Editorial

As I have been indicating in the last few Newsletters, it will soon be time to hold elections for our SIG, so that the mandate of the new executive committee begins at the World Congress in Glasgow in August, following our general assembly. In this newsletter you will receive details about the elections procedures and the call for nominations, including the positions and terms of office for the SIG executive committee.

I strongly encourage you to become candidate for an executive position, to actively participate in advocating for better pain management for older persons. The executive committee will be formed of the following positions:

- Chair/treasurer
- Communication (newsletter, website, etc.)
- Meetings (workshop for each IASP meeting, Satellite Symposia)
- Chairs of subcommittees on
  - Clinical matters
  - Education
  - Scientific matters

It is important that the executive committee be multidisciplinary and multinational, so I hope we will get several candidates. We will soon be proposing SIG bylaws to govern future elections. These will be put before the members for comment and a vote as well.

If you still need encouragement and motivation to get actively involved with the SIG, the two articles of this issue of the Newsletter, by Stephen Gibson and Benny Katz, provide very good reasons to do so, by highlighting the importance of coordinating our efforts in order to be more effective in building research capabilities, and advocating for better pain management.

So please keep your eyes open for the call for nominations, and think of nominating yourself or somebody else!

David Lussier, MD, FRCP(c)
Over recent years there have been repeated calls for more research on pain in older persons (Weiner 2006, Lussier 2006, Gibson 2007). In part this reflects a clear recognition of the aging of the world’s population and the significant problem that bothersome pain represents for the older segments of our community. However, there has also been a growing awareness of the current lack of scientific evidence to inform clinical practice in pain management for older persons, both in relative and absolute terms. For instance, it has been noted that only 1% of research papers published on pain each year focus on older adults (AGS 2002). In Australia, less than 0.6% of research funding from the National Health and Medical Research Council is devoted to studies of Geriatrics or Gerontology, and less than 1% of training research fellowships are awarded in these areas (LeCoutuer et al. 2002). This paucity of research is perhaps surprising given that over 35% of the total health expenditure is devoted to the provision of health services and medications to older adults.

There are a number of ways in which research on pain and aging could be improved, including increased funding opportunities for issues related to aging, dedicated government backed initiatives, better education of health care professionals about the current lack of research, and the initiatives of various professional associations to promote the cause of an aging population, with the formation of the IASP SIG on older people being a salient example of this approach. One core element in being able to improve research is building research capacity and particularly in training a new research workforce with expertise in age-related issues and attracting existing pain researchers into the field of aging.

As the SIG on pain in older persons thinks about the best methods to improve the quality and quantity of research output, it may be opportune to reflect upon one training/research model that was initiated at a Geriatric Pain Centre in Melbourne, Australia. The outpatient geriatric pain clinic commenced operation in 1988 as a collaborative venture between the National Ageing Research Institute and the local health care network (Helme et al. 1996). The aim was to develop a world class, state-of-the-art outpatient service for older persons suffering from chronic pain and to undertake professional education activities and an extensive research program into geriatric pain. Of note in the present context was the strong link between clinical practice and research activity. Indeed, the operational model adopted by the clinic from its conception essentially viewed research, ongoing professional development, and best clinical practice as inseparable components of the same process. For instance, the need for appropriate clinical assessment of older pain patients demands a comprehensive understanding of age differences in pain perception and report, the use of valid and reliable pain assessment tools and due consideration of the unique issues (both medical and psychosocial) that are relevant to the treatment of older persons. Similarly, good clinical practice requires age-appropriate assessment tools, the constant monitoring of treatment outcomes, and the adaptation of program components to better meet the special needs of older patients. Whenever such information is lacking, it prompts dedicated research programs in order to help inform age-appropriate clinical practice. This process also ensures that clinical need is a major source of material for setting research questions, thereby improving the relevance and clinical utility of research efforts.

One key feature of the clinic research and training program focused on encouraging all clinical staff to take an active role in investigator-driven research. Dedicated time was provided so that all staff could meet for a weekly discussion of research ideas and projects, and this time was included in the clinical budget. A particularly suitable framework allowed clinical staff the opportunity to undertake a higher research degree by providing protected time away from clinical duties. This ensured that research activities were of personal relevance to the clinic staff and of high personal motivation to ensure the success of the research project. Moreover, clinicians involved in active research tended to have the most up-to-date knowledge of evidence-based options for assessment and treatment. In this way, the quality of the clinical service was also improved. The National Ageing Research Institute provided experienced research nurses and post-doctoral research scientists to contribute to the clinical research program. Expertise in research design and analysis, the conduct of clinical trials, and aspects of measurement and outcome assessment were thereby made available to the clinic. In addition, the research staff could provide advanced hands-on training and mentoring in research methods for interested clinical staff. I believe that this strong interface between pain management service delivery and ongoing research activity provided a unique and state-of-the-art training platform for patient-based clinical research, and helped to promote an effective translation of new research outcomes into routine clinical care. When required, there were also links into the basic biology laboratories of the National Ageing Research Institute, and this allowed for parallel animal studies to be conducted in order to better understand age-changes in pharmacology or to explore more basic mechanisms of pain in those diseases that commonly affect older persons. As mentioned above, this relationship was entirely interactive and symbiotic with the flow of questions and information proceeding from the clinic to the laboratory and back to the human research efforts and the clinic itself.

Overall, it is important for all members of the SIG on pain in older persons to consider new ways to help build research capacity in pain and aging, as this is essential for improving evidence-based practice in the management of pain in older persons. Ideally, research activities should span the full spectrum, from the most basic cellular and physiological processes through to epidemiological studies of whole populations. The range of possible topics is equally broad, from developing a better understanding of the underlying neurophysiology and neurobiology of pain in older persons, testing of age differences in pain perception and its...
biopsychosocial impacts, development of age-appropriate assessment tools, including special populations (i.e. those with dementia), improving our understanding of the phenomenology of the pain experience in older adults, an examination of age-related factors that can potentially modify the pain experience, through to new and better pain management strategies for this vulnerable population. Most of these research areas are dependent upon attracting a competent research workforce with special expertise in age-related issues. The model discussed in this article represents one small initiative to build aging research capacity in patient-based clinical research. Nonetheless, it is a convenient and scaleable workforce training model that may be appropriate for many of the clinical pain services devoted to the needs of older persons. If adopted widely, such initiatives would help bridge the large gap in current research activity and provide a much needed boost to research capacity in the important area of aging and pain.

References


Weiner D.K. Pain and aging: a call to those with the power of inquiry, the skills to teach, and the desire to heal. Pain Medicine, 2006, 7(1), 57-59.

A great deal of resources are expended dealing with the problem of pain in older persons, yet the clinical outcomes remain very disappointing. The fact sheet produced for the IASP Global Year Against Pain in Older Persons (2006-07) states that persistent pain affects more than 50% of older persons living in the community. 45.8% of older persons admitted to the hospital report pain, 19% have moderately or extremely severe pain, and 12.9% are dissatisfied with their pain control. Persistent pain may affect 80% of nursing home residents.1

Policies, guidelines, and resources are not enough unless they are rigorously and consistently applied. Unfortunately, the issue of pain in older people has not been given the priority required to have a major impact. Fragmentation of effort remains a major issue. Prior to the formation of our Special Interest Group, there was no forum or group of experts exclusively focused on dealing with this problem. As a SIG, we have the opportunity to make work collectively to increase the priority given to management of pain in older persons.

All ministers for health in Australia have agreed on a National Health Priority Action Plan covering seven major areas of concern.2 The aim is to identify, advocate, and facilitate action across the continuum of care (including prevention, detection, management, rehabilitation, and palliation) and to drive improvements in health services to achieve better outcomes. The National Health Priorities include cardiovascular disease, cancer, and mental health; but as yet pain has not achieved priority status despite the high prevalence and resources already committed to this area.

An example of a systems approach to improve pain management is that of the Joint Commission on Accreditation of Health Care Organizations. This is an independent, not-for-profit body that evaluates and accredits more than 15,000 health care organizations and programs in the United States. In 1999, it launched an initiative to improve pain management in health care settings. Pain management was made a patients’ rights issue, as well as focusing on education and training, encouraging the systematic assessment of pain, encouraging the use of standardized pain instruments, and stressing the need for safer pain management. Guidelines such as these have been employed in other countries and settings, providing a structure to improve the assessment and management of pain.

The translation of policy and knowledge into clinical practice progresses slowly3. Individuals adapt to change in different ways. A range of integrated strategies is required to implement change, including in-service education, dissemination of literature, and direct observation of role models. Individuals who are prepared to adopt change need to be identified to promote a culture of pain awareness within our organizations. The majority will follow these innovators. A minority of staff who prefer traditional approaches may resist change. They are more likely to discontinue an innovation after implementation. They require ongoing professional development and need to be prevented from disrupting the change process.

One of the first initiatives of our SIG was to establish this newsletter. Many members have now had the opportunity to discuss their individual achievements, particularly during the Global Year Against Pain in Older Persons. As we approach the 12th World Congress on Pain in Glasgow, we will be seeking IASP’s ratification of our SIG in formation to an official SIG. While this may appear to be a formality, it does place an increased responsibility on each member of the SIG. If we are to be effective, every member of the SIG will need to work collaboratively guided by an elected committee. The newsletter will report on the work of the committee and continue to publish contributions from members about their own achievements.

Translating Knowledge into Clinical Practice

Benny Katz, geriatrician and pain medicine specialist,
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I was involved in a series of in-service education sessions during the Global Year Against Pain in Older Persons. Ward staff agreed that pain was an important issue for their patients but tended to underestimate the magnitude of the problem when compared with the results of pain audits undertaken in their wards. Inconsistent documentation was identified as a major problem, and when pain was recorded it did not tend to influence management.

To address this issue, a new pain chart was developed in conjunction with the Australian Centre for Evidence Based Aged Care (ACEBAC). The design of the ACEBAC Pain Chart enables three days of pain observations and interventions to be documented on a single page using a string of symbols. On admission to the ward, all patients are questioned as to whether they have pain. If pain is present, then pain is charted for three days using either a numerical rating scale or a word descriptor scale. In addition, descriptive behavioral indicators were developed from the Abbey pain scale and pain-AD for people unable to verbally communicate. Once selected, the same scale is used throughout the admission. The patient’s activity at the time of pain measurement is documented; for instance in bed, seated, walking or during rehabilitation activities. This is followed by a code for the pain intervention; for example analgesia, hot pack, massage, etc. The response to the intervention is then recorded. The ACEBAC Pain Chart is currently being evaluated in geriatric hospital and residential care settings.

Another project undertaken during the Global Year Against Pain in Older Persons was the development of an Internet-based tutorial for interns and junior hospital doctors on the topic of Pain Management in Older People. This is one of a series of 10 tutorials being developed by the Victorian Geriatric Medicine Training Program. Other topics include dementia, delirium, incontinence, and falls. The modules offer a variety of avenues for training encompassing adult learning principles, including interactive case studies, an electronic text book, a quiz, and frequently asked questions. The program will be hosted on the Australian and New Zealand Society for Geriatric Medicine website, www.asgm.org.au, and is expected to go live in April 2008. Your feedback on this tutorial is most welcome.

Access to specialist pain services is difficult for older people. Kee and colleagues conducted a survey of 96 pain treatment facilities in the United States, reporting that none excluded patients on the basis of age, although 28% of the programs had not admitted a patient aged over 70 years, and one-third excluded patients with concurrent medical illnesses, an indirect barrier to older patients. We developed a pain clinic to cater for the specific needs of older people more than two decades ago. Despite the imperative of an aging population, this model has not flourished in the same manner as following the establishment of John Bonica’s multidisciplinary pain clinic at the University of Washington in the 1960s. I am aware of three Pain Management Clinics for Older People in Melbourne Australia, and one in Montreal, Pittsburgh and Florida, and integrated programs in Veterans Administration Medical Centers at Tampa, Richmond, Ann Arbor, and Durham. I am keen to be informed of any omissions or inaccuracies in this list.

The population of people who have pain is heterogeneous. I like to consider two groups, “patients with pain” and “pain patients.”
I come across patients with pain every day in geriatric medical practice. They are found in the community, hospitals, and residential aged care facilities. They may be referred for a multitude of reasons such as management of medical problems, rehabilitation, and assessment of cognition or mobility. Many also have pain, but not necessarily as their major problem. In this population, pain is frequently underrecognized, underdiagnosed and undertreated. Others are satisfied with the management of their pain and do not want any further intervention. The management of patients with pain is every clinician’s responsibility.

On the other hand, pain patients are those who remain troubled by pain that has proven refractory to standard management. The transition from a patient with pain to a pain patient occurs when standard management has not been successful and pain continues to have a major impact on life. These individuals require the expertise of a pain specialist or multidisciplinary pain management clinic.

An 88-year-old woman was referred for rehabilitation following admission to hospital with pneumonia. Although pain was not listed as an important problem on the referral note, she was more concerned by postherpetic neuralgia than by an unsteady gait and poor stamina following the acute illness. Her family doctor had previously tried her on a wide range of pharmacological and non-pharmacological treatments without success. Severe persistent pain was having a major impact on her mood and activities of daily living. She is a pain patient. I arranged to see her in the pain clinic. She had a gratifying response to treatment with a 75% reduction in pain scores and improvement in her mood. This led me to question why she had not been referred to a pain clinic earlier. Was it because of her age, perceived poor prognosis, or co-morbid medical conditions? Or was it because her doctor perceived that a referral to a pain clinic would not be accepted?

I wrote to the heads of six pain clinics in Melbourne asking whether they would have accepted this 88-year-old with postherpetic neuralgia. Three were specialist pain clinics for older people, and three predominately dealt with individuals of working age. All six agreed to see her. I then informed them of her other medical conditions and asked whether this would influence their decision or management. I described her as being very frail, with a history of dementia (MMSE 20/30), occasional falls, and incontinence. None of the specialists would refuse to see her. All would modify their program to suit her special needs, predominantly focusing on pharmacological approaches rather than cognitive-behavioral therapies. This small survey suggests that access barriers to older individuals attending specialist pain clinics may be breaking down, although reluctance to refer, or be referred, may be an ongoing problem. It is imperative that multidisciplinary pain clinics accepting older patients have the expertise and resources to deal with their special needs.

The role of the SIG may be different for these groups of patients. An approach for patients with pain might focus on increasing general awareness of pain in older persons, whereas for pain patients, the approach might focus on ways that pain clinics might modify assessment and management protocols to better suit the needs of older pain patients. The SIG could also focus on collaborative research.

As basic and clinical science progresses, further treatment advances and management tools will be found to improve the care of older patients who live with pain. In the interim, we have the ability to achieve better pain control using the resources that are currently available. There are substantial gaps between the development and dissemination of recommendations and their implementation in practice. This is not just confined to pain. Guidelines have been developed for various conditions such as cardiac failure, hypertension, and hyperlipidaemia, yet many older people remain inadequately managed. The reasons are complex and include a combination of factors related to clinician, patient adherence to therapy, and the nature of treatments. A challenge for the SIG is to work out ways to ensure that contemporary knowledge and resources are most effectively employed to improve pain management in older adults.

If our SIG is to have a major impact, we will need to elect a strong committee to coordinate the efforts of our SIG membership in influencing the actions of policy makers, funding agencies, and care providers.

References

1. http://www.iasp-pain.org/AM/Template.cfm?Section=Resources&Template=CM/ContentDisplay.cfm&ContentID=3611


3. McCaffery M, Ferrell BR. Nurses' knowledge of pain assessment and management: how much progress have we made? J Pain Symptom Manage. 1997; Sep; 14(3):175-88


Call for Nominations

Nominations are invited for the positions listed below for the board of the SIG on Pain in Older Persons.

Current SIG members can nominate themselves or another SIG member for any position. Please ensure that the person you nominate has agreed to stand and is a member of the SIG. The usual terms of office will be 4 years. Since this is the first election for the board of the SIG, and to avoid renewal of all the board at the same time, half of the positions will have a 2-year term for this time, and the other half will have a 4-year term.

Please email your nomination to IASP at: kathyh@iasp-pain.org before May 30.

The positions available are:
- Chair / secretary-treasurer: 4-year term
- Vice-chair / communication (newsletter, website, etc.): 2-year term

Chairs of subcommittees on:
- Meetings (workshop for each IASP meeting, Satellite Symposia): 4-year term
- Clinical matters: 2-year term
- Scientific matters: 4-year term
- Education: 2-year term

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

SIG Information

SIG on Pain in Older Persons 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$7,021.

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