

Patient-Centered Pain Care and Reducing the Risk Associated Stigma

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Abstract

Stigma associated with having chronic pain, especially when opioid therapy is used as a treatment modality, is a major concern and has far-reaching effects on patients and all those involved in their care. The different facets of stigma at the patient, provider, and social levels collectively serve as a significant barrier to effective treatment of chronic pain. There is a growing body of empirical research into stigmatization and the resulting barriers to care. Studies suggest that patients who are receiving or who have previously received long-term opioid therapy for non-malignant pain face both subtle and overt stigma from their family, friends, co-workers, the health care system, and society at large for their opioid treatment modality.

Keywords: Healthcare systems; Psychosocial challenges; Medication-assisted treatment; Behavioural health; Buprenorphine; Public pain education

Introduction

Compassionate, empathetic care in a provider-patient partnership is best for countering the stigma, isolation, and psychosocial challenges of living with pain. Feelings of guilt, shame, judgement, and embarrassment resulting from such stigma can increase the risk for behavioural health issues, such as anxiety and depression, which can further contribute to symptom chronicity. Reducing barriers to care that exist as a consequence of stigmatization is crucial for patient engagement and treatment effectiveness. Furthermore, the sub-population of patients with painful conditions and comorbid SUD face additional barriers to treatment because of stigmatization of both chronic pain and addiction [1]. Chronic pain is common among individuals with SUD, including opioid misuse, yet stigma remains a significant barrier to implementation of programs and treatments for OUD, such as medication-assisted treatment and naloxone. Patients with comorbid problematic opioid use and chronic noncancerous pain report significant perceived stigma associated with methadone and buprenorphine treatment. Clinicians who treat acute and chronic pain, particularly with opioids, may experience stigma from colleagues and society in general that in addition to fear of scrutiny from state medical boards and the DEA may also dissuade them from using opioids appropriately. Clinicians are overburdened with time constraints, EHR demands, and other administrative tasks, which has led to unprecedented levels of burnout among physicians. Stigma, combined with the enhanced time required to effectively evaluate and treat pain, leads to over-referral and patient abandonment. According to one study, only 12.2% of individuals who require treatment for a SUD actually seek treatment [2]. In addition, stigma is found to be a significant barrier, with 20.5% not seeking treatment because of negative consequences associated with their work and around 17% being concerned about negative judgements by friends or community. The evidence base for public education about pain is limited. Whereas some evaluation of mass media campaigns for low-back pain has been conducted in other countries, analyses in the United States are lacking.

Discussion

The gaps and recommendations specific to public pain education, as outlined below that will inform best practices in public pain education are consistent with those described elsewhere. There is a significant need for improved public education on and understanding

of the distinction. Between acute and chronic pain notably, that chronic pain, regardless of its etiology, can become a chronic disease itself, with measurable changes in the nervous system, spinal cord, and brain. An estimated 50 million to 100 million people have chronic pain, making it the most prevalent, costly and disabling health condition in the United States. Yet, despite its pervasiveness, it remains largely unknown to the broader public. Patient education is another key component of any best practice model for outcomes. Patients benefit from a greater understanding of their underlying disease process and pain triggers as well as knowing how to seek appropriate professional care. It is important for patients to know that pain as a symptom is typically a warning of injury or disease that can affect the body and mind [3]. Finding the precipitating and perpetuating causes of the pain and addressing them with appropriate multimodal therapy is considered the best management strategy for improving patient outcomes. It is also important for patients to understand that pain can be a disease in its own right, particularly when pain becomes chronic and loses its protective function. In this context, pain is often detrimental to the patient's health, functionality, and QOL. A category of diseases is characterized by chronic debilitating pain. In such conditions, there is rarely a cure, but appropriate assessment; accurate diagnosis; and patient-centred, multidisciplinary treatment can optimize pain relief, improve function, and enhance QOL. Self-management skills training may include relaxation, pacing, cognitive restructuring, maintenance planning, and relapse prevention [4]. Innovative delivery systems, including tele-health and other Web-based applications, can offer technology-based education and self-management support to further engage and empower patients in their care plan. Experts have noted the benefits that could be realized from the development of a more comprehensive pain curriculum for training and continuing education of providers. Encouraging licensing and education practices that do more to emphasize safe and effective pain assessment and management

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has the potential to improve pain management and mitigate factors that contribute to the current opioid crisis. Health care professionals who prescribe opioids are in a key position to balance the benefits of analgesics against the risk of adverse clinical outcomes [5]. It is estimated that apart from federal prescribers who are required to be trained, fewer than 20% of the over one million health providers licensed to prescribe controlled substances have training on how to prescribe opioids safely and effectively. Providers can access educational resources, receive accreditation, or renew existing licenses through public- or private-sector enterprises. National stakeholders have recommended that accrediting organizations develop, review, promulgate, and regularly update core competencies for pain care education, licensure, and certification at the pre-licensure and post licensure levels. Educational interventions for pain should be guided by core competencies and target both the training and practice levels. Provider education research specific to patient outcomes is limited, but systematic reviews on continuing medical education programs indicate that interventions that include multimedia, multiple instructional techniques, and multiple exposures are associated with improved provider knowledge outcomes compared with alternatives. Likewise, regardless of whether educational interventions are targeted at clinicians in training or in practice, aligning educational interventions with core competencies for pain care education is a best practice [6]. In addition, although Frank demonstrated the effectiveness of a longitudinal distance learning approach that uses telemedicine to change clinical pain practice in primary care, a recent systematic review by Rochfort found a scarcity of studies on the effectiveness of educational interventions implemented by a PCP designed to promote optimal patient outcomes. Results do indicate that education and skills training of PCPs may positively affect patient performance of self-management pain-reduction activities, improve patient lifestyle behaviours, and increase perceived QOL. This finding underscores the importance of further training for health care professionals in patient self-management support as part of patient-centred care and as a mechanism for improving pain outcomes. Chronic Pain and Headache Management TeleECHO, with Project ECHO, is a tele-health approach that supports clinicians' education and training regarding treating patients with chronic pain and safe opioid management [7]. The model is based on workplace learning, with cases selected by participants from their patient panels combined with short lectures by experts. Gaps exist in pain management understanding and education throughout the health care provider community. There is a need for further education regarding acute and chronic pain for all health care providers in professional school curricula, postgraduate education, and further clinical specialty training. Policymakers, regulators, and legislators at both the federal and state levels play an important role in formulating policy, issuing guidelines and direction, and passing legislation on issues related to acute and chronic pain management, payment mechanisms, and the use and regulation of controlled medications. The issue of pain management is complicated, so every decision made, law passed, or guideline issued has a cascading effect on many aspects of pain management [8]. As such, a deep understanding of the issues, especially the potential for unintended consequences of these decisions, is essential in formulating effective comprehensive policy. In the United States, the estimated number of patients with chronic daily pain is 50 million, with 19.6 million having chronic, high impact pain. Several factors act as barriers to adequate care, including inadequate insurance coverage for pain management services, shortages of medical and behavioural pain management specialists, provider underestimation of patients' reports of pain, poorly functioning drug supply systems, lack of research on innovative and effective pain management approaches, and more recently widespread

fear among providers of regulatory scrutiny. The recent advent of retail pharmacies limiting the duration of prescriptions, making unrequested changes to dosages, or placing barriers to obtaining properly prescribed pain medications has had the unintended consequence of limiting access to optimal pain care [9]. Without such access, many patients face significant medical complications, prolonged suffering, and increased risk of psychiatric conditions. Medical complications from inadequately treated acute pain may include prolonged recovery time, unanticipated hospital readmissions, and transition to chronic and persistent pain. Unremitting and inadequately treated pain is also associated with increased anxiety, depression, disability, unemployment, and lost income. In addition to experiencing medical and psychiatric consequences, individuals who receive inadequate pain treatment may transition to illicit opioid or other substance misuse. Although the pathway to illicit substance use in pain is not well understood, a small but growing number of individuals who misuse prescription opioids without the supervision or oversight of a medical provider transition to using illicit substances, such as heroin, within a year of use [10].

Conclusion

The nonmedical and illicit use of opioids may increase an individual's risk for substance use problems, accidental or intentional overdose, or death. Heroin, fentanyl, and other illicit synthetic opioids continue to drive increasing numbers of overdose deaths. Understanding the indicators associated with inappropriate opioid use may improve the ability of health care providers to tailor treatments and surveillance without placing arbitrary limitations on all patients who are prescribed opioids. This understanding could also potentially improve access to effective care.

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Conflict of Interest

None

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