioid drugs and confuse the appropriate clinical use of opioid medications – including the need to increase the dose when tolerance occurs – with drug-seeking behavior and addiction. The media attention given to the war on illegal drugs, societal problems linked to drug addiction, and the prevalence of substance abuse increases patient concerns about using opioids for pain relief.

2) Patient Barriers to Pain Management

- Failure to report pain to the physician
- Thinking one can "see the pain through"
- Underestimating the level of pain
- Fear pain portends a serious illness or poor diagnosis
- Concerns about side effects of opioids
- Confusion of the appropriate clinical use of opioids with addiction
- Unwillingness to take more pills or injections
- Satisfaction with pain management, despite moderate or severe pain

Healthcare system barriers to pain assessment and management include a historical absence of clearly articulated practice standards and failure to make pain relief a priority. For example, some healthcare organisations have failed to adopt a standard pain assessment tool or provide staff with sufficient time and chart space for documenting pain-related information. However, according to some authors, the greatest system barrier to appropriate pain management is a lack of accountability for pain management practices.

The growth of managed care, greater emphasis on outpatient treatment, and new reimbursement policies has introduced additional barriers to pain management. Fragmented patient care increases the risk of poor coordination of care across treatment settings. Furthermore, the use of gatekeepers and formularies by some managed care programs may impede access to pain specialists, comprehensive pain management facilities, or more effective analgesics.

Adding to these obstacles is the fact that 39 million Americans have either no or inadequate health insurance to cover healthcare costs, and Medicare and many private insurance programmes

do not cover the cost of prescription drugs. According to the American Cancer Society, low-income people experience greater pain and suffering from cancer than do other Americans and a disproportionate share of people with little or no insurance are minorities. For those who are insured, reimbursement policies may favour the use of more expensive pain management modalities over less expensive ones. Reimbursement policies on pain management should be studied to enable further understanding of those that promote the most cost-effective pain management.

3) **Barriers Related to the Healthcare System**

- Failure to adopt a specific assessment tool
- Failure to give staff sufficient time and space to document pain
- Lack of accountability for pain management practices
- Emphasis on outpatient care
- Reimbursement policies
- Reduced access to specialists, pain management facilities, or analgesics in managed care
- Inadequate health insurance or no health insurance, for some patients

OVERCOMING THE BARRIERS

To overcome the barriers to effective pain management, physicians and other healthcare personnel need to be aware of any personal biases that interfere with clinical judgment, and to apply knowledge in a rational, scientific manner. Management should include thorough pain assessment and consideration of a multimodal strategy. A persistent negative attitude toward the patient with pain and bias against opioids as a class of drugs must be corrected if pain treatment guidelines are to be widely implemented.

Priority for pain management must be established, equating pain relief with disease treatment. New approaches are necessary if current pain treatment guidelines are to become incorporated into routine medical practice and the standard of pain treatment improved. Clinicians must view effective pain management as important. With organisations such as JCI now requiring that pain assessment and relief be monitored as indicators of quality of care, and standards for quality improvement in pain management released by medical specialty groups such as the Pain Management Services, these processes may prove to be the means to ensure practical learning for those clinicians who choose not to adopt current standards because of attitudinal barriers. ■