Pain Management: Time to Minimize Variations in Practice

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ABSTRACT: There continue to be great variations in the management of pain in palliative care. Efforts need to be made within the field develop strategies to address this to avoid undue distress in patients.

KEYWORDS: Pain, palliative care, variation, standardization

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We observe, in clinical care, a disconnect between the science, including pharmacology, of the use of opioids and the practice of pain management. The biggest variable seems to be clinical culture.

The World Health Organization (WHO) stepladder was introduced in 1986 as a global tool to improve patient outcomes by facilitating a common approach to the practice of pain management. The 3 steps provide guidance to clinicians in identifying the right pain medication based on its intensity.[1] These guidelines were developed primarily for patients with cancer pain.

More than 30 years later, pain continues to be suboptimally treated. This is true not only for patients with a diagnosis of cancer; more studies are providing evidence of pain being underrecognized and inadequately treated in patients with other diagnoses.[2,3] In addition, the WHO stepladder intended to address pain from a physical perspective - in applying the principles of palliative care; we know that pain is multidimensional and requires a more holistic approach to incorporate aspects such as psychological and spiritual realms to adequately manage it.

Even when limiting the focus to managing the physical aspect of pain, there is great variation in treatment practices. Variations exist between individuals within a team, the measurement of symptoms, the choice of opioids to manage pain, the frequency and manner of dosage escalation, and the personal choices and comfort in the use of opioid conversions. This variation in performance has been highlighted in a recent study across 38 programs in the United States.[4]

Within health care systems, we observe variations in the approach to management and time to control symptoms. This may vary between programs in the same hospital (eg, anesthesia pain versus palliative medicine versus surgical services) or in different hospitals within the same system. We also routinely observe variations on different floors/units within one hospital because nursing staff assess or apply the same physician orders differently. For no other drug class does nurse "comfort" with the order have any bearing on whether or not the ordered medication is administered. Often, the nursing staff on oncology units can be more relied on to assess and manage pain appropriately, especially in end of life scenarios. This is because they are usually more experienced in taking care of patients with cancer pain and those who are terminally ill.

Importantly, the WHO stepladder is effective 80% to 90% of the time in controlling pain.[5] As the field of palliative care evolves, we need to add qualifiers to the selection of medications in terms of how they need to be prescribed and titrated to ensure timely relief from symptoms.

How can there be such persistent divergence between science and practice after more than 30 years? We think this is due, in part, to the variations in literature and the education clinicians receive. Although there is a great push for training clinicians to treat pain, the lack of a common curriculum magnifies the variation in approach. In addition, there are personal preference issues that contribute to this disconnect. A case-in-point is the use of various conversion tables within our specialty and between specialties. For example, it is not uncommon for different specialties managing pain in the same facility to use different opioid conversion tables and order as needed doses in varying frequencies. The reason for the variation is the weakness of the underlying data and the personal preferences of those preparing the tables.

How can the most important factor that dictates the delivery and timeliness of pain management be the culture of

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clinical practice—of individuals, teams, programs, units, services, and systems?

If we attempt to look at this issue from a patient's perspective, it leaves a lot of room for confusion and dissatisfaction. It is not uncommon in clinical practice for there to be drastic changes in the plan for managing pain when clinicians switch care, such as weekend coverage or a change in the clinician "on service." We call for us, as a field, to look at minimizing these variations to ensure that there are no delays in addressing pain when we know there are effective strategies to control it in most of our patients. We need to develop better consensus for uniform practices. Due to the magnitude of the problem of uncontrolled pain, we recommend dissemination of safe and rapid methods for symptom control to minimize patient suffering by experts in the field.[6]

Author Contributions

PB: Prepared and edited manuscript. BES, SD and CFvG : Reviewed, edited and contributed to the manuscript.

REFERENCES

1. World Health Organization. *Cancer Pain Relief*. Geneva, Switzerland: WHO; 1986.
2. Kwon JH. Overcoming barriers in cancer pain management. *J Clin Oncol*. 2014;32:161727–161733.
3. Udeoji DU, Shah AB, Bharadwaj P, Katsiyiannis P, Schwarz ER. Evaluation of the prevalence and severity of pain in patients with stable chronic heart failure. *World J Cardiol*. 2012;4:250–255.
4. Bischoff KE, O'Riordan DL, Fazzalaro K, Kinderman A, Pantilat SZ. Identifying opportunities to improve pain among patients with serious illness [published online ahead of print October 10, 2017]. *J Pain Symptom Manage*. doi:10.1016/j.jpainsymman.2017.09.025.
5. http://www.who.int/cancer/palliative/painladder/en/.
6. https://www.medscape.com/viewarticle/747777.