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The Pain and Palliative Medicine Clinic

A Description of the Ohio Region's Pain and Palliative Medicine Program

The capability of providing high quality pain management always ranks near the top of our organization's "challenge list." Clinicians are eager to discuss this subject, as is evidenced by the many manuscripts on pain management received by* The Permanente Journal, *and the proposal by some readers suggesting that we consider this as a future Systems Challenge topic.

The following article addresses the Ohio Permanente Medical Group's approach to pain management and provides a good basis for future dialogue on the subject within the Permanente community. Let us hear your opinion on this important subject.

– Lee Jacobs, MD, Associate Editor

Introduction

Inadequate treatment of chronic pain continues to plague American society.[1] In response, the Permanente Medical Groups across the country have been reevaluating the way we deliver care to patients in chronic pain.[2] This article will illustrate some of the consequences of inadequate and uncoordinated care, review the evolution of Pain Management as a specialty, and describe an interdisciplinary approach to pain management developed by the Kaiser Permanente (KP) Ohio Region. Readers are encouraged to consult standard texts for detailed reviews of pain management.[3]

Case Example

A 31-year-old man came to the emergency department (ED) after sustaining a whiplash injury in a motor vehicle accident. A two-week course of opioid agents, muscle relaxants, tricyclic antidepressants, and bed rest was prescribed, and the patient was instructed to follow up with his primary care physician. Persistent neck and head pain led to the patient being referred to a neurologist, who confirmed the diagnosis of muscle strain, but also sent the patient to the mental health department to rule out underlying psychopathology. The patient did not follow through with recommendations and came to the ED three more times. Magnetic Resonance Imaging (MRI) showed two herniated cervical disks. A neurosurgeon was consulted, and a three-level laminectomy with fusion was performed. The patient continued to have pain and four weeks later was referred to the anesthesiology department for epidural corticosteroid injections. Still in pain, the patient was told to return to the neurosurgeon. The patient came to the ED several more times before changing health plans.

This case illustrates some of the consequences of improper and uncoordinated pain management. The cost to the patient in terms of lost productivity and suffering was incalculable. Dissatisfaction was high among the patient, his employer, and physicians involved in his care. In addition, the health plan experienced high resource utilization and ultimately lost the member to another health plan.

Change is underway. Ample evidence indicates that patients, their families, and the public are becoming less tolerant of poor pain management and that this may be the ultimate driving force behind improving care.[4] In addition to increased public demand, advances in pain management have provided an additional impetus for improving access to pain treatment. Regulatory bodies are examining how health care providers are responding to these challenges. Moreover, substantial sums have been awarded in lawsuits claiming inadequate treatment of pain.[5]

Evolution of the Pain and Palliative Medicine Clinic

To appreciate current models of pain clinics, a brief history is in order. Anesthesiologists gained proficiency in use of regional anesthesia after topically applied cocaine was developed in 1884.[6] Subsequently, Rovenstine established a nerve block clinic at Bellevue Hospital in 1936.[7] Nerve block clinics function under a biomedical model wherein the site of nociception is identified and interrupted by application of local anesthetic agents, neural destructive agents, or neural augmentative procedures. This model persisted until the emergence of multidisciplinary clinics in the 1960s, developed by Winnie and Bonica as described by Bonica in 1990.[8] Multidisciplinary clinics favor a biopsychosocial approach and are often available only in teaching hospitals and tertiary care centers. In contrast to multidisciplinary clinics, specialty clinics give care that is heavily influenced by the primary specialty of

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(bottom right) RONALD COPELAND, MD, FACS, is the Medical Director for the Ohio Permanente Medical Group. Prior to assuming his current role a year ago, he served as the Vice President and Associate Medical Director.

the treating physician. Several types of pain clinics may function concurrently in the same institution. Anesthesiologists typically direct nerve block clinics; neurologists and internists direct medication clinics; physiatrists direct physical therapy clinics; psychologists and psychiatrists direct cognitive-behavioral clinics; and practitioners of alternative medicine have developed their own programs. Each of these clinics may use treatment modalities from various specialties, but lack of integration and coordination may cause fragmentation of care and confuse patients and physicians alike.[9,10]

Recognizing this possibility, the American Board of Pain Medicine (ABPM) has developed a process of certification in pain medicine now recognized in the State of California for physicians of different specialties. Eligible candidates must be Board-certified in their respective specialties and must demonstrate additional training or experience in treating pain. The ABPM is working toward being recognized by the American Board of Medical Specialties (ABMS). Recently, ABMS approved a joint proposal by the American Board of Psychiatry and Neurology (ABPN) and the American Board of Physical Medicine and Rehabilitation (ABPMR) to offer subspecialty certification.[11]

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The KP Ohio Region's Response

In January 1997, after conducting a needs analysis, the KP Ohio Region implemented an interdisciplinary Pain and Palliative Medicine Program with a threefold mission: patient care, physician education, and institutional policy development. The expertise of several disciplines was collected under the direction of an anesthesiologist certified by the American Board of Anesthesiology (ABA) and by the ABPM. Representing the physical medicine and rehabilitation, behavioral medicine (psychiatry, social work, addiction, psychology), pharmacy, and nurse education departments, members developed a broad-based biopsychosocial model for treating the entire person, not just the site of injury.

The team cares for patients after their initial evaluation by the medical director, who regularly schedules case conferences with team members to synthesize information and to develop treatment plans. In keeping with the biopsychosocial model, the central components of patient care are the pain management groups and classes, which give patients a focus of control other than medications and procedures. In a series of 10 sessions, patients are taught "life management skills" to redirect their focus from cure to self-care and rehabilitation. The sessions aim to decrease pain and suffering, increase recreational and vocational activities, and decrease reliance on the health care system. Nerve block, medications, and physical treatment modalities are provided by specialists when appropriate.

Flaws in methodology have caused outcome data from pain clinics to be criticized. However, unless an indicator of care is measured, improvement cannot occur. The research suggests that patient satisfaction is directly related to treatment effectiveness.[12] Before and after treatment, therefore, we measure patients' satisfaction, level of physical activity, and depression as well as their primary care and ED utilization. Preliminary data are encouraging (Fig. 1).

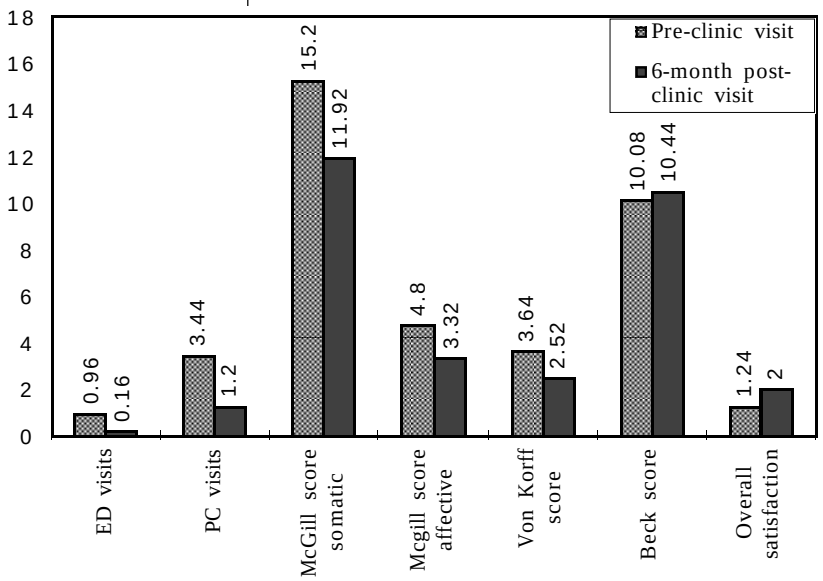

Fig. 1. Preliminary outcome data for 25 patients seen in the pain clinic, KP Ohio Region.

Multiple studies have shown that physicians' education in pain management has been uniformly inadequate.[13] In our program, therefore, we have incorporated pain and symptom control as an integral component of educating primary care providers. Educational activities are modeled after the International Association for the Study of Pain Core Curriculum for Professional Education[14] and the American Board of Internal Medicine's "Caring for the Dying—Identification and Promotion of Physician Competency Program."[15] These programs are regularly given at monthly department meetings and at various office locations.

Pain control cannot be improved by clinics and patient education alone: An institutionwide change in culture is needed. Development, implementation, and monitoring of practice guidelines for treatment of acute, chronic, and cancer pain is just a beginning.[16-19] Using as policy the belief that untreated pain and suffering is unacceptable and will not be tolerated is the top priority of our KP Ohio Region. We have therefore

combined a "top-down" as well as "bottom-up" approach, which has been a major accomplishment of the Pain and Palliative Medicine Clinic.

Conclusion

The profile of the "pain patient" is familiar to health care providers and administrators and is frequently associated with dissatisfaction with care, lost workplace productivity, and excessive resource utilization. We have illustrated the possible result of fragmented pain care and described the program developed in the KP Ohio Region. We hope this article inspires other KP Regions to improve pain management by identifying areas of opportunity and developing similar models so that the entire Kaiser Permanente Medical Care Program may be known as the leader in effective pain management. ❖

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