Key Points

1. Treatment of chronic pain is controversial, with FDA trying to control use of pain meds and advocacy groups pushing for more liberal use of drugs
2. Many doctors are not comfortable dealing with chronic pain
3. Survey was sent to members of West Virginia Family Physicians association to determine beliefs and knowledge of dealing with chronic pain
4. Doctors were not hesitant to use opioids in treating cancer related pain, but were hesitant in using them for non-cancerous pain
5. 60% felt their medical training did not prepare them for dealing with pain
6. >80% expressed frustration in dealing with non-cancerous pain patients and felt these patients were very time consuming
7. Knowledge questions uncovered gaps in how to use certain drugs and alleviate their side effects
8. Results indicate a national survey would be useful to see if results can be generalized

Definitions

central pain - abnormal pain arising from damage to the central nervous system

chronic - long lasting, persistent

fentanyl - a strong narcotic

malignant pain - pain associated with cancer

narcotic - class of drugs derived from the opium plant - or created synthetically for the same effect; used as pain-killers

neuropathic - abnormal pain caused by damage to the nervous system

Family Physicians Don't Feel Trained To Handle Chronic Pain

Sixty percent of West Virginia family physicians responding to a survey believed that their formal medical training did not prepare them to effectively manage pain. That was one of the key findings of an award-winning study published by Dr. Charles Ponte, with the West Virginia University School of Pharmacy, in the August, 2005 issue of the journal Family Medicine.

Weighing in on the controversial subject of how the medical community handles chronic pain, Dr. Ponte, along with Jennifer Johnson-Tribino, decided to assess the attitudes and knowledge of West Virginia Family Physicians in regards to pain. Their work was recognized with an award at the American Academy of Family Physicians 2004 Annual Scientific Assembly.

To research how Family Physicians in West Virginia deal with pain, the pair constructed a survey with three parts (see Fig 1). The fist part collected demographic information, such as age, years of experience, and type of practice.

Figure 1
Structure of Survey Used

- Demographic characteristics
- 10 attitude questions covering: when medicines are prescribed, scrutiny by regulatory agencies, minimizing side effects, patient satisfaction, provider frustration, dealing with the elderly, time expenditure, and formal training
- 10 knowledge questions covering: drugs of choice, routes of administration, analgesic associations, adverse effects

The second part, comprised of 10 questions, related to the attitudes and beliefs of the physicians. The doctors responded to a statement on a 5-point scale, ranging from strongly disagree to strongly agree. For the purposes of analysis, the responses were later grouped together as either agree or disagree. Topics in this section included, but were not limited to, whether doctors were apprehensive about prescribing narcotics, whether patients were satisfied, whether the doctors were frustrated in dealing with pain, and whether their training had prepared them for treating pain.

The final section included 10 true or false knowledge based questions. The questions were designed to assess knowledge in what drugs to use, how to administer them, and adverse side effects.

The survey was mailed to all 537 members of the West Virginia chapter of the American Academy of Family Physicians. The researchers allowed two weeks for responses and within that time received 185, or 34.5% of the total number sent. The typical doctor who responded was a male (77%) with an average of 15.5 years of experience. More than 70% were in private or group practice, with the remainder working at hospitals, health centers, or clinics.

The results of the attitude questions revealed a big difference in how cancer related pain (malignant) and non-cancer related pain (non-malignant) are perceived. While 80% of the doctors reported they were not apprehensive about prescribing opioids for cancer pain, an equal number were reluctant to do so for chronic, non-cancer related pain. In addition, 85% reported frustration in dealing with patients with non-malignant, chronic pain and 89% found it time consuming to deal with these patients.

Despite this disparity in approach, and apparent frustration, 93% of the doctors believed that their patients were satisfied with their pain management (note, this result was not broken down for cancer versus non-cancer pain), and a vast majority (84%) did not believe that patients should have to tolerate as much pain as possible before being treated.

Treatment plans also seemed to be influenced by the pressure doctors feel from government regulations. More than two-thirds of the doctors reported that scrutiny from regulatory agencies effected how they prescribe pain medicines. Finally, as mentioned at the beginning of the article, and in contrast with the perceived patient satisfaction, 60% of the physicians believed their training did not prepare them to effectively manage pain.

The results of the knowledge section of the survey seemed to indicate a possible reason why the majority of physicians did not feel adequately trained. On six of the ten questions (which were True or False), more than

non-malignant pain - pain due to something other than cancer

NSAID - non-steroidal anti-inflammatory, class of drugs, such as ibuprofen, commonly used for pain

opioid - narcotic

pain - an unpleasant sensory and emotional experience associated with actual or potential tissue damage

peripheral pain - pain arising from the outer - or peripheral - nervous system, the ends of the nerves

propoxyphene - narcotic drug which tends to be less addictive than other narcotics

refractory - not responsive to treatment

Source

Ponte CD, Johnson-Tribino J. Attitudes and knowledge about pain: an assessment of West Virginia family physicians. Fam Med. 2005 Jul-Aug;37(7):477-80.

1/4 of the doctors answered incorrectly (see Figure 2 below) and on two of the questions, more than half failed to get the right answer.

Figure 2
Results From Knowledge Section of Survey

Statement/Question (paraphrased)	Correct Answer	% Incorrect
Oral route is preferred for opioids in chronic pain	True	21
Pain is not real if it can be relieved with a placebo	False	13
Mild acute pain is best managed with aspirin or acetaminophen	True	3
Transdermal fentanyl can be given to opioid naive patients in severe pain	False	67
NSAIDs are useful for bone pain	True	8
Propoxyphene is appropriate for mild pain in the elderly	False	36
Promethazine reliably potentiates opioid analgesia	False	41
Opioid related constipation can be treated with bulk forming laxatives	False	46
Laxatives should be prescribed for patients taking chronic opioids	True	25
Oxygen should be used to manage opioid-induced respiratory depression	False	51

While the results of this study may be somewhat discouraging for pain patients, care needs to be taken in interpreting and generalizing the results. The authors readily admit that the number of doctors who responded is low, and may not be representative of a broader, national group. In addition, while they did use a pilot study to create their survey, it has not been statistically shown to be valid or reliable.

Despite these limitations, the authors believe their results are strong enough to warrant a national survey of Family Physicians to both validate and expand on their initial findings. For pain patients, especially those with Chiari and syringomyelia, the results appear to indicate the importance of seeking treatment at a multi-disciplinary pain clinic, with knowledgeable and experienced specialists, if at all possible.

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