RACGP Specific Interests

TEMPO

A generalist approach to Chronic Non-Cancer Pain, polypharmacy, multimorbidity and addiction

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RACGP Royal Australian College of General Practitioners

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The Ancient Sumerians: 4000 BC

The opium poppy: "hul gil" (the plant of joy)

An ancient cure-all for pain, anxiety and depression.

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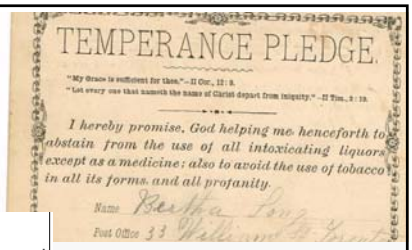
1800's: Industrial revolution

Battlefield medicine during the American Civil War, made morphine dependency "the soldier's disease." A million Americans were dependent by the end of the 19th Century.


BAYER Pharmaceutical Products
HEROIN—HYDROCHLORIDE
The Cheapest Specific for the Relief of Coughs
FARBENFABRIKEN OF ELBERFELD COMPANY
40 Stone Street, NEW YORK

In 1898, a "wonder drug" to treat morphinism was freely available over the counter: "Heroin."

The temperance movement


TEMPERANCE PLEDGE.

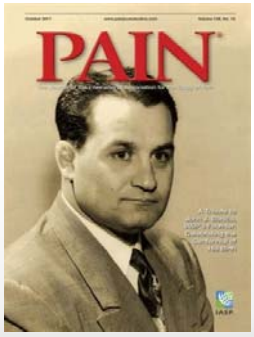
"My Grace is sufficient for thee."—II Cor., 12: 9.
"Let every one that nameth the name of Christ depart from iniquity."—II Tim., 2: 19.

I hereby promise, God helping me henceforth to abstain from the use of all intoxicating liquors except as a medicine; also to avoid the use of tobacco in all its forms and all profanity.

Name Bertha Long

Post Office 33 Williams St Grant

Opioids became relatively inaccessible therapeutically due to their destructive impact.



During WW2, John Bonica was promoted to Chief of Anesthesiology in Washington.
Appalled by the (lack of) pain care for his wounded veterans[1], his military hospital pioneered the multidisciplinary approach[2] and use of regional techniques.
He founded the American Pain Society and the International Association for the Study of Pain (IASP).
Access to such services have always been limited by costs and by remuneration tensions within a fee-for-service model.

A US study of 690 million outpatient visits related to chronic pain (2000-2007) found that only 0.12% involved pain specialists[3].

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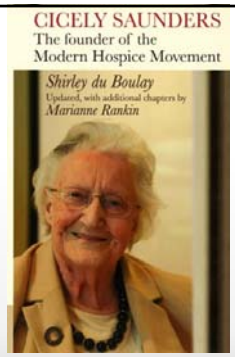
[1] Loeser Pain 2017, [2] Kaiser PAIN 2017, [3] Rasu 2017)



In 1960's, Dame Cicely Saunders taught "total pain" required care for physical, psychological, social & spiritual distress.

Her hospice movement campaigned, on ethical grounds, for the liberal use of opioids for life-ending symptoms, regardless of their addictive potential.

Cancer pain then was brief and brutal. Forty years ago, only a quarter diagnosed with cancer would have survived 10 years whereas now half will (Torjesen 2014).

In 1986 the World Health Organisation guideline recommended a stepwise analgesic ladder for cancer pain; matching the progression of "pain level" to opioid "strength".

Cancer is increasingly becoming chronic with survivors comprising 3.6% Australian population (AIHW 2012).
Cancer pain is frequently associated with other chronic painful illnesses.
Advocacy for a better model of palliative care and economic forces operationalised all chronic pain into an opioi-centric care model.

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The GP's dilemma: resources

* Pain medicine identifies tertiary multidisciplinary care as the paradigm of best pain care with RCTs showing improved outcomes compared to control care - GP "treatment as usual"[1].

* GP care is undoubtedly the cheapest care.

* GP care becomes **non** cost-effective when including loss of earnings and productivity … until, or unless, exercise and behavioural counselling are added in [2] !

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[1] Kamper BMJ 2015 [2]Lin 2011

The GP's dilemma: multi-morbidity is common

* In adult Australians in 2012, the prevalence of any pain in last month was 68%[1].
* About 1 in 4 adults have multi-morbidity with half of these reporting their activity is limited by arthritic pain [2].
* A US study of 385 GP consults showed 48% included discussions about pain [3].
* Despite escalating opioid provision, the prevalence of pain has not decreased in USA [4,5] or Australia [6].

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[1] Miller 2017 [2] Barbour 2017 [3] Tai-Searle 2011 [4] Mazer-Amirshahi 2014 [5] Daubresse 2013 [6] Miller 2017

The GP's opportunity

*As the MBS remunerates productivity over quality, GPs cannot reproduce the intensity of care of tertiary multidisciplinary centres.

* Many (non-pain) chronic disease outcomes improved by non-pharma multimodal interventions with reductions reported in pain, fatigue & depression of 10-20% [1].

* Most CNCP patients can't, or won't, access a multidisciplinary clinic.

* The exclusion of GPs in this tertiary model gives a problem & an opportunity.

* GPs can offer quality **trans-disciplinary multimodal** non-pharma care for pain **&** other chronic illnesses with accessible micro-interventions over decades.

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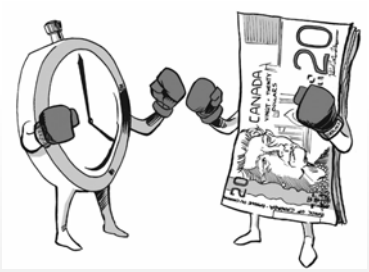
[1] Barbour MMWR 2017

Time and money pressures



Requests for pain-killers rarely involve the first issues raised. Complex patients suffer from 'time poverty,' so ensure they receive sufficient consultations and continuity of care.

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Time and money

Swap time and money pressures around so that they work for you.

- Refuse phone scripts gives more frequent face-to-face consultations
- Ensure the MBS items for complex care are systematically utilised

Plan time and resource efficient strategies

- Have a practice policy ensuring continuity of care
- Put up a sign in the waiting room about your medication policy

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Insert the name of your clinic here.

Pain-killer & sleeping pills policy (e.g. oxycontin & morphine)

Except for end-of-life care, our policy is that we will not prescribe these medicines:

- at your first appointment.
- for a phone request.
- without a proper assessment.
- over the long-term (we prefer safer and better options).

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- Doctors love our role of solving people's problems.
- People come to us because they need us to fix their problems.
- But our analgesics (especially our opioids) are failing to resolve the disability of chronic pain.

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Shifting care from doctor-centred to patient-centred

The new care paradigm aims to help patients get activated.
Doctors become coaches to re-impower and rehabilitate.

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It may seem counter-intuitive but we need to …

- acknowledge the limitations of the passive or medical approach focusing on sensory experience and pain reduction.
- address pain-related thoughts, emotions and behaviours (drivers of neuroplasticity).

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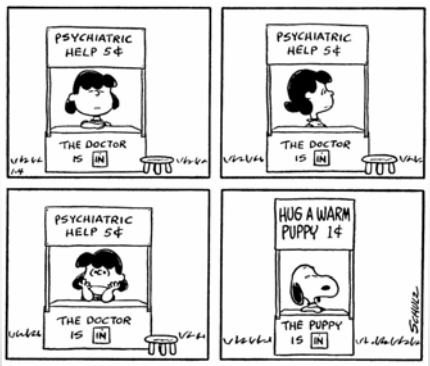

In this way, we can facilitate their journey from patient to person.

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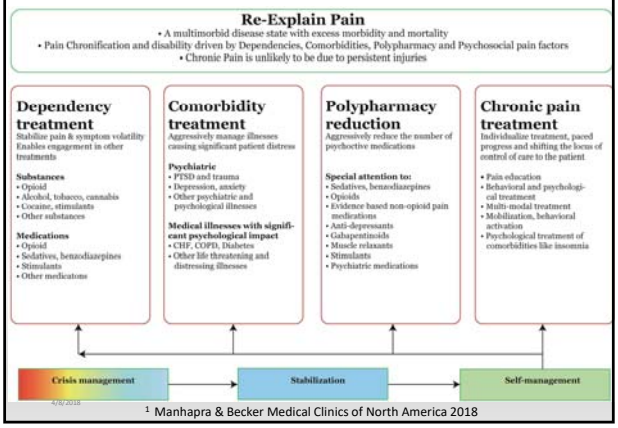
We often cannot treat pain and addiction as separate problems.



[1] Manhapra & Becker Medical Clinics of North America 2018

Quick Quiz:

In the TV show "Yes Minister, which hospital was the most efficient?

A model of care designed on Military Hospitals &/or Hospices may not be a suitable one for long-term & common conditions.

Accessible & inexpensive generalists are able to offer chronic pain care that:

. Is empathetic & patient-centred
. Can deprescribe polypharmacy
. Can deal with multi-morbidity
. Can offer care for stigmatised substance-related behaviours (iatrogenic or not)
. Can refer to specialists or Allied Health when necessary.

A Biopsychosocial approach to chronic pain

Active self-management:

- Assessment and measurement
- Neuro-education
- Social activation: Family and work
- Cognitions, Beliefs & Mood
- Physical activation: Goals & Activity pacing
- Sleep
- Diet

Analgesics

- Medicines, deprescribing and drugs
- Opioids and harm minimisation

Come over and see us this afternoon