

INITIATIVES FOR BETTER PAIN RELIEF

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SUMMARY

Pain has a significant impact upon society and our health care system. Forty-five percent of Americans will seek care or treatment for persistent pain at some point in their lives. Pain is the most common reason Americans seek medical care. Seventeen percent of Americans experience some form of arthritis pain, and fifteen percent experience frequent back pain. Each year, it is estimated that some 25 million doctor visits result from back pain alone.

Studies show that pain is the leading cause of lost productivity in the employed population, costing employers almost \$80 billion annually. Chronic pain is a leading cause of disability, and thus also imposes a tremendous cost on the American economy, in addition to the personal suffering of those afflicted on a long term basis. Efforts on the part of organizations and governments are crucial to the advancement of optimal pain care for all.

INTRODUCTION

The management of pain has made great strides in the last 50 years since John Bonica wrote the first textbook on managing pain in 1953 and the first pain clinics were established, introducing the multidisciplinary concept of pain treatment. Subsequently several organizations were formed to promulgate the message that pain was being undertreated and, more importantly, that there were many means available to alleviate this suffering. Subsequently several governmental and regulatory agencies have provided legislation and guidelines to help ensure that adequate pain relief was a priority.

PAIN SOCIETIES

In 1974, the International Association for the Study of Pain (IASP) was established and has done much to promote pain relief through education, legislative initiatives and introduction of a universal taxonomy for pain terms. In 1979 the American Pain Society was formed as a chapter of IASP and today there are chapters in 67 countries around the world and IASP boasts over 6900 members in 109 countries. IASP has also published a number of clinical updates on timely topics in pain management. In addition, the organization highlights one topic each year and focuses efforts on education, legislative support and advancement in that area. The topic for 2006-2007 is "Pain in Older Persons".

IASP also has published curricula for medical school and fellowship training in pain medicine and for training in pain management for other allied professions. More recently, IASP convened a multidisciplinary task force which has published guidelines on desirable characteristics for pain treatment facilities. These guidelines put forth definitions of the various types of pain treatment facilities which include pain clinics, multidisciplinary pain centers such as those found in large teaching hospitals and modality-oriented clinics such as acupuncture clinics.

The American Pain Society (APS) is a multidisciplinary community that brings together a diverse group of scientists, clinicians and other professionals to increase the knowledge of pain and transform public policy and clinical practice to reduce pain-related suffering. This organization has published clinical practice guidelines on the following topics:

- Guideline for the Management of Cancer Pain in Adults and Children, (2005).

- Guideline for the Management of Fibromyalgia Syndrome Pain in Adults and Children, (2005).
- Guideline for the Management of Pain in Osteoarthritis, Rheumatoid Arthritis and Juvenile Chronic Arthritis, (2002).
- Guideline for the Management of Acute and Chronic Pain in Sickle-Cell Disease, (1999).

APS also publishes a guide for persons with pain.

The American Pain Society may choose to address controversial policies or significant clinical matters by publishing a position statement. Position statements are typically commissioned by the Board of Directors for their review and approval. Following are several position statements the society has developed and endorsed in recent years:

- Improving Quality of Acute and Cancer Pain Management (Approved 1995, Reviewed and Updated 2005).
- Racial and Ethnic Identifiers in Pain Management: The Importance to Research, Clinical Practice, and Public Health Policy (Approved 2004)
- Public Policy Statement on the Rights and Responsibilities of Healthcare Professionals in the use of Opioids for the Treatment of Pain (Approved 2004)
- The Use of 'As Needed' Range Orders for Opioid Analgesics in the Management of Acute Pain (Approved 2001, Revised and Updated 2004)
- Promoting Pain Relief and Preventing Abuse of Pain Medication: A Critical Balancing Act (Approved 2001)
- APS Position Statement on the Use of Placebos in Pain Management, 2005. *The Journal of Pain* Vol 6 No 4 (April) 2005: pp 215-217 (Approved 2005)
- The Assessment and Management of Acute Pain in Infants, Children, and Adolescents (Approved 2001, Reviewed and Updated 2006)
- Definitions Related to the Use of Opioids for the Treatment of Pain (Approved 2001, Under Reviewed 2006)
- Pediatric Chronic Pain - A Position Statement from the American Pain Society (Approved 2001, Reviewed and Updated 2006)
- The Use Of Opioids For The Treatment Of Chronic Pain (Approved 1996, Reviewed and Updated 2006)
- Pain Assessment and Treatment in the Managed Care Environment (Approved 2000, Reviewed and Updated 2006)
- Treatment Of Pain At The End Of Life (Approved 1997, Reviewed and Updated 2006)

PAIN CARE COALITION

As the major pain advocacy group in the United States, the APS monitors governmental policies pertaining to pain. Several other

organizations have also worked on legislative initiatives to improve pain control. APS, the American Academy of Pain Medicine (AAPM), and the American Association for the Study of Headache formally organized the Pain Care Coalition (PCC) in June 1998. In 2004, the American Society of Anesthesiologists also became a member. The PCC works to provide a unified voice regarding pain medicine causes in the legislative process in the United States. The mission of the PCC is to develop, monitor and advocate for responsible federal healthcare policy of behalf of persons with pain by addressing quality of care and access to care issues through legislative, regulatory, and policy research mechanisms

The Coalition's work led to drafting and introduction of the first comprehensive pain care bill at the national level in the United States, the National Pain Care Policy Act

In addition to its work with this bill, the Pain Care Coalition has been involved in a number of other activities. It has worked to get pain included as an area of heightened National Institutes of Health (NIH) reporting and congressional oversight. It has also worked with the Drug Enforcement Agency (DEA) to further enhance a physician's ability to write multiple prescriptions at one time and it continues to monitor governmental payment changes which impact pain practices.

LEGISLATIVE EFFORTS

The National Pain Care Policy Act (US House of Representatives Bill 1020) which was mentioned above was introduced in March 2005 by Representative Michael J Rogers of Michigan and is the first comprehensive, proactive pain care legislation that has been introduced in the US Congress. Over the years, many advocates within the pain care community have worked tirelessly on behalf of pain patients for the introduction of this kind of legislation. Congress has already declared the ten-year period of 2000 through 2010 as the Decade of Pain Control and Research, and this legislation will help cement that important commitment.

The following is a summary of provisions of H.R. 1020:

- Directs the President to convene a White House Conference on Pain Care to identify barriers to appropriate pain care.
- Amends the Public Health Service Act to direct the Secretary of Health and Human Services to establish within the National Institutes of Health (NIH) the National Center for Pain and Palliative Care Research. Establishes an advisory council for the Center.

- Requires the Director of NIH to establish at least six regional pain research centers.
- Requires the Director of Agency for Healthcare Research and Quality (AHRQ) to develop and advance the quality, appropriateness, and effectiveness of pain and palliative care. Permits the Secretary to award grants, cooperative agreements, and contracts to public and private entities to educate and train health care professionals in pain and palliative care.
- Directs the Secretary to implement a national campaign to inform the public on responsible pain management, related symptom management, and palliative care.
- Requires the Secretaries of Defense, Homeland Security, and Health and Human Services to develop and implement a pain care palliative initiative in all health care facilities of the uniformed services.
- Amends Title XVIII of the Social Security Act (Medicare) to require Medicare Advantage organizations to meet certain pain care standards. Requires TRICARE (a Department of Defense managed health care program) to meet such pain care standards.
- Requires the Secretary of Veterans Affairs to develop and implement a pain care initiative in all health care facilities of the Department of Veterans Affairs.

This bill is an important legislative effort for a variety of reasons. Not only has it attracted Congressional support from both parties but it has also acted as an impetus for other patient and professional organizations in the pain field and has increased general awareness of pain as a public health problem among legislators and their staff.

In 2005, Senator Ron Wyden from Oregon introduced US Senate Bill 999, the Conquering Pain Act of 2005, which also addressed the treatment of people experiencing pain. The bill would provide for a public response to the public health crisis of pain, including a Web site containing evidence-based practice guidelines for pain treatment, a Surgeon General's report on the state of pain and symptom management, and grants to establish National Family Support Networks in Pain and Symptom Management, among other provisions. The bill also included a provision that would have require NIH to convene a national conference to discuss the translation of pain research into the delivery of health services, including mental health services, to chronic pain patients and those requiring end-of-life care.

Both of these bills are currently in progress and are only 2 of many bills which have been brought forth on both a national and state level in the United States in an effort to improve pain control. For example, recently the California legislature passed a bill mandating that all physicians in

the state of California earn 12 hours of continuing medical education credit in pain management.

JCAHO

In 2001, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) published new standards regarding pain management for hospitals. Under the new standards, health care providers are expected to be knowledgeable about pain assessment and management, and facilities are expected to develop policies and procedures supporting the appropriate assessment of pain and the use of analgesics and other pain control interventions. Some key concepts include:

- recognize the right of patients to appropriate assessment and management of pain
- assess the existence and, if so, the nature and intensity of pain in all patients
- record the results of the assessment in a way that facilitates regular reassessment and follow-up
- determine and assure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff
- establish policies and procedures which support the appropriate prescription or ordering of effective pain medications
- educate patients and their families about effective pain management
- address patient needs for symptom management in the discharge planning process
- maintain a pain control performance improvement plan In terms of pain measurement, the standards include the following statement. "An organization selects pain intensity measures to ensure consistency across departments, for example, the 0-10 scale, the Wong-Baker FACES pain rating scale (smile-frown), and the verbal descriptor scale. Adult patients are encouraged to use the 0-10 scale. If they cannot understand or are unwilling to use it, the smile-frown or the verbal scale is used."

The JCAHO standards have done a tremendous service toward a better understanding of the need for assessment and treatment of pain. This initiative is often said to have been responsible for adding pain as the "fifth vital sign" in addition to pulse, temperature, respiration and blood pressure.

After policies were put in place at the Mayo Clinic to comply with the new JCAHO standards such as a mandatory numeric pain scale in the post anesthesia care unit, Frasco and colleagues studied 1082 post-

operative patients and detected an overall increase in the average consumption of opiates (morphine equivalents) in 2002 compared with 2000 which was not associated with an increased length of stay, an increase in the requirement for naloxone, or an increase in treatment for postoperative nausea and vomiting.

GOVERNMENTAL EFFORTS

Between 1992 and 1996 the United States Agency for Healthcare Research and Quality (AHRQ) (formerly, the Agency for Healthcare Policy and Research (AHCPR)) convened multidisciplinary task forces of experts which produced 19 clinical guidelines for a number of difficult medical topics. The fact that the first guideline published by this group was on Acute Pain Management is a testament to the amount of importance this issue was given. The Acute Pain Management Guideline was published in 1992. Subsequently Guidelines on Cancer Pain (1994) and Acute Low Back Pain (1994) were published resulting in 3 of the 19 important pain topics being related to pain management.

In response to the Acute Pain Management guidelines (1) the author undertook a survey of 200 hospitals and 500 patients across the US in 1995 to determine the extent of the acute pain problem and the impact of these guidelines. She found that forty-two percent of the hospitals had acute pain management programs, and an additional 13% had plans to establish an acute pain management program as a result of the AHCPR guidelines. Seventy-seven percent of adults believed that it is necessary to experience some pain after surgery and fifty-seven percent of those who had surgery cited concern about pain after surgery as their primary fear experienced before surgery. Seventy-seven percent of adults reported pain after surgery, with 80% of those experiencing moderate to extreme pain. This survey was repeated by Apfelbaum and colleagues in 2003 with similar findings.

The AHCPR guidelines mentioned above are but a few of the guidelines and initiatives which have been brought forth in an attempt to optimize pain control. The National Guideline Clearinghouse (guideline.gov) lists 818 guidelines for pain treatment from hundreds of organizations around the world.

BIBLIOGRAPHY

1. Acute Pain Management: Operative or Medical Procedures and Trauma Clinical Practice Guideline No. 1. ;AHCPR Publication No. 92-0032: February 1992

2. Management of Cancer Pain. Clinical Guideline Number 9 AHCPR Publication No. 94-0592;; March 1994

3. Acute Low Back Problems in Adults. Clinical Practice Guideline 14 AHCPR Publication No. 95-0642;; December 1994

4. Warfield CA, Fausett H, editors. Manual of Pain Management. 2nd ed. Philadelphia: Lippincott, 2002.

5. Warfield CA, section editor. Complications of Regional Anesthesia. In Textbook of Regional Anesthesia. P. Raj, ed. Churchill-Livingstone, NY, 2002.

6. Rice A, Warfield CA, McGrath P, Justins D, editors. Clinical Pain Management. London: Arnold, 2003.

7. Warfield CA, Bajwa Z, editors. Principles and Practice of Pain Management. 2nd ed. New York: McGraw-Hill, 2003.

8. Warfield CA, Kahn CH. Acute pain management. Programs in U.S. hospitals and experiences and attitudes among U.S. adults. *Anesthesiology*. 1995 Nov;83(5):1090-4.

9. Apfelbaum JL, Chen C, Mehta SS, Gan TJ. Postoperative pain experience: results from a national survey suggest postoperative pain continues to be undermanaged. *Anesth Analg*. 2003 Aug;97(2):534-40,

10. Frasco PE, Sprung J, Trentman TL. The impact of the joint commission for accreditation of healthcare organizations pain initiative on perioperative opiate consumption and recovery room length of stay. *Anesth Analg*. 2005 Jan;100(1):162-8.

11. Joint Commission releases new pain management standards. *Rep Med Guidel Outcomes Res* 2000; 11: 7–10.

12. Deer T, Rosenquist R. ASA and the Pain Care Coalition. *ASA Newsletter* 70(12), 9-10, 2006.

13. APS website: ampainsoc.org

14. IASP website: IASP-pain.org