

By Dr Yeo Sow Nam

## State-of-the-art Pain Management in Singapore

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, 9 out of 10 Americans aged 18 or older reported suffering pain at least once a month, and 42% of adults reported experiencing pain every day. Women, minority groups, elderly persons (especially nursing home residents), and individuals with cancer are at appreciable risk of sub-optimal pain assessment and treatment. Effective pain management presents a significant challenge for physicians, other healthcare professionals, and their patients.

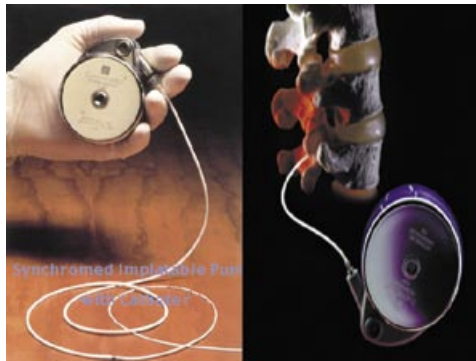
In large epidemiological surveys conducted in US, Europe and Australia, chronic pain is found to afflict 1 in 5. Some 75 million Americans experience persistent pain, and at least 9% of the US adult population is estimated to suffer from moderate to severe non-malignant pain. Patients with persistent 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, a large epidemiological survey of the prevalence and impact of chronic pain is now underway, with the concerted efforts of the council members of Pain Association of Singapore, and pain experts from Australia and Europe. The survey is targeted to complete by end of December 2005.

### 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.



*A lady with bilateral multiple ribs osteoporotic fractures almost succumbed to chest infections, as a result of intractable pain and poor respiratory efforts. An implanted device delivering a combination of local anaesthetic gave the patient significant pain relief, and the infection cleared with antibiotics, improved respiratory efforts and physiotherapy.*



*From L-R: Dr Yeo's nurse, the patient, Dr Yeo and patient's daughter.*



Dr Yeo Sow Nam is Consultant and Director of the Pain Management Services, and Director of Acupuncture Services, in Singapore General Hospital. He is also the President of Pain Association of Singapore, and a MOH-appointed Advisory Member for Pain Management. He owns a practice called "The Pain Specialist" in Mount Alvernia and Mount Elizabeth Hospitals. Dr Yeo has been described as evangelical in Pain Management. He is co-author for MOH's Clinical Practice Guidelines for Cancer Pain, and also author of MOH's CPG for Use of Opioids for Non-Cancer Pain. Recognising that pain is multidisciplinary, he started an Advisory Board of many members of different disciplines for Pain Association of Singapore. His current research is in a large epidemiological survey of the prevalence and impact of chronic pain in Singapore.

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 under-treated 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 the postgraduate school must involve teaching of systematic approaches 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 ageing 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.



*A lady with intractable pain from a pathological fracture of the right neck of femur from advanced cancer of colon. She had severe drowsiness from high doses of morphine, severe chest infection and impending death from sepsis, yet pain was poorly relieved. An implanted intrathecal device conferred pain relief, and she cleared her chest infection as she began to sit up. She lived on for nine months, and sat on a wheelchair and travelled on a MRT for her monthly reviews. She remained pain-free even up to her last moments.*

## 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

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- Fear that pain portrays 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.



*A continuous femoral catheter confers superb pain relief in this patient who just had a total knee replacement, without compromising his motor functions. This technique also avoids the sedative effects of large doses of morphine often required after such surgery.*

- 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

With the introduction of pain as the fifth vital sign in Singapore General Hospital since April 2004, many hospitals have now similarly embarked on this. The pace is in no doubt accelerated by JCI accreditation in all major hospitals.

### **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 multi-modal 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 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 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 Ministry of Health's Clinical Practice Guidelines (CPG) on opioids in cancer and non-cancer pain, 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. ■