PROFESSIONALISM AND COMMENTARY

Bridging the Gap: Pain Medicine and Palliative Care

The Problem

Chronic, progressive diseases bring a host of difficult symptoms and causes of suffering. There are disease-mediated symptoms, such as pain, dyspnea, fatigue, and loss of mobility, and there are the typical accompanying negative emotional states, such as depression, anxiety, and a sense of uselessness [1]. These symptoms and mood states intertwine and interact in a complex manner, and each one deserves attention. This complex interplay of the biomedical, social, and psychological is the basis of the interdisciplinary model of care endorsed by both the specialties of Hospice and Palliative Medicine and Pain Medicine. Of the many symptoms experienced by those with advanced illness, pain is one of the most common and most feared [2]. High-quality pain control is equally important in order to prevent family stress, and prolonged and pathological grief in surviving loved ones [3].

Nevertheless, pain continues to be underrecognized as a serious and significant problem, as evidenced by the prevalence data reported by the Institute of Medicine [4] and findings of a recent Research!America survey (in partnership with Zogby Analytics). In this poll, only 18% of respondents considered chronic pain a major public health problem, but 60% believed pain tends to be dismissed by the public and doctors [5]. Perhaps it is this persistent dissonance between facts and perceptions that leads pain to be undertreated, even when prevalence rates and syndromes are well understood, and the means of relief are within clinicians’ capabilities to provide directly or through consultation.

With careful assessment and a comprehensive plan of care that addresses the various aspects of the patient’s needs, incorporating the analgesic guiding principles of the World Health Organization, debilitating pain can be controlled in the majority of cases. As valuable as this basic approach has proven to be, only 70-80% of patients reach a reasonable level of comfort [6]. This is where access to specialized or expert pain care becomes relevant. Awareness and provision of primary and specialized interventions can ensure comfort for patients through all stages of advanced illness [7].

To provide optimal pain control, all health care professionals must understand not just the causes and prevalence of pain, but the full array of treatment options that may provide timely, enduring, and cost-effective relief. Professional medical societies outside the American Academy of Hospice and Palliative Medicine have embraced the importance of pain management within the larger sphere of palliative care. For example, this journal that reflects the values of its parent organization, the American Academy of Pain Medicine (AAPM), initiated a Palliative Care Section in 2006. The American College of Physicians has produced guidelines to improve symptom management in far advanced disease [8]. These are important milestones in the evolution of contemporary medicine, but they are only the beginning of what needs to be a concerted effort to coordinate these burgeoning specialties as a functional unit to optimize care for the tens of millions of Americans living with pain-producing chronic progressive illnesses, including the more than one million people who are receiving hospice care every year. Each specialty has its unique capabilities and skills, but each alone is insufficient to address the needs of patients with advanced illness or injury, and their families.

Prevalence of Pain in the Patients with Advanced Illness

Approximately one third of the people who are actively receiving treatment for cancer and two thirds of those with advanced malignant disease experience pain [9-11]. Almost 75% of patients with advanced cancer who are admitted to the hospital report pain on admission [12]. In a study of cancer patients who were very near the end of life, pain occurred in 54% and 34% at 4 weeks and 1 week prior to death, respectively [13]. Uncontrolled cancer pain also predicts hospital admissions [14]. In an outpatient cancer center, an evaluation of more than 5,000 patient encounters where the pain intensity scores were high (7–10 on a scale of 0–10) demonstrated that 29% of these patients were hospitalized within 30 days of those visits. In another study of more than 13,000 cancer patients in U.S. nursing homes, an average of 30% of the patients reported daily pain. In those patients, pain varied according to age, sex, race, marital status, physical function, depression, and cognitive status [15]. In other studies of patients admitted to palliative care units, pain often is the dominant symptom, along with fatigue and dyspnea [2].

Until recently, it was widely believed that patients dying from nonmalignant disease did not have high levels of pain. However, it is now known that patients dying from cardiac failure, chronic obstructive pulmonary disease, end-stage renal disease, and other end-stage diseases suffer similar levels of pain to those found in patients with
malignant disease [16,17]. In fact, comparing advanced cancer patients to those with symptomatic congestive heart failure (CHF), it is now clear that the symptom burden is as great, or greater, in the latter [18]. In a multicenter Veterans Administration study of the symptoms CHF patients experience, it was noted that over 55% of them had pain, the majority of which rated their pain as moderate to severe. This was more common than the sensation of dyspnea [19].

People at particular risk for undertreatment include older adults, minorities, and women [20,21]. People living with human immunodeficiency virus (HIV)-acquired immunodeficiency syndrome represent another vulnerable group. An attempt has been made to characterize the pain experience of those with HIV disease because of the frequency for this disorder seen in palliative care settings. More than 56% of patients with HIV disease report pain, with the most common manifestations being headache, abdominal pain, chest pain, and neuropathies [22,23]. There have been many reports of undertreatment of patients with HIV disease, including those patients with a history of addictive disease [24].

The Solution

The solution to the fact that too few patients with advanced illness ever see a pain specialist for evaluation and treatment of intractable pain is up to us. By way of example, recognizing the critical importance of expert-level pain care—and as a first step in transforming advanced illness care—Capital Caring (a hospice and palliative care program serving the greater Washington DC metropolitan region) is undertaking a first-of-its-kind initiative to “marry” specialist-level pain care to hospice and palliative care. Under one roof, in a newly constructed facility, inpatient hospice care, ambulatory palliative care (including counseling services), and pain medicine will coexist, completing the care continuum for this vulnerable population. We believe that this model is a critical step in “bridging the gap” between palliative care and pain medicine, creating a coherent, rational, and cost-effective continuum of advanced illness coordinated care.

At the 29th annual AAPM meeting held in April 2013 at the Fort Lauderdale Conference Center, we took a convenience sample survey of attendees’ experiences with hospice and palliative care (Table 1). Albeit too limited to assert sweeping conclusions, it is nonetheless clear from this survey that there is identified need among pain specialists for formal educational offerings in this area, and a strong desire to integrate and coordinate with hospice and palliative care teams and the population of patients they serve.

Pain specialists cannot wait to be “invited to the party.” We must gracefully and diplomatically assert our presence, creating the connections that will lead to timely consultations. Please accept the challenge to identify your local hospital’s palliative care team and your community’s hospice provider(s). Invite yourself to meet with their inter-disciplinary teams (IDTs), become acquainted with their culture, and describe what you do and what you can do to be of service. Volunteer an hour or two a week to help develop a pain Quality Assurance Performance Improvement initiative, built upon well-founded metrics. Ask to attend their weekly IDT meetings and help identify those patients who have difficult-to-control pain problems, or whose therapies are causing intolerable adverse effects or unsustainable costs. And most importantly, become “just a phone call away.”

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Table 1 Survey of 34 attendees at the 29th annual American Academy of Pain Medicine (AAPM) meeting in Fort Lauderdale, FL (April 11–12, 2013)

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<th>Questions</th>
<th>Responses</th>
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<td>Q1: How many cases do you serve in a hospice setting (inpatient or outpatient) annually?</td>
<td>Range: 0–1,500* Mode: 0</td>
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<td>Q2: As a pain specialist, do you recognize a need for your services in the hospice population that does not currently access your expertise?</td>
<td>Yes: 28 (82%) No: 6 (18%)</td>
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<td>Q3: As a pain specialist, do you recognize a need for your services in the palliative care population that does not currently access your expertise?</td>
<td>Yes: 30 (94%) No: 4 (12%)</td>
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<td>Q4: Is the amount of continuing education content that AAPM provides in hospice and palliative care just right, too little, or too much?</td>
<td>Just right: 6% Too little: 94% Too much: 0%</td>
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* A total of 3,425 cases (consultations) were reported of which two physicians accounted for 2,500 and five other physicians accounted for 800 of this total.

References
Commentary