In this issue of the Newsletter, you will find very good examples of the challenges associated with treating pain in older persons, as well as solutions proposed by SIG members, through innovative clinical and education programs.

Drs. Luis Camara, Eduardo Stonski, and Daniel Weissbrod, from Buenos Aires, Argentina, describe their pain management program, designed specifically for older persons, which includes not only clinical care, but also an important education component. To my knowledge, there are only a few such programs worldwide. Drs. Benny Katz, Robert Helme, and Stephen Gibson, from Australia, created the first pain program for older persons, where patients are admitted to a comprehensive multidisciplinary program. Dr. Debra Weiner, in Pittsburgh, USA, is a rheumatologist and geriatrician working in a pain clinic. In Montreal, Canada, we have created a Geriatric Pain Clinic with an interdisciplinary team with expertise in pain and geriatric medicine. If any SIG member is working in a similar program, please let me know, so that we can all learn from each other.

Speaking of Dr. Weiner, she describes a very interesting case where a combined expertise in pain medicine and geriatric medicine was essential in providing good care to this patient. The issues she raises are surely familiar to clinicians trained in geriatric medicine, but much less to other health care professionals treating older patients. Since it is clearly impossible to have enough clinicians trained in both geriatric and pain medicine to respond to the needs of older persons in pain, it will be necessary to disseminate the knowledge to clinicians working in pain clinics, and whose clientele includes a large proportion of older persons with cognitive impairment. We will achieve this only if we continue our constant efforts to educate the medical community about the specific needs of older persons.

In addition to good clinical care and educating health care professionals, the other important part to improve pain management in older persons is educating the general public. This is what Dr. Lucia Gagliese, from Canada, has done via a national public lecture series, held in all major Canadian cities. She describes this initiative, which will hopefully inspire others to organize similar events.

2008 will be an important year for our SIG. After being “in formation” for three years, our status will be reviewed by the IASP Council, who will decide whether we can become an official SIG of IASP. If so, we will have to hold elections and form an executive committee, which will be responsible for all SIG activities. This new executive committee will hold its first meeting during the Glasgow Congress in August. We will ask for nominations for executive committee positions in March and to hold elections in the following months. The executive committee will include positions with the following responsibilities: chair/treasurer, communication (e.g., newsletter, website), meetings (workshops and Satellite Symposia during World Congresses), coordinator of subcommittees (e.g., clinical matters, education, scientific matters). Please think about nominating yourself for one of these positions, to help our SIG move on to its next step.

David Lussier, MD, FRCP(c)
The Older Persons Pain Relieve Group (GADA\textsuperscript{1})
Luis Cámara, Eduardo Stonski and Daniel Weissbrod
Geriatric Medicine Program, Italian Hospital, Buenos Aires, Argentina

Introduction
The Older Persons Pain Relieve Group (GADA) was established in 2004 by the Geriatric Medicine Program (PMG\textsuperscript{1}) of the Italian Hospital in Buenos Aires, Argentina. The PMG serves a population of about 35,000 older patients within a health maintenance organization (HMO). Other programs within the PMG include an Older Persons Functional Evaluation Group, a Depression Group, a Cognitive Impaired Group, and a Stroke Group.

The importance of chronic non-malignant pain within the population led to the formation of GADA, offering patients integrated, multidimensional, and multidisciplinary assessment and management.

Coordination of GADA
GADA is coordinated by:
- Dr. Luis Cámara, PMG Director
- Dr. Eduardo Stonski, specialist in Internal Medicine and Geriatrician, Master in Pain, together with a postgraduate trainee in Pain Assessment and Treatment
- Dr. Daniel Weissbrod, specialist in Internal Medicine and Geriatrician, together with a postgraduate trainee in Pain Assessment and Treatment

Also participating in GADA are a number of medical specialists from other disciplines, as well as nurses, who play an important role in the patient’s assessment.

The roles of GADA
GADA works in several areas related to the multidimensional assessment and management of patients with pain. These include:
- Investigation
- Education of:
  - patients and relatives
  - primary care physicians, internists, geriatricians, etc.
  - doctors from other disciplines interested in pain evaluation and treatment
  - nurses
- Patient Care
  - Multidimensional Assessment
  - patients with non-malignant chronic pain
  - patients with chronic wounds
  - Pain Management in Older People (MADA\textsuperscript{2})
  - pharmacology
  - non-pharmacology
  - Follow-up

How does the multidimensional assessment work?
The patients are usually referred by their primary care physician, who provides a clinical summary outlining the medical history, pain problem, and difficulties managing the case. The patient attends Pain Assessment in Older People (EDA\textsuperscript{3}), a component of PMG, usually accompanied by a relative or caregiver. The evaluation typically lasts between two and three hours.

On arrival, they are met by a nurse trained in Pain and Geriatric Assessment, who outlines the assessment process. Following evaluation by the nurse, the patient is assessed by a pain physician, who writes a report outlining the presumptive diagnosis, investigations, suggested management plan, and follow-up. The report is then sent to the referring primary care physician who knows the patient best, who makes the therapeutic decisions and follows up most cases. The primary care physician is able to communicate with the pain physician to discuss any concerns regarding the assessment or management plan. The team members communicate by various means, such as radio messages, phone, cellular phone, email, mail, and facsimile.

Multidimensional Assessment of Older Patients with Pain
The primary goal is to relieve pain and suffering. In order to do this, we need to know more than simply what hurts or the pain location.

We work with the concept of “Total Pain.” A multidisciplinary geriatric assessment approach was adopted with a pain orientation. With the passage of time, the model was improved, with different scales being introduced as part of the multidimensional assessment.

This evaluation has two parts. The first portion is made by trained nurses, and the second by doctors specialized in pain evaluation and treatment.

Information collected includes demographic details, economic status, social supports, environmental factors, and family structure. The patient identifies the important supports, whether family, caregivers, friends, or neighbors. We then draw a diagram to show the important relationships and any conflicts that exist between them. In this stage, we usually find out data about recent mourning (some not so recent), or pathological issues caused by the loss of relatives. We also may find mourning related to retirement, loss of economic status, social status, or other factors.

We also evaluate patient education level, as well as present and past activities, such as what the does in his or her spare time. We inquire about the religious affiliation and whether the patient still actively practices it. We ask about the home and any areas of conflict, such as family, job, economy, and health.

\textsuperscript{1} PMG comes from the Spanish words: Programa de Medicina Geriátrica
\textsuperscript{2} MADA comes from the activity’s name in Spanish: Manejo Adecuado del Dolor en Ancianos
\textsuperscript{3} EDA comes from the activity’s name in Spanish: Evaluación del Dolor en Ancianos
The clinical assessment focuses on factors that can modify the pain or change therapeutic decisions. Addictions are a very important issue. We ask about smoking, alcohol use (we used a scale called RAPS4CF, similar to the CAGE, validated for our population), or other hard drugs, and we look for addiction to pharmaceutical drugs.

We make a detailed history of the medications the patient is taking at the moment, including drug name, commercial name, doses, inter-interval doses, positive and adverse effects, who prepares the drug, who administers the medication, and the level of knowledge the patient has about the medication. We pay attention to the medication history and other non-pharmacologic treatments.

We continue with the sleep assessment, bowel and urinary habits, vision testing, and hearing assessment.

To assess the patient’s cognitive aspects, we use the Mini Mental State Examination (Folstein), and the Clock Test. We evaluate depression using the Yesavage Geriatric Depression Scale (short form – 15 yes/no questions), and the PHQ9. We use another scale called PRIME-MD. This scale allows us to assess anxiety, somatic disorders, nutritional disorders, and alcoholism as well.

We also assess the quality of the patient’s life by using the EQ5D scale.

We assess the pain using a visual analog scale (VAS), a pain drawing using a three-color scheme (red, green, and blue). We evaluate the pain interference in the patient’s life using the activities of daily living (ADL), instrumental activities of daily living (iADL), and the Brief Pain Inventory Scale (BPI). We add the McGill pain questionnaire to all these assessments.

We complete the patient’s physical examination oriented to the pain problem. We also perform a neurological examination, including thermal sensitivity. Primary and dynamic posture is assessed. We review the past investigations.

Using this information, we establish:
- the presumptive diagnosis
- the diagnostic plan
- the suggested therapeutic plan
- the follow-up plan

We also arrange further investigations or assessment by other specialists who interact with the GADA (such as spine specialist, psychiatry, etc.)

We then send a written report to the patient’s primary care physician. As noted before, we offer the patient’s primary care physician several ways to contact us for further information. We include in the report our interpretation of what is happening with the patient, physiopathological mechanisms, and therapeutic options. We indicate how to increase doses, likely adverse effects, and information that the doctor must give to the patient about each treatment.

We also educate the patient and his or her family about the pain causes, changes of life habits, and home adaptations, among other issues.

Pain Assessment in Chronic Wounds (EDHEC+)

We conduct a similar assessment of patients with chronic wounds. This assessment is called EDHEC. To the multidimensional assessment described previously, we add a detailed wounds assessment and advanced care, in which we apply a pain treatment protocol with local lidocaine plus opioids in the wound. An analgesic management plan is recommended for each patient.

Continuous Medical Education in GADA

A meeting is held each week in which all GADA members participate (physicians, nurses, and all other specialists who work with us, such as psychiatrists, psychologists, spine and knee specialists, etc.). We also invite the other work groups of the Geriatrics Medicine Program of the Italian Hospital of Buenos Aires (Cognitive Evaluation, Depression, Polypharmacy, and Gait groups) to join us in the meeting. We discuss the most complex patients’ cases and delineate joint strategies.

Conclusions

The multidisciplinary model we have developed has created a structure that allows us to gain a multidimensional understanding of our patients and their pain. Other problems or diagnoses are often identified that may or may not relate to the pain problem, but may influence the therapeutic decisions. This model allows us to identify patients who require further investigations or assessment by other specialists. In addition, the patients’ satisfaction is huge. They appreciate the multidimensional approach, which helps them confront their pain. Last but not least, this assessment allows us to select better pharmacological and non-pharmacological treatment schemes, customized for each individual patient.

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4 EDHEC comes from the Spanish name: Evaluación de Dolor en Heridas Crónicas
Caregivers of older adults with dementia and pain frequently struggle with how to alleviate suffering of their loved ones. Depending on the severity of dementia, accurate pain assessment may be difficult because of impaired verbal reporting skills. A number of behavioral scales have been developed that rely on expression of non-verbal pain indicators, such as negative vocalizations, guarded movement patterns, and facial grimacing (1). In addition to communicating physical pain, what else can pain behaviors tell us? How can they guide us in prescribing appropriate treatment? The following case and quality improvement project may help to elucidate the answer to these questions.

**Case Report**

An 82-year-old woman presented to the University of Pittsburgh’s Older Adult Pain Management Program with a two-year history of low back pain and right leg pain. She had been told that her symptoms were related to lumbar spinal stenosis identified with magnetic resonance imaging. She had been very active, working full time in a dress shop until two years earlier, when she was forced to retire because the company was downsizing. She lived alone, and her pain started after she retired. She reported increased pain intensity with prolonged standing and walking, and improvement with application of heat. She denied fever, chills, weight loss, paresthesias, lower extremity weakness, or change in function of her bowels or bladder. She denied nocturnal symptoms. It had become increasingly difficult for her to do heavy housework. She reported frequent near-falls, passive suicidal ideations, and fear of going on the bus alone, so she was spending more time at home alone. Her medications included gabapentin, oxycodone CR, celecoxib, tramadol, acetaminophen, olanzapine, escitalopram, and lorazepam. Physical examination was notable for very impaired righting reflexes, marked kyphoscoliosis, and tenderness on palpation of the right sacroiliac joint, tensor fascia lata, and erector spinae. Strength testing was limited by extreme guarding behavior. Her performance on the clock drawing test, a sensitive screen for dementia (2), was also very impaired.

She was admitted to a nursing home for detoxification. All of her medications were discontinued with the exception of regularly scheduled acetaminophen and prn tramadol. Her balance and cognitive function improved markedly, and her pain complaints became infrequent. Assisted living facility placement was recommended, but the patient and her family refused. Within 24 hours of discharge, the patient’s pain complaints escalated. She began calling frequently, asking for more pain medication. Because I remained firm in my conviction that the patient’s social situation was driving her pain behavior, I did not change her analgesic regimen. She, therefore, sought out another pain provider, who escalated her pain medication regimen that culminated in a morphine pump trial, which failed. Ultimately, the patient was admitted to an assisted living facility, where she did well.

**Quality Improvement Project**

In 2004, a study was published by Baier and colleagues that examined the efficacy of a multifaceted intervention in 21 nursing homes in Rhode Island, USA, designed to improve pain management (3). The components of the intervention included education on pain management, audit and feedback, systematic quality improvement, one-on-one mentoring for each nursing home, and collaboration between participating homes. The goals of the intervention were to increase pain assessments for residents with documented pain, increase use of non-pharmacological pain treatment, and improve the appropriateness of analgesic prescribing. While the intervention did not significantly impact analgesic prescribing, the frequency with which appropriate pain assessments were documented and non-pharmacological pain management strategies were used increased significantly. In addition, the prevalence of pain decreased significantly, from 12.2% to 7.2%.

**Discussion**

What does the case presented and the quality improvement project teach us about pain in older adults with dementia? Published data suggest that community-dwelling older adults may not be disabled by chronic pain (4,5) and that depression rather than pain per se is a strong predictor of disabling low back pain in older adults (6). We know from studies in younger patients with chronic pain that physical pathology cannot itself explain disability. Dysfunctional psychological attributes, such as catastrophic coping, impaired self-efficacy, and fear-avoidance are powerful predictors of physical disability (7-11), and cognitive behavioral therapy designed to ameliorate the deleterious effects of these psychological attributes is an essential component of interdisciplinary treatment programs for patients with chronic pain (12). These programs result, on average, in 30-50% reduction in pain intensity and approximately 50% improvement in function (13). How can we apply these principles of chronic pain rehabilitation to older adults with dementia?

As highlighted by Farrell, dementia is often associated with loss of social context (14). When the older adult with dementia and chronic pain loses social context, the end result may be fear and pain perseveration, such as that expressed by our patient described above. Lang-Porter and colleagues performed a laboratory-based study to examine behavioral and physiological correlates of pain associated with venipuncture in cognitively intact and cognitively impaired older adults with Alzheimer’s disease (15). Those with Alzheimer’s disease had a blunted physiological response and exaggerated behavioral response (i.e., more facial expressions) to the venipuncture. These findings underscore the importance of understanding the meaning and drivers of pain behaviors in those with dementia. We know that dementia itself is disabling. Thus, when prescribing treatment to improve quality of life in older adults with pain and dementia, should the pain itself be the primary focus of our treatment efforts, or should we, to the extent possible, attempt to modify the

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**One Community Dweller and A Multi-Site Nursing Home Quality Improvement Project: What Can They Teach Us About Pain in Older Adults with Dementia?**

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dysfunctions that impair gate control (i.e., fear, anxiety)? In the case presented above, social isolation that created fear was the primary driver of the patient’s pain behaviors (i.e., pain perseveration and associated verbalization), and providing a safe environment ameliorated the patient’s fear and exaggerated pain behaviors without the need to escalate her analgesics.

What happens when older adults with advanced dementia lose all sense of social context? That is, what happens when they have no awareness that they are safe? The quality improvement initiative by Baier and colleagues was successful in increasing the use of pain assessment tools and increasing the use of non-pharmacological pain modalities, but not in increasing the use of pharmacological modalities. Even so, the prevalence of pain decreased to a significantly greater degree in nursing homes exposed to the intervention as compared with nursing homes in the control group. Non-pharmacological pain modalities employ attention and touch (e.g., application of heat and/or cold, massage, repositioning, or recreational therapy as a mode of distraction). Perhaps, therefore, the non-specific effects of touch and attention were the therapeutic element that resulted in elimination of “pain” in some residents.

What are nursing home residents trying to communicate when they express pain behaviors? What would happen to behavioral manifestations of pain in nursing home residents if staff were taught to administer massage at bedtime? What if staff were taught to touch patients using a nurturing and therapeutic approach rather than an antiseptic one? What if home-based caregivers were taught these and other approaches to helping their loved ones optimize quality of life rather than eliminating pain? Until cures for Alzheimer’s disease and chronic pain have been discovered, we as investigators must test the efficacy of broader approaches to pain management in these vulnerable individuals, and we as practitioners must think creatively and resist the urge to gravitate to traditional pain management.

Reference List


A case study in public education about pain: Being older does not mean being in pain.
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“The solution to needless pain is education in all its facets … If we can pursue these goals together – as scientists and therapists, as members of the full range of the scientific and health professions – we can hope to meet the goal we all strive for: to help our fellow human beings who suffer needless pain.”
(Melzack, 1988)

The IASP Year against Pain in Older Persons (YAPOP) provided an exciting opportunity to increase awareness about pain and aging among researchers, clinicians, and community members. The University of Toronto Centre for Studies in Pain (UTCSP), of which I am a member, has a strong commitment to pain education, including its groundbreaking interprofessional pain week training program (Watt-Watson et al., 2004) and educational activities for the public.

Why is public education about pain important? Education is a well-recognized component of pain management. As “health
literacy” increases in other fields (Cleary et al., 2007), it is important that we also maximize “pain literacy,” because it is critical to interpreting symptoms, seeking health care, making treatment decisions, and adhering to management plans (Ferrrell and Juarez, 2002). In addition to providing information about pain, the need to address attitudes and beliefs about pain and analgesics, especially opioids, has also recognized (Ferrrell and Juarez, 2002). As people live longer, they are more likely to develop chronic conditions that may be associated with pain, such as osteoarthritis or neuropathies (Jones and Macfarlane, 2005). Therefore, education about pain for older people may be instrumental to maximizing active participation in care and quality of life. Unfortunately, increasing age has been associated with lower health literacy (Gazmararian et al., 1999), and studies have highlighted pain-related information gaps among older people (Ross et al., 2001). Therefore, there is a special need for education in this group. Importantly, older people need to be informed of the distinction between changes associated with normal aging (e.g., graying hair) and those associated with health conditions that increase in prevalence with age but are not part of normal aging (e.g., pain due to osteoarthritis). If people falsely believe a symptom is part of normal aging, they may not seek health care but instead limit their physical and social activities to adapt to their deteriorating condition (Goodwin et al., 1999; van Eijken et al., 2004). Delays in seeking treatment for pain also may contribute to the well-known pattern of older people being diagnosed with more advanced, and potentially less treatable, illnesses than younger people (de Perrot et al., 1999; Kraemer et al., 2000; Ryan and Zerwic, 2003). Therefore, public education may be an important step to relieving pain and maximizing quality of life for older people.

The best strategies to educate older people about pain are not clearly established. There is some limited evidence that brief educational interventions (i.e., a 20-minute lecture) are associated with improvements in pain and disability among older people with back pain (Kovacs et al., 2007). Other effective strategies include lectures combined with a collaborative or interactive component, such as a “question and answer” or discussion period, testimonials from those living with chronic pain, and the presence of local community knowledge experts (Curry et al., 2002).

In Canada, the first week of November has been designated National Pain Awareness Week (www.canadianpaincoalition.ca/index.php/en/national-pain-awareness-week/senate-resolution). Awareness and education events for professional and community audiences are held throughout the country. The UTCSP holds an annual research symposium, often tied to the theme of the IASP Global Year, targeted to pain researchers, clinicians, and community members. I first discussed the possibility of working with the UTCSP to create educational opportunities about pain in older people with Michael Salter, the director of UTCSP, in April of 2006. He was immediately supportive of two initiatives: a half-day research symposium and a national public lecture series. For the symposium, I invited speakers with expertise in some of the most common pain conditions experienced by older people. All but one of the speakers was based in Toronto, to convey the message of strong local expertise and advocacy. Gillian Hawker (Women’s College Hospital, University of Toronto) described her important research on older people living with osteoarthritis. She presented data on the psychosocial impact of arthritis pain and on the decision-making process involved in joint replacement surgery.

Without funding, the public lecture series would not be possible. The first step to obtaining that funding was developing a proposal. We identified several potential sources of funding, including corporations and pharmaceutical companies with a history of funding public health education initiatives. The proposal described the IASP Global Year and the magnitude of the problem of pain in older Canadians (Scudds and Ostbye, 2001). It highlighted information gaps and their association with poor pain relief and quality of life. It provided a brief overview of the proposed content of the lectures. In addition, the compatibility of the project with the objectives of the funding source was outlined. Finally, it included a detailed timeline and budget. The initial proposal was reviewed, and much improved, by Michael Salter, Allan Gordon (Wasser Pain Management Centre), and Celeste Johnson (McGill University).

In addition to funding, it was important to secure endorsement from the Canadian Pain Coalition (CPC) and the Canadian Pain Society (CPS), a chapter of IASP (canadianpainsociety.ca). The Canadian Pain Coalition is an umbrella group of patient groups,
health professionals, and researchers with an interest in pain (canadianpaincoalition.ca). Together, the CPS and CPC are the national voice of pain in Canada and share a strong advocacy mandate. Their endorsement would signify to potential funders and audience members that the materials presented were credible and consistent with the organizations’ overall message and objectives regarding the importance of pain relief. I presented the initial project idea to the President of the CPS, Roman Jovey, and to the Board of the CPC. They were unanimous in their support of the sketchy project plan but postponed full endorsement until details were finalized.

With this preliminary support, we sent the proposal to several possible funding sources. Some of the potential funders were simply not interested, and others were interested in pain education but did not want the lectures to focus on older persons. Others required control and ownership of the lecture content, speakers, and venues. Fortunately, Merck-Frosst Canada, a large national pharmaceutical company, agreed with our objectives and gave a generous unrestricted financial and in-kind contribution to fund the lectures in partnership with the UTCSP. They were to be acknowledged as a collaborative partner during the lectures and in all related materials. Importantly, there was no commercial bias, and they did not participate in setting or controlling the content or speakers. I worked closely on the program with Amanda McWhirter (Manager, Public Affairs) and Susan MacLean (Health Science Associate). They are real champions of patient education and worked long, often frustrating, hours to make the lecture series a reality. Their input was critical to the successful completion of the project. In terms of timelines, Merck-Frosst agreed to fund the lecture series in November 2006, and the funding agreement was finalized in February 2007, leaving eight months to develop and deliver the lecture series.

One of the stipulations of the funding was that an Advisory Committee be formed to provide feedback as the project went forward. The following colleagues generously agreed to serve in this capacity: Celeste Johnston (McGill University), Michael Salter (UTCSP), David Lussier (McGill Pain Centre), John Clark (University of Calgary), and Susan McLean (Merck Frosst Canada). Over the next few months, each would be called on to provide feedback on materials and input into decisions required to move the project forward. Each time I went to them, their response was generous, timely, thoughtful, and supportive. Membership in the Advisory Committee was finalized in January 2007.

One of the Advisory Committee’s first tasks was to approve a preliminary roster of speakers. In mid-February, I emailed these potential speakers, described the project and requested simply a commitment to participate in principle, without any set date other than before the end of the YAPOP. I must admit to some wariness as I wondered how I might respond to such a vague request. My anxiety was without basis, as the response was incredible. Suddenly, the lectures were no longer just something we “could” do but something we were actually doing. The infrastructure was in place: funding, endorsements, and speakers. It was time to fill in the blanks: venues, content, and advertising. Merck-Frosst hired a public relations (PR) company to help with the logistics of the sessions. This team booked venues, ordered catering, and coordinated advertising and speakers. The timing of the sessions was crucial – winter was impossible given difficulties with travel that older people might have, and the PR experts felt summer was equally bad because people would be on vacation. Therefore, we set a very small window of April to early June. This meant we had less than two months before the first session. There was considerable debate regarding the venues for the lectures. The literature suggested that the lectures should be held in the community, such as in churches or senior centers (Haber, 1996), but in the end, they were held at universities and hospitals. We further decided to offer the lectures in the afternoon. I now believe they should have been held in the early evening. These missteps arose, I believe, from my inexperience. I did not appreciate the importance of taking the content to my audience rather than expecting them to come to us (Haber, 1996). In retrospect, a PR company that specializes in community events, public health promotion, or older people would have been a better choice for this project.

The content for the lectures came together through an iterative process. The first step was a review of the literature regarding pain, pain beliefs, knowledge, and barriers to treatment among older people that led to the identification of main themes (see Table). This was circulated to the Advisory Committee and revised based on their feedback. The revised themes were then sent to the speakers and revised yet again based on their feedback. Using the final revised themes, I created a first draft of slides, which the Advisory Committee reviewed. Because it is important that the target audience provide feedback on content (Cleary et al., 2007), community members who varied in age (but were predominantly over 55 years old), education level (from less than high school to PhD) and English literacy (to reflect Canada’s cultural diversity) reviewed the slides. Following revisions to eliminate jargon and increase readability, the slides were sent to the speakers. More revisions followed, including the addition of slides created and generously donated by Maggie Gibson and David Lussier. Soon after, I circulated a second draft. Speakers

In Montreal, a city that is bilingual, both an English and French session would be offered.

With the speakers and funding in place, we could move forward with obtaining full CPS and CPC endorsement. Specifically, we wanted permission to include the CPS and CPC logos and URLs on signage, and promotional and educational materials. In addition to increasing credibility, the URLs would provide those interested in the topic — whether an older person with pain, a family member, or a professional caregiver — with an ongoing educational resource. The lecture series was also endorsed by the UTCSP (who provided excellent administrative support through Nancy Mitchell), York University, and the University Health Network (UHN). Because I hold appointments at each, their contribution was my time. In addition, UHN contributed space and audiovisual equipment for the Toronto session. It was now January 2007, and we hoped to mount the first lecture in May 2007 during the Annual Meeting of the CPS. Fortunately, by March 2007, we had secured endorsement from both organizations.

In mid-February, I emailed these potential speakers, described the project and requested simply a commitment to participate in principle, without any set date other than before the end of the YAPOP. I must admit to some wariness as I wondered how I might respond to such a vague request. My anxiety was without basis, as the response was incredible. Suddenly, the lectures were no longer just something we “could” do but something we were actually doing. The infrastructure was in place: funding, endorsements, and speakers. It was time to fill in the blanks: venues, content, and advertising. Merck-Frosst hired a public relations (PR) company to help with the logistics of the sessions. This team booked venues, ordered catering, and coordinated advertising and speakers. The timing of the sessions was crucial – winter was impossible given difficulties with travel that older people might have, and the PR experts felt summer was equally bad because people would be on vacation. Therefore, we set a very small window of April to early June. This meant we had less than two months before the first session. There was considerable debate regarding the venues for the lectures. The literature suggested that the lectures should be held in the community, such as in churches or senior centers (Haber, 1996), but in the end, they were held at universities and hospitals. We further decided to offer the lectures in the afternoon. I now believe they should have been held in the early evening. These missteps arose, I believe, from my inexperience. I did not appreciate the importance of taking the content to my audience rather than expecting them to come to us (Haber, 1996). In retrospect, a PR company that specializes in community events, public health promotion, or older people would have been a better choice for this project.

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were instructed to present the main points but also to tailor the content to their particular interests or expertise, if they preferred. For instance, Allan Gordon, John Clark, David Lussier, and Pat Morley-Forster discussed their pain services, and Maggie Gibson discussed pain in older people with dementia. Translation into French was provided by Merck-Frost with our French speakers (David Lussier and Aline Boulanger) having input. This extensive collaborative process resulted in presentations with up-to-date and important content, which were relevant to the informational needs and interests of older people with chronic pain.

Studies of one-time educational interventions for older people have shown that providing written materials enhances learning and retention of content (van Eijken et al., 2004). Given this, the Advisory Committee gave the go ahead to create a brochure, which Merck-Frosst funded. The brochure was designed to reinforce the main messages of the lectures but also to be informative for someone who had not attended the lecture. As far as possible, it was based on recommendations for the development of effective patient education materials. This included using common questions as a starting point, addressing common concerns and misconceptions, limiting use of technical terms and defining any that were used, using nonalarmist and nonpatronizing language, including sources for further information, keeping information concise and well structured, and stating who prepared the information including all sponsorship (Coulter et al., 1999; van Schaik et al., 2007). Community members, the advisory committee and the speakers reviewed the first draft of the brochure. Their feedback was instrumental in clarifying the message and maximizing potential impact. The final product is a tri-fold brochure entitled “Pain in the Older Person: Answers to common questions”. It covers questions such as “What is chronic pain?”, “Are my aches and pains just part of getting older?”, and “Can pain in older people be managed?” It includes links to the CPC and CPS and is currently available in English but will be translated into French. If you would like to receive the brochure, please contact me at the email address included with this article.

As a researcher, I was interested in outcomes. How would we know if we had communicated our message effectively? One way to assess this was with a simple pre-post design, which would fit our budget and not require extensive financial or human resource support. With feedback from the Advisory Committee, we created a survey to collect basic demographic, health status and pain-related information. Based on our literature review, I extracted several knowledge items about pain, aging, and analgesic use that reflected the main content of the lecture. Prior to the lecture, attendees would complete the survey. Following the lecture, the knowledge questions would be readministered and a general evaluation of the lectures and speakers would be completed.

The next step was advertising. How does one best advertise a public lecture about pain to older people and stay within a limited budget? The public relations company advised that newspaper ads and posters in health care settings would be the most effective. In addition, several media outlets picked up press releases they circulated. As a result, our lectures were included in the community events listings of several newspapers. In response to low attendance at the first two sessions, we expanded our advertising strategies in ways that were still within our budget. We distributed posters to community and senior centres and public libraries in each city. We used new media: CPS and CPC sent announcements to their mailing lists. CPS, CPC, UTCSP, the Chronic Pain Association of Canada, and many of the local universities and hospitals posted announcements on their websites. We sent emails and postings to online community events listings and organizations geared towards older people in each city. These strategies led to improved attendance, but the very short time line (often only a few days between sessions) limited our ability to advertise broadly and implement new advertising strategies.

The sessions were held from April 24 – June 6 2007. They were a mixed success. Attendance was lower than hoped for, but good considering the short timeline and some of the barriers to attendance we discovered. Examination of the evaluation forms revealed that two groups had attended: older people and health care providers. This was surprising as the lectures were clearly advertising as targeted to the public. Most importantly, the lectures themselves were outstanding experiences. The speakers, to a person, gave wonderful talks. They were lively, organized and engaged their audience. This was evident in the question and answer periods that followed the talks. It seemed that older people had found a place to describe their pain, express their worries, and learn how to get the care so many of them desperately wanted. The local champions were able to spell out the process for obtaining referral to pain clinics and to expertly address the audience’s concerns about pain, psychological distress and the use of analgesics. Preliminary analyses of the evaluation forms suggest that there were significant changes in knowledge among the older people and the health care professionals. The lectures and speakers received excellent evaluations, and there were many comments expressing high interest in further sessions on the topic. These data are currently undergoing statistical analyses, and the results will be reported in detail in a future manuscript.

There was considerable media coverage of the public lectures. Following the first session in Toronto, CFMT News, a television channel catering to Toronto’s diverse multicultural population, aired a segment in Italian that included snippets of the lectures. Importantly, Daniela Sanzone, the Italian-speaking reporter, summarized the main points of the lectures very well. Following the session in Montreal, The Montreal Gazette carried an article about pain in the older person. This article was picked up by the Canadian Associated Press and was reprinted in the Calgary Herald, Vancouver Province, Montreal Gazette, Ottawa Sun; Winnipeg Free Press, Brantford Expositor, Prince George Citizen, Times and Transcript (Moncton); Orillia Packet and Times; The Record (Kitchener, Cambridge and Waterloo); and the Windsor Star. The headlines for this article included “Chronic pain afflicts half of the elderly; it’s not part of aging process,” “Chronic pain is common, and often goes untreated” and “Debilitating pain shouldn’t be regular fact of life”. Linked with the Ottawa session, I was a guest on Sunday House Call a national syndicated radio show hosted by Barry Dworkin and heard in Canadian cities including Vancouver, Winnipeg, Windsor, Toronto and Ottawa.

(http://www.cfra.com/chum_audio/SHC-Dr.Gagliese.June.03.07.mp3).

This extensive media coverage suggests that the topic of chronic pain and, more specifically, pain in older people, is of interest and that these outlets can be used to raise awareness and provide
education. This may be an effective way to reach isolated or mobility-limited older people.

Overall, the UTCSP’s activities related to the Year against Pain in Older Persons were a success. We reached older people, caregivers, health care workers and researchers. We created educational materials that we will continue to disseminate. For instance, the brochure is now available to cancer patients at Princess Margaret Hospital, Toronto Canada. In addition, the National Initiative for the Care of the Elderly (NICE) has agreed to distribute it to their membership. Several of the speakers have used the slides for subsequent public lectures. This is very exciting and makes all of the stress worthwhile. Where do we go from here? There are several outstanding tasks. Most significant of these is continued and enhanced dissemination of the content. Two of the lectures, one in French and one in English, were recorded. We are actively seeking a website to host them as well as the brochure and lecture content. Recent evidence suggests that older people are willing to use the internet as a source of health-related information and support (Sullivan et al., 2003). This would be an excellent way to provide information specifically developed for the public. Finally, hard copies of the brochure are awaiting further distribution (please request some if they would be useful to you). Other future goals include the expansion of the brochure into a booklet and the empirical testing of the impact of this information. In addition, we are interested in developing strategies to reach older people who may be isolated due to mobility or language limitations.

Lessons were also learned. If I could go back, I would make several changes. I would rethink the venues. I would take the lectures to my audience. The sessions may have been better attended if they had been held in retirement homes, community centres, or public libraries. I would have spent more time exploring the possibility of simulcasting the lectures to various locations. This was done in London, Ontario and was very well received. I would have started the project much earlier. There was a whirlwind effect that increased everyone’s stress level. The short interval between sessions made it difficult to integrate feedback and implement strategies for improvement across sessions. A longer time frame also would have allowed more comprehensive advertising and the creation and testing of more extensive educational take-home materials. I would have chosen a public relations company that specializes or at least has extensive experience with public outreach. The evaluation would have included a long-term follow-up to assess maintenance of knowledge gains and its relationship to action. This type of data collection would have required participant contact information and additional funds for materials and research personnel that we did not have.

The attendees of both the NPAW symposium and the public lectures sent three strong messages: 1) Older people have significant information gaps about pain but they are willing to learn. In fact, there is a thirst for solid, evidence-based information about pain and its management. Related to this, older people, like many younger patients, are not always able to discern evidence-based management choices from nonproven, potentially fraudulent pain relief gimmicks. 2) Older people have a strong desire for pain management but may not know how to advocate for these services. Many of those who have sought help have encountered health care worker barriers including being told that pain is “normal” at their age. They also have encountered systemic barriers including scarce pain management services and long waiting lists. 3) Older people want better information about pharmacological pain management but they are also interested in nonpharmacological strategies. In making treatment decisions, they do not want their physical and mental functioning compromised by the adverse effects of analgesics. Many reported a fear of addiction and the belief that analgesics should be “saved” for severe pain. Many were using physical and psychosocial pain management strategies but knowledge regarding these modalities is limited. In addition, cost and access barriers may be associated with some of these interventions.

Given these messages, it is evident that efforts to develop and disseminate educational programs for older people should continue beyond the Year against Pain in Older People. These programs are expensive and require significant investments of time, effort and resources. In addition, there is often little support for clinicians or researchers to be involved in community education as most institutions only consider publication of research papers and grant funding in assessing productivity and impact (Cleary et al., 2007). Nonetheless, we know that pain education is a cornerstone to effective pain management. We need advocates to continue these efforts and to expand them beyond Canada. On behalf of the UTCSP, I invite those who share an interest in public education about pain to contact me regarding further development and dissemination of the educational resources we have created. Finally, I wish to thank all the colleagues, community members and consultants who contributed to the success of this program. It would not have been possible without you.

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References


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**The Newsletter**

Members are encouraged to contribute to this newsletter. Please consider submitting an article on your research, a case study, conference report, literature review, etc. For details please contact Benny Katz at elderpainsig@connexus.net.au

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**SIG Information**

**SIG on Pain in the Elderly statistics:**

The SIG currently has 189 members representing 25 disciplines in 40 different countries.

**Treasurer’s report:**

As of September 30, 2007, the SIG account balance was US$6,110.

**The Pain in Older Persons SIG objectives are:**

- to increase awareness and promote education about pain in older persons
- to provide an international and interdisciplinary forum for people interested in clinical and research questions on pain in older persons
- to develop/endorse best practice guidelines for assessment and management of pain in older persons
- to promote discussion and research on pain in older persons, including:
  - senescence of pain perception
  - multidimensional assessment of pain and its consequences
  - pharmacological and non-pharmacological management of pain
  - uniqueness of the pain experience in patients with cognitive impairment
- to facilitate the development of international collaborative research efforts on pain in older persons

**SIG Membership**

Membership in SIGs is open to any members of IASP. Members wishing to join the SIG should indicate their preference on the annual IASP membership renewal form with the $20.00 SIG dues. This can be done online at: www.iasp-pain.org under membership, or contact the IASP main office directly at: members@iasp-pain.org