RACGP

Curriculum and syllabus for Australian general practice (7th edition)

Pain management

RACGP Curriculum and syllabus for Australian general practice (7th edition): Pain management.

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Recommended citation

The Royal Australian College of General Practitioners. Curriculum and syllabus for Australian general practice (7th edition). Pain management. East Melbourne, Vic: RACGP, 2026.

The Royal Australian College of General Practitioners Ltd

100 Wellington Parade

East Melbourne, Victoria 3002

Tel 03 8699 0414

Fax 03 8699 0400

www.racgp.org.au

ABN 34 000 223 807

Published September 2026

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Pain management

Context

Pain is a common reason for presentation to general practice and a major contributor to disability, reduced quality of life and health system burden in Australia. Pain is defined as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.[1] The experience of pain is subjective and shaped by biological, psychological, social, and cultural factors, requiring GPs to move beyond a purely biomedical approach.[2]

GPs assess and manage acute, subacute, and chronic pain across the lifespan and in diverse settings, often as the first point of contact and the clinician providing ongoing care. Chronic pain, defined as pain persisting for more than three months, is not simply prolonged acute pain but reflects complex neurobiological, neuroendocrine, and neuroimmune processes.[3] Around one in five Australians live with chronic pain, with higher prevalence among women, older people, Aboriginal and Torres Strait Islander peoples, and those living in rural and remote communities.[4,5] Chronic pain commonly coexists with mental health conditions, multimorbidity, and social disadvantage, amplifying its impact on individuals, families, and communities.[5,6]

General practice plays a central role in early identification of factors associated with pain chronicity, provision of timely and evidence-based interventions, and coordination of multidisciplinary care over time.[7,8] Effective pain management focuses not only on pain intensity but on improving function, participation and quality of life. This requires person-centred and culturally appropriate care that validates lived experience, supports shared understanding of pain, and aligns management with the person's goals, values and context.[8–10]

GPs use a combination of non-pharmacological and pharmacological strategies, support self-management, and promote physical and psychological wellbeing. They also provide health education to address unhelpful beliefs and reduce fear and avoidance.[8–11] A key professional responsibility is the safe, ethical, and regulatory stewardship of opioid prescribing. GPs must balance potential harms and benefits, recognise opioid-related risks (including dependence, toxicity, and opioid-induced hyperalgesia), and engage in careful monitoring, review, and deprescribing where appropriate.[12–15]

Across metropolitan, rural, and remote settings, GPs provide continuity, clinical judgement and coordination in a complex care environment – where access to specialist pain services may be limited. Through reflective practice, quality improvement activities, and culturally safe approaches to care (including for Aboriginal and Torres Strait Islander peoples) GPs are well placed to deliver compassionate, equitable, and evidence-based pain management that responds to current and emerging community needs.[16–18]

References

1. International Association for the Study of Pain (IASP). IASP curricula [Internet]. Washington DC: IASP; 2025. Available at: https://www.iasp-pain.org/education/curricula/ [Accessed 18 Aug 2025].
2. Fillingim RB. Individual differences in pain: understanding the mosaic that makes pain personal. *Pain.* 2017;158(Suppl 1):S11–18.
3. Mifflin KA, Kerr BJ. The transition from acute to chronic pain: understanding how different biological systems interact. *Can J Anaesth*. 2014;61(2):112–22.
4. Australian Institute of Health and Welfare. Chronic pain in Australia. Canberra: AIHW; 2020. Available from: https://www.aihw.gov.au/reports/chronic-disease/chronic-pain-in-australia [Accessed 22 Jan 2026]
5. Australian Government Department of Health. National strategic action plan for pain management. Canberra: DoH; 2021. Available from: https://www.health.gov.au/resources/publications/the-national-strategic-action-plan-for-pain-management [Accessed 22 Jan 2026]
6. Racine M. Chronic pain and suicide risk: a comprehensive review. *Prog Neuropsychopharmacol Biol Psychiatry*. 2018;87(Pt B):269–80.
7. Henderson JV, Harrison CM, Britt HC, et al. Prevalence, causes, severity, impact, and management of chronic pain in Australian general practice patients. *Pain Med.* 2013;14(9):1346–61.
8. Thomas H, Best M, Mitchell G. Whole-person care in general practice. *Aust J Gen Pract*. 2020;49:54–60.

9. Ng W, Slater H, Starcevich C, et al. Barriers and enablers influencing adoption of a biopsychosocial approach to musculoskeletal pain. *Pain.* 2021;162(8):2154–85.

10. Linton SJ, O'Sullivan P, Zetterberg H, et al. Competencies needed to provide psychologically informed pain care. *Scand J Pain*. 2024;24(1).

11. Therapeutic Guidelines Limited. Pain and analgesia [Internet]. North Melbourne: Therapeutic Guidelines; 2020. Available at: https://tgldcdp.tg.org.au [Accessed 22 Jan 2026]

12. The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice: Part C2 – the role of opioids in pain management. East Melbourne: RACGP; 2017. Available at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/drugs-of-dependence/part-c2 [Accessed 22 Jan 2026]

13. Therapeutic Goods Administration. Prescription opioids: information for health professionals. Canberra: DoH; 2021. Available at: https://www.tga.gov.au/resources/explore-topic/prescription-opioids-hub/prescription-opioids-information-health-professionals [Accessed 22 Jan 2026]

14. Australian Commission on Safety and Quality in Health Care. Opioid analgesic stewardship in acute pain clinical care standard. Sydney: ACSQHC; 2022. Available at: https://www.safetyandquality.gov.au/standards/clinical-care-standards/opioid-analgesic-stewardship-acute-pain-clinical-care-standard [Accessed 22 Jan 2026]

15. Heavey SC, Bleasdale J, Rosenfeld EA, et al. Collaborative care models to improve pain and reduce opioid use in primary care. *J Gen Intern Med*. 2023;38(13):3021–40.

16. Slater H, Briggs A. Strengthening the pain care ecosystem to support equitable, person-centred, high-value care. *Pain.* 2024;165:S92–107.

17. Lin I, Flanagan W, Green C, et al. Clinical yarning education to improve communication in Aboriginal health care. *BMC Med Educ*. 2023;23:908.

18. Burke HK, Sample PL, Bundy AC, et al. Teaching reasoning, reflective practice and evidence-based practice. *J Occup Ther Educ.* 2024;8(4):7.

Learning outcomes

The GP is able to:

- facilitate shared understanding and decision-making by helping the patient make sense of their pain in a way that is meaningful for them, and foster an equal therapeutic alliance where the patient is an active participant in care decisions
- encourage self-management by fostering confidence, life skills, and ongoing reassurance and guidance through a biopsychosocial, collaborative, person-centred approach
- apply the recognised definitions and contemporary pain theories in practice
- explain possible pain mechanisms and biopsychosocial influences on each person's pain experience
- deliver evidence-based pain education and management options (including non-pharmacological, basic psychological, and pharmacological strategies) tailored to the person's needs
- collaborate with interdisciplinary teams using shared language
- recognise the public health and socioeconomic impacts of pain and opioid use
- apply culturally responsive, trauma-informed, and safe approaches that address diversity in people's experience of pain
- engage in reflective practice to identify and address personal biases – delivering equitable, bias-free care to diverse groups experiencing chronic pain or opioid use
- develop, review, and implement practice-wide (and individual) clinical processes and policies to maintain quality prescribing, documentation, and monitoring of opioids.

Key areas of learning

For a patient living with acute or chronic pain, consider the person's cultural, spiritual and religious beliefs, values and background, and their community context; appreciating the wide diversity of cultural perspectives of pain and its management.

Have a comprehensive understanding of medico-legal issues around the prescription, administration, and storage of Schedule 8 medications (eg opioids, benzodiazepines).

Perform a functional assessment of a person living with pain and consider the need to adapt your assessment when there are significant communication barriers (eg language differences, cognitive impairment, neurological conditions).

Through assessment, identify:

- any possible predisposing, precipitating and perpetuating factors that might be contributing to the pain
- its effect on the person's life
- any self-coping and protective / supportive factors being used or already in place

Prepare treatment plans with people experiencing pain using shared decision-making and a respect for culture and community to promote autonomy and dignity.

Understand common chronic pain conditions including prevalence, typical presentation, and management principles.

With reference to current guidelines and evidence, develop effective management plans (including pain education, lifestyle changes, psychological therapies, allied health, pharmacology, and referral to tertiary pain services) for:

- acute pain including following trauma / injury
- pain associated with acute illness (eg acute abdomen pain)
- chronic headaches and migraines
- chronic back pain (without neuropathic component)
- chronic neck pain (without neuropathic component)
- neuropathic arm or leg pain
- chronic arthropathies (eg osteoarthritis)
- fibromyalgia
- chronic pelvic pain (eg endometriosis, painful bladder syndrome, and painful vulval syndrome)
- post herpetic neuraglia
- complex regional pain syndrome.

Identify and describe the indications, contraindications, risks / cautions and typical dosages used in chronic pain management for pain-treatment pharmacological therapies, such as:

- opioid medications
- non-opioid analgesics (eg paracetamol)
- non-steroidal anti-inflammatories (systemic and topical)
- medicinal cannabinoids
- adjuvant medications, including:
- tricyclic antidepressants
- serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants
- anticonvulsants
- anaesthetic agents
- muscle relaxants.

Describe the ways in which pain and opioid dependence impacts on whole communities, and the social, economic, and public health effects and implications.

Identify and describe the possible signs and symptoms of opioid dependence, opioid hyperalgesia and opioid toxicity.

Outline the signs, symptoms and emergency management of opioid overdose, including resuscitation for people with respiratory depression or arrest from opioids.

Outline when to refer to non-GP specialists.

Identify when procedural interventions may be considered

Have a mechanistic understanding of pain

- Contemporary pain theories and education: Apply modern understanding of pain as a complex, multi-faceted protective process, recognising complex biological mechanisms including neuroendocrine and neuroimmune systems. Distinguish between nociception and pain, know that pain and tissue damage are often poorly correlated, and provide clear, evidence-based explanations to patients after a shared understanding of pain is reached.
- Biopsychosocial approach: Including considering lifestyle, stress, sleep, home and work, and cultural context.
- Types of inflammation: Understand acute inflammation, neurogenic inflammation, neuroinflammation, low-grade systemic inflammation, and the ‘PEACE & LOVE’ approach for soft tissue injuries.
- Nociceptive pain: Recognise and use evidence-based pharmacological and non-pharmacological approaches.
- Neuropathic pain: Recognise neuropathic patterns and use evidence-based pharmacological and non-pharmacological therapies.
- Nociplastic pain: Understand central sensitisation and other pain processing problems including altered nociception and implement tailored strategies. Recognise when multidisciplinary care is needed.

Address beliefs about pain:

- Pain language and communication: Listen actively and show compassion. Use validating, neutral, or safe language to reduce fear and unhelpful beliefs.
- Education: Provide clear, evidence-based information and address myths and uncertainties.
- Complex pain encounters / patient agency: Help patients make sense of their pain in meaningful ways. Build therapeutic alliances. Involve patients in decisions while also providing guidance and reassurance.
- Darlow (2013) framework and counter-messages: Identify unhelpful beliefs and provide positive messages to counter fragility narratives and encourage activity, safety, and recovery.
- Imaging and structural findings: Avoid reinforcing unhelpful beliefs by ordering unnecessary imaging or overemphasising abnormal findings – guide patients from fear to safety.

Use non-pharmacological and psychological strategies

- Retraining the pain system, including contemporary pain education, graded activity and pacing, and knowing when referral is appropriate for other neuroplasticity-focused approaches.
- Psychological strategies including relaxation and breathing techniques for stress reduction, social support, and referral for psychological therapy or mindfulness if applicable.
- Non-pharmacological strategies: Sleep management, basic exercise, movement and nutrition advice, nature prescription, and referral for physical therapy or other allied health if appropriate.

Understand specific populations and contexts

- Cancer pain: Provide evidence-based care strategies tailored to the patient's condition and needs.
- Equity and diversity: Understand how cultural, linguistic, gender, age, and socio-economic factors influence pain experience and healthcare engagement. Apply culturally responsive, bias-free approaches to assessment and management, tailoring interventions for Aboriginal and Torres Strait Islander peoples, women, children, older adults, and people with comorbidities.
- Complex trauma and trauma-informed practice: Recognise the impact of past trauma on pain experience and healthcare engagement. Apply trauma-informed approaches to create psychological safety, support effective pain management, and avoid retraumatisation

Opportunities for learning

Words of wisdom

- Remember that experiencing pain and suffering is a universal human experience. In caring for someone in pain, we meet them as a fellow human being – one of us with more clinical expertise, the other with lived experience. Believe the patient when they tell you about their pain. Read widely in non-medical literature about experiences of illness, pain, and suffering to help you understand and have empathy for what it might be like to live with chronic pain. For example, some interesting perspectives can be found in What's Wrong with Me by Meghan O'Rourke, How to be Sick by Toni Bernhard and Illness as Metaphor by Susan Sontag. True healing begins in the space of shared humanity and mutual respect. Keep the patient's experience central to your decisions and recommendations.

- Living with chronic pain can be a terrifying and lonely time for people, even those with a lot of people around them. Having someone available to share their struggles with and share the journey can transform that person's experience of chronic pain. Approach your care with curiosity, humility, and empathy. Sometimes your consultations with people living with chronic pain can feel unproductive and frustrating in their lack of apparent progress but take heart from knowing that being present on the journey can be immensely more helpful than pharmaceutical treatments.

- Never forget the complex intertwining of chronic pain, stress, complex trauma, intergenerational trauma, sleep, lifestyle, and low-grade systemic inflammation. Always explore these – you may need to spread the exploration out over many consultations. Shaming someone to try and change their behaviour rarely works.

- With all this said, remember that your patients are not your friends, and sometimes you will need to make difficult decisions that jeopardise the relationship for the sake of clinical and professional safety. Even when you make decisions that damage a patient's perception of you, or their relationship with you, if you made those decisions in a respectful, professional, and safe way, with the wellbeing of the patient as the priority, you have done your job – whether they recognise that or not. Encourage the practice you work in to implement a consistent, practice-wide opioid policy, including the use of opioid treatment agreements with patients when indicated.

- Be aware that opioid hyperalgesia can lead to an increase in pain, and the temptation can be to increase the opioid dose, thereby potentially causing opioid toxicity and ironically worsening pain. It is rare that daily ongoing opioid use improves chronic pain and unfortunately very common that opioid use causes side effects and disconnects users from their life.

Learning strategies

On your own

Make a list of common causes of chronic pain. Make another list of non-pharmacological therapies, different analgesics, and adjuvant medications used in the treatment of pain and come up with a pain management plan for each of the causes of chronic pain that you identified.

- *Which pain syndromes did you find most challenging to identify treatment options for?*
- *Is there any area of pharmacology that it would be helpful for you to revise (eg opioid-induced hyperalgesia, neuropathic agents, medicinal cannabis)?*
- *What learning needs did you identify in doing this activity? How will you address these learning needs? Where can you learn more about pain management and treatments?*

Are there any other foundation topics that you would benefit from revising?

- *Communication skills (eg patient-centred, dethreatening language, validating patient beliefs, trauma-informed care)?*
- *Contemporary pain neuroscience (eg nociception is not always pain, tissue damage is not always pain)?*

With a supervisor

Identify a patient who is (or was) living with chronic pain. Discuss with your supervisor and explore what has been tried and reflect on what else might be considered.

- *Why were this person's symptoms so difficult to manage? Were there factors about their context (trauma, social stressors, or health beliefs) complicating treatment?*
- *Were the initial treatment choices evidence-based? What do treatment guidelines recommend for that situation?*
- *Was the treatment plan carried out in the way the doctors intended? Did the patient understand the treatments, including non-pharmacological approaches (eg sleep hygiene and pacing)?*

Ask a patient who you have treated for chronic pain what they thought about your care. Discuss the feedback with a supervisor or trusted colleague.

- *What feedback did you receive? Did it highlight your ability to validate the lived experience of pain and avoid reinforcing fear, perhaps through avoidance of unnecessary imaging?*
- *How could you apply this feedback to future patients?*
- *With your supervisor, develop a learning plan for any aspects that you identified for improvement.*

Conduct an audit of all the patients you've prescribed opioids for over the course of a period of time and discuss with your supervisor. In your audit include the following information:

- What was the medical diagnosis for which the opioids were prescribed?
- What kind of pain was being treated (nociceptive, neuropathic, nociplastic, mixed)?
- Was it a new prescription or a repeat prescription? How long had the patient been on opioids?
- What non-opioid pharmacological therapies were being used?
- What non-pharmacological therapies were being used, or had been offered / attempted?

- Were there any cultural considerations in the care provided (eg communication style in exploring pain experience and /or support services for patients who identify as Aboriginal or Torres Strait Islander)?
- What other therapies might be considered for these patients?
- How do your results compare with clinical guidelines?
- How are you managing risk in your opioid prescribing? Could this be improved (eg monitoring for opioid-induced hyperalgesia or toxicity, treatment agreements)?
- How does your prescribing compare to your supervisor's?

In a small group

Role-play: One participant acts as a patient presenting to a new GP, requesting a prescription for opioid analgesics for chronic back pain. The patient has never had a regular GP and typically attends a local bulk-billing clinic to obtain scripts for paracetamol with codeine or opioids.

- *If you are watching the role-play, write down helpful comments or suggestions about the GP's communication skills.*
- *Did the GP validate the patient's concerns or introduce contemporary pain neuroscience concepts (eg 'Did you know that sometimes when on daily opioids for a while pain can actually get worse?').*
- *Were alternative management strategies introduced? Were there other communication strategies that might have been effective?*

Discuss your approach when seeing a patient who has moved into your area and is on opioids for chronic pain. You note from their records they had regularly attended their previous practice, there are multiple pain specialist reviews in the files, and the legal elements of prescribing (such as permits) have been followed.

- *How do you approach the initial consultation? How do you approach subsequent consultations?*
- *What if you are unsure about the opiate? Where do you find reliable and validated opioid conversion charts or tables? Safer Care Victoria has an opioid conversion resource.*

With a friend or family member

Invite a trusted friend or family member to share with you a time when they had severe pain (eg labour pain, kidney stone). Ask them to describe what it felt like and the impact the pain had on their mental wellbeing and daily activities. Your role is to just listen to their story. Don't try to offer any solutions or suggestions that might have helped alleviate the pain, and don't critique any pain management strategies they used.

- *How did it feel listening to someone you know and trust share an experience of pain?*
- *Was this story new to you? If not, how did hearing it again give you a different understanding of it?*
- *Did you find it challenging to hear their story and be unable to offer advice?*
- *How might this influence your management of pain in the future – especially your ability to listen, validate, and avoid inadvertently reinforcing fear?*

Ask a variety of friends and family members who have children what they have done in the past when one of their children was experiencing pain.

- *How did they manage it? What non-pharmacological approaches did they try? Did they use medications?*
- *What would prompt them to take the child to the doctor?*
- *Did they consider sleep, stress, or comfort measures?*

Case example

Sam, 43, presents with a long history of worsening back pain that began several years ago. The pain is felt in the lumbar spine and radiates to both buttocks. Sam previously worked as an events organiser but has been unemployed since redundancy last year. More recently, Sam's mother was diagnosed with stage-four metastatic breast cancer and has been unwell. For pain relief, Sam uses paracetamol with codeine 500mg / 30mg three to four times daily and occasionally takes oxycodone capsules prescribed to a family member for cancer pain. Sam requests a prescription for more paracetamol with codeine and possibly oxycodone, reporting it provides better relief.

In a case-based discussion, questions relating to each role could be:

Communicator

- What ideas might Sam hold about pain and its management, and how might these differ from contemporary understanding of chronic pain?
- What are Sam's expectations and concerns in this consultation, and how could you explore them?
- If your management plan differs from Sam's expectations, how might you use shared decision-making to negotiate an alternative?

Clinician

- What additional history and information from Sam (or past records) would inform ongoing management?
- Which investigations or examinations might be relevant for chronic back pain, and how would results influence management?
- What red flags must be excluded in Sam's presentation?
- How would older age or long-term steroid use change your assessment? What pain characteristics and contributing factors are important in guiding treatment?
- How might socio-economic factors influence Sam's decisions around treatment?
- What management options could be considered in Sam's case, and how might these evolve over time?
- What non-opioid pharmacological treatments are available for chronic back pain?
- How would management differ for an older adult in residential aged care, or for a sedentary younger adult?
- At what stage would referral to a specialist pain service be appropriate?
- How might treatment decisions differ if Sam identifies as Aboriginal or Torres Strait Islander?
- What biases, assumptions, or prejudices might affect care for Sam?
- How might chronic pain affect Sam's mood, relationships, and work capacity?
- What subconscious assumptions might you have made about Sam's gender, and how could these affect your approach?
- How might assumptions about socio-economic status, occupation, appearance, or health literacy impact care?
- What personal thoughts or emotions arise when a patient requests opioids, and how might these influence the consultation?
- How would you manage an accidental opioid overdose or signs of opioid toxicity?
- What serious causes of back pain warrant urgent referral, and what red flag symptoms suggest these?

Health advocate and leader

- What other people may be involved in Sam's care team? How can you lead the team as his GP?

Professional

- What are the legal and professional obligations for prescribing opioids for cancer vs non-cancer pain?
- Where can you access reliable information on Sam's prescribing history?
- If prescribing opioids, what risk management strategies protect Sam, the community, and the treating team?

Scientist, educator and researcher

- Could acupuncture be considered for Sam's pain, and what evidence supports its use? Is training in acupuncture a skill you might consider developing?

Learning resources

The curriculum website includes learning resources within each unit.

Assessment

Content in this unit will be assessed in a variety of ways.

Workplace based assessments

Mini-CEX	RCA	MSF	CBD	Reflective exercise	Audit	Mid and end term assessment

Fellowship examinations

AKT	KFP	CCE

KEY

- Expected to be assessed here always
- Often assessed here but not in every example / case / assessment
- May at times be here or contribute to the assessment

ABBREVIATIONS

Mini-CEX – Mini-clinical evaluation exercise

RCA – Random case analysis

MSF – Multi source feedback

CBD – Case-based discussion

AKT – Applied knowledge test

KFP – Key feature problem

CCE – Clinical competency exam