

Desirable Characteristics for Pain Treatment Facilities

Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities

IASP believes that patients throughout the world would benefit from the establishment of a set of desirable characteristics for pain treatment facilities. The principles set forth in this document can serve as a guideline for both health practitioners and those governmental or professional organizations involved in the establishment of standards for this type of health care delivery. This Task Force has not addressed the issues of pain management in the postoperative or post-trauma setting. Such treatment programs may occur within a pain treatment facility, but they are not required for the assessment and treatment of patients with chronic pain.

Definition of Terms

The following terms will be briefly defined in this section; a more complete description of the characteristics of each type of facility appears in subsequent portions of this report.

1. Pain treatment facility:

A generic term used to describe all forms of pain treatment facilities without regard to personnel involved or types of patients served. Pain unit is a synonym for pain treatment facility.

2. Multidisciplinary pain center:

An organization of health care professionals and basic scientists which includes research, teaching and patient care related to acute and chronic pain. This is the largest and most complex of the pain treatment facilities and ideally would exist as a component of a medical school or teaching hospital. Clinical programs must be supervised by an appropriately trained and licensed clinical director; a wide array of health care specialists is required, such as physicians, psychologists, nurses, physical therapists, occupational therapists, vocational counselors, social workers and other specialized health care providers.

The disciplines of health care providers required is a function of the varieties of patients seen and the health care resources of the community. The members of the treatment team must communicate with each other on a regular basis, both about specific patients and about overall development. Health care services in a multidisciplinary pain clinic must be integrated and based upon multidisciplinary assessment and management of the patient. Inpatient and outpatient programs are offered in such a facility.

3. Multidisciplinary pain clinic:

A health care delivery facility staffed by physicians of different specialties and other non-physician health care providers who specialize in the diagnosis and management of patients with chronic pain. This type of facility differs from a Multidisciplinary Pain Center only because it does not include research and teaching activities in its regular programs. A Multidisciplinary pain clinic may have diagnostic and treatment facilities which are outpatient, inpatient or both.

4. Pain clinic:

A health care delivery facility focusing upon the diagnosis and management of patients with chronic pain. A pain clinic may specialize in specific diagnoses or in pains related to a specific

region of the body. A pain clinic may be large or small but it should never be a label for an isolated solo practitioner. A single physician functioning within a complex health care institution which offers appropriate consultative and therapeutic services could qualify as a pain clinic, if chronic pain patients were suitably assessed and managed. The absence of interdisciplinary assessment and management distinguishes this type of facility from a multidisciplinary pain center or clinic. Pain clinics can, and should be encouraged to, carry out research, but it is not a required characteristic of this type of facility.

5. Modality-oriented clinic:

This is a health care facility which offers a specific type of treatment and does not provide comprehensive assessment or management. Examples include nerve block clinic, transcutaneous nerve stimulation clinic, acupuncture clinic, biofeedback clinic, etc. Such a facility may have one or more health care providers with different professional training; because of its limited treatment options and the lack of an integrated, comprehensive approach, it does not qualify for the term, multidisciplinary.

Desirable Characteristics of Multidisciplinary Pain Centers

1. A multidisciplinary pain center (MPC) should have on its staff a variety of health care providers capable of assessing and treating physical, psychosocial, medical, vocational and social aspects of chronic pain. These can include physicians, nurses, psychologists, physical therapists, occupational therapists, vocational counselors, social workers and any other type of health care professional who can make a contribution to patient diagnosis or treatment.
2. At least three medical specialties should be represented on the staff of a multidisciplinary pain center. If one of the physicians is not a psychiatrist, physicians from two specialties and a clinical psychologist are the minimum required. A multidisciplinary pain center must be able to assess and treat both the physical and the psychosocial aspects of a patient's complaints. The need for other types of health care providers should be determined on the basis of the population served by the MPC.
3. The health care professionals should communicate with each other on a regular basis both about individual patients and the programs which are offered in the pain treatment facility.
4. There should be a Director or Coordinator of the MPC. He or she needs not be a physician, but if not, there should be a Director of Medical Services who will be responsible for monitoring of the medical services provided.
5. The MPC should offer diagnostic and therapeutic services which include medication management, referral for appropriate medical consultation, review of prior medical records and diagnostic tests, physical examination, psychological assessment and treatment, physical therapy, vocational assessment and counseling and other facilities as appropriate.
6. The MPC should have a designated space for its activities. The MPC should include facilities for inpatient services and outpatient services.
7. The MPC should maintain records on its patients so as to be able to assess individual

treatment outcomes and to evaluate overall program effectiveness.

8. The MPC should have adequate support staff to carry out its activities.
9. Health care providers active in a MPC should have appropriate knowledge of both the basic sciences and clinical practices relevant to chronic pain patients.
10. The MPC should have a medically trained professional available to deal with patient referrals and emergencies.
11. All health care providers in an MPC should be appropriately licensed in the country or state in which they practice.
12. The MPC should be able to deal with a wide variety of chronic pain patients, including those with pain due to cancer and pain due to other diseases.v
13. An MPC should establish protocols for patient management and assess their efficacy periodically.
14. An MPC should see an adequate number and variety of patients for its professional staff to maintain their skills in diagnosis and treatment.
15. Members of a MPC should be carrying out research on chronic pain. This does not mean that everyone should be doing both research and patient care. Some will only function in one arena, but the institution should have ongoing research activities.
16. The MPC should be active in educational programs for a wide variety of health care providers, including under-graduate, graduate and postdoctoral levels.
17. The MPC should be part of or closely affiliated with a major health sciences educational or research institution.

Desirable Characteristics for a Multidisciplinary Pain Clinic

The distinction between a Multidisciplinary Pain Center and a Multidisciplinary Pain Clinic is that the former has research and teaching components that need not be present in the latter. Hence, items #15, 16 and 17 above are not required for a Multidisciplinary Pain Clinic. All of the other items should be present.

Desirable Characteristics for a Pain Clinic

1. A Pain Clinic should have access to and regular interaction with at least three types of medical specialties or health care providers. If one of the physicians is not a psychiatrist, a clinical psychologist is essential.
2. The health care providers should communicate with each other on a regular basis both about individual patients and programs offered in the pain treatment facility.
3. There should be a Director or Coordinator of the Pain Clinic. If he or she is not a physician, there should be a Director of Medical Services who is responsible for the monitoring of medical services which are provided to the patients.
4. The Pain Clinic should offer both diagnostic and therapeutic services.

5. The Pain Clinic should have designated space for its activities.
6. The Pain Clinic should maintain records on its patients so as to be able to assess individual treatment outcomes and to evaluate overall program effectiveness.
7. The Pain Clinic should have adequate support staff to carry out its activities.
8. Health care providers working in a Pain Clinic should have appropriate knowledge of both the basic sciences and clinical practices relevant to pain patients.
9. The Pain Clinic should have a trained health care professional available to deal with patient referrals and emergencies.
10. All health care providers in a Pain Clinic should be appropriately licensed in the country and state in which they practice.

Discussion

The Task Force is strongly committed to the idea that a multidisciplinary approach to diagnosis and treatment is the preferred method of delivering health care to patients with chronic pain of any etiology. Not every patient referred to a pain treatment facility is in need of multidisciplinary diagnosis or treatment, but the facility should have those resources available when they are appropriate. Although the Task Force recognizes that health care resources are not uniformly distributed throughout any country or the world and that compromises will be necessary, all health care providers should strive to attain the standards set forth in this document for the care of patients with chronic pain. Health care providers in pain treatment facilities should be encouraged and expected to be members of IASP and its national chapters in order to facilitate exchange of information and research activities.

The primary goal for a pain treatment facility is to provide effective, humane care for those who suffer from chronic pain. The complexities of the chronic pain patient must be recognized to accomplish these goals. In the modern era, however, the issue of cost effectiveness must also be considered and we cannot erect standards for chronic pain treatment which are above and beyond the standards for patients with other types of complaints. Moreover, health care delivery systems are rapidly changing and standards that prevent innovation and progress should not be proposed.

All patients with chronic pain should be appropriately evaluated before treatment is implemented. Facilities that offer only one type of treatment or have limited access to professionals in various disciplines must demonstrate appropriate patient selection prior to the initiation of therapy. Patients who attend such a health care facility should have been fully evaluated elsewhere before such a referral is made. For example, if a "pain clinic" specializes in headache patients and offers only biofeedback therapy, the patients referred to such a facility must have an appropriate medical evaluation prior to embarking on this treatment program. Pain treatment facilities must go beyond this stereotypic approach and determine what services the patient needs prior to embarking upon one or another type of treatment. If what the patient needs is not available, the patient should be referred elsewhere.

Resources and patient demands vary throughout the world, and there is no single guideline that can be made which will apply to every location. In developing nations, pain treatment facilities

may appropriately consist of a small number of health care professionals with limited resources. Such groups may mainly see chronic pain due to cancer or to nervous system injuries; the problems of chronic pain as seen in the industrialized nations may have not yet arrived. Treatments may be limited to nerve blocks and drugs if economic conditions preclude more expensive treatment strategies. It is unlikely that research activities will be carried out in such an environment, but the mission of teaching other health care providers should never be overlooked.

In the developed nations of the world, there would seem to be no reason to allow an isolated practitioner to call himself a pain clinic. The diagnosis and management of patients with chronic pain has become so complex that multiple skills and knowledge are required. There are many possible combinations, but such a facility must have at least one physician who assumes responsibility for obtaining a complete history and performing a screening physical examination. Old records must also be reviewed. The specialty of the physician performing this review is not particularly relevant, but clearly someone with expertise in the type of disease process responsible for the patient's chronic pain should be either the referring physician or part of the pain treatment facility's assessment team. At least two other medical specialties as well as other types of health care providers should be represented to justify the term, multidisciplinary pain clinic. There is some question as to whether any pain management facilities which are not multidisciplinary should exist in a developed nation.

Other types of health care professionals are of great value in a pain treatment facility. These include psychologists, nurses, physical therapists, occupational therapists, social workers, vocational counselors and others. The variety and number will be determined by the types of patients seen and the number of visits per year to the facility. We should remember that the etiologies of chronic pain are not well understood; medical treatments have already failed many of these patients and effective evaluation and treatment may be administered by other health care professionals.

In summary, the developed nations should require that any facility calling itself a pain clinic or pain center offer a multidisciplinary array of diagnostic and treatment facilities. Single modality therapy programs should be identified by the modality they utilize; e.g. "Biofeedback Clinic" rather than the term, "Pain Clinic." Neurosurgeons who perform pain-relieving procedures do not call themselves a "Pain Clinic", nor should any other solitary specialist. Health care facilities which specialize in one region of the body should be identified by that region in their title; e.g. "Headache Clinic", rather than "Pain Clinic". A Multidisciplinary Pain Clinic or Center should provide comprehensive, integrated approaches to both assessment and treatment.

In developing nations, it may not be immediately possible to amass the professional and physical resources to establish a multidisciplinary pain clinic. A single health care provider may initiate a health care facility with the goals of adding other personnel as the institution evolves. This should be encouraged by IASP even though the health care facility at its inception may not meet the desired standards.

Pain Clinics and Pain Centers require not only physical resources but also specially trained health care providers. There is no specific training program in pain management at this time, so all health care providers have entered this area from existing specialties. Fellowships in pain management are beginning to develop, and those individuals who wish to specialize in pain

management should be encouraged to obtain such a period of training. Others become reasonably skilled through their work with pain patients, but the field should move toward the establishment of specific training programs in pain management and the development of a method of evaluation and certification of individual health care providers by responsible leaders.

All pain clinics should work toward the use of a single method of coding diagnoses and treatments. Although the ICD-9 system is utilized in many countries, it is not particularly good for illnesses in which pain is the major complaint. The IASP Taxonomy system is a step in the right direction, but it will need further refinement before it becomes clinically acceptable. Nonetheless, excellence in pain management will require a standardized reporting system which can be used by all types of treatment facilities throughout the world.

Finally, excellence is dependent upon education of young health care providers who may wish to enter this field. Pain Centers need to establish educational programs on all levels to accomplish this goal. These programs should attempt to integrate with degree granting institutions in all the health sciences as well as post-graduate educational programs.

This document has been prepared by a Task Force appointed by the President of IASP, Dr. Michael J. Cousins, and chaired by the Secretary of IASP, Dr. John D. Loeser.

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