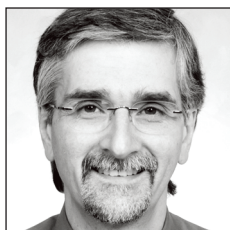


## Taking the Hurt Out of Pain—The Role of the Pharmacist

a report by

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Pain has been referred to as the lowest common denominator of the human experience. The word pain comes from the Latin word *poena*, which literally means 'punishment'. However, not many patients would appreciate hearing from a healthcare provider that their painful condition is retribution for some past deed or act. The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." What this definition fails to recognize is that pain is a very complex, subjective experience that is both difficult to define and measure. The best possible management requires a working knowledge of the etiology of the painful condition and its natural history. Treatment strategies must be individualized, multidisciplinary and multimodal. The effective management of pain (acute, chronic malignant, and non-malignant pain) requires the collaboration of various healthcare providers, including physicians, nurses, psychologists/social workers, the clergy, and even non-traditional alternative providers (including massage therapists, acupuncturists, herbalists etc.). As an integral member of the healthcare team, the pharmacist has an important role to play in providing pharmaceutical care to people with pain.

Since the earliest known record of pharmacy practice in Babylon (2600 BC), the art of the apothecary has been an integral component of healthcare. The pharmacist remains a respected trustee of the public's health. The role of the pharmacist has changed from primarily the compounding of therapeutic medicaments to the provision of sophisticated multidimensional care. Since the early 1990s, the pharmacy profession has embraced the paradigm shift called pharmaceutical care.

Pharmacists providing this patient-focused care have a shared responsibility with physicians and other providers for the outcomes of cost-effective drug

therapy, including improved clinical and quality-of-life indicators. Health promotion and disease prevention are also integral components of this new practice philosophy. Given the biopsychosocial and economic consequences of pain, the pharmaceutical care model is prepared to impact the lives of those afflicted with this significant problem.

Several years ago, a leading pharmacy journal published a report on the development and impact of a pharmacist-based pain management service in a large teaching hospital.<sup>1</sup> The services were well received and resulted in improved clinical and economic outcomes. Recently, the findings from a primary care, multidisciplinary disease management program (involving physicians, pharmacists, and a psychiatrist) were published.<sup>2</sup> Depression, disability, and pain scores improved in a cohort of opioid-managed, chronic, non-malignant pain patients. It is likely that the published results from future clinical outcomes and pharmaco-economic investigations in pain patients will further elucidate the value of pharmaceutical care to healthcare providers, patients, third-party payers, and the public.

Along with the healthcare providers mentioned earlier, the patient must also be empowered to assume an active role in their own health and well-being, so that the full benefits of pharmaceutical care can be achieved. A noted pharmacy educator and pain expert espoused the importance of including the patient in the pain assessment process in a recently published editorial.<sup>3</sup> In it, the author expresses the need for the patient (including the spouse or other caregiver) to preferentially judge the "true cost" of pain and its treatment using patient-centered quality-of-life assessment instruments. Pharmacists are also encouraged to utilize these tools in their own practices in keeping with several important pharmaceutical care tenets, namely patient satisfaction and patient well-being.<sup>3,4</sup>

1. Lothian ST, Fotis MA, Von Gunten CE, et al., "Cancer pain management through a pharmacist-based analgesic dosing service", *Am J Health-Syst Pharm* (1999);56: pp.1119-1125.
2. Chelminski PR, Ives TJ, Felix KM, et al., "A primary care, multi-disciplinary disease management for opioid-treated patients with chronic non-cancer pain and a high burden of psychiatric comorbidity", *BMC Health Serv Res* (2005);13;5(1): pp. 3.

The community pharmacist has long been recognized as the most accessible healthcare provider. Many smaller, isolated, or rural communities may lack readily available healthcare services from a physician or other midlevel providers (physician assistants and nurse practitioners). Yet, one will typically find in these areas a community pharmacy with access to one or more pharmacists. Given their extensive training and expertise, pharmacists can be valuable resources for patients (and their families and/or caretakers) with a variety of painful conditions. The pharmacist is in a good position to triage patients to the appropriate provider or community service. The pharmacist can also serve as an educational resource for providers and patients and their families/caretakers that go beyond traditional patient counseling. Areas of contribution might include the appropriate use of opioid and non-opioid analgesics, adjuvants, and other products/devices used in the management of pain. The pharmacist, along with the patient and his/her primary care provider(s), can share in the development of a specific management plan, including prospective patient monitoring and assessment to ensure that the appropriate outcomes are realized by the patient.

The community pharmacy can be a repository or clearing house for various information related to pain conditions and their treatment. Likewise, information concerning available community resources can be kept at the pharmacy for easy access by patients and other interested individuals. One could also envision a community pharmacy serving as an 'Internet café' or Wi-Fi hotspot where the World Wide Web could be searched for pain-related information from in-house computer stations or from a laptop/notebook/handheld PC or BlackBerry.

In spite of the aforementioned benefits of pharmaceutical care, the provision of pain management

services requires the attainment and maintenance of clinical competencies. It is well known that healthcare providers receive little formal training in the pathophysiology and management of pain. As a result of this, many providers, including pharmacists bring considerable 'baggage' to the table that may adversely affect the care of persons in pain.<sup>5-7</sup> Misconceptions about opioid dependency, concerns about adverse drug effects, and the fear of scrutiny by regulatory agencies, may contribute to patient mismanagement and unnecessary patient suffering. In recent surveys assessing attitudes and knowledge about pain, nurses and physicians scored higher than pharmacists and were more knowledgeable about pain assessment of cancer patients.<sup>8,9</sup> There continues to be trepidation about the dispensing of controlled substances, the fear of robbery, and a lack of awareness concerning state- and federal-controlled substance policies by pharmacists.<sup>6,7</sup>

Even though these findings are somewhat disturbing, they should serve as a wake-up call to the profession. In a survey of primary headache education in 65 US pharmacy schools, average pharmacy students receive a median of one contact hour of headache instruction and no elective contact hours per professional year.<sup>10</sup> However, it was encouraging to note that seven schools planned to increase the number of lectures devoted to this topic. The results of a recent phone survey of faculty members from 28 US schools of pharmacy who teach pain management highlight the fragmentary nature of pain lectures, the lack of curricular content devoted to pain management topics, and the lack of a single comprehensive reference source targeted to pharmacy students.<sup>11</sup> It is apparent that pharmacy school curricula should reflect a heightened awareness and sensitivity to pain and its management. The American Pharmacists Association has recently sponsored a Pain Management Cognitive Abilities

3. Supernaw RB, "On the pharmacist's role in pain-related quality-of-life measures", *J Am Pharm Assoc* (2000);40: p. 352.
4. Bonomi AE, Shikier R, Legro MW, "Quality-of-life assessment in acute, chronic, and cancer pain: a pharmacist's guide", *J Am Pharm Assoc* (2000);40: pp. 402-416.
5. Krick SE, Linley CM, Bennett M, "Pharmacy-perceived barriers to cancer pain control: results of the North Carolina Cancer Pain Initiative Pharmacist Survey", *Ann Pharmacother* (1994);28: pp. 857-862.
6. Greenwald BD, Narcessian EJ, "Opioids for managing patients with chronic pain: community pharmacists' perspectives and concerns", *J Pain Symptom Manage* (1999);17: pp. 369-375.
7. Joranson DE, Gilson AM, "Pharmacists' knowledge of and attitudes toward opioid pain medications in relation to federal and state policies", *J Am Pharm Assoc* (2001);41: pp. 213-220.
8. Lebovits AH, Florence I, Bathina R, et al., "Pain knowledge and attitudes of healthcare providers: practice characteristic differences", *Clin J Pain* (1997);13: pp. 237-243.
9. Furstenberg CT, Ahles TA, Whedon MB, et al., "Knowledge and attitudes of health-care providers toward cancer pain management: a comparison of physicians, nurses, and pharmacists in the state of New Hampshire", *J Pain Symptom Manage* (1998);15: pp. 335-349.
10. Wenzel RG, Neidich MR, "Headache education in pharmacy schools", *Ann Pharmacother* (2002);36: pp. 612-616.
11. Singh RM, Wyant SL, "Pain management content in curricula of U.S. schools of pharmacy", *J Am Pharm Assoc* (2003);43: pp. 34-40.

Assessment Project in an attempt to quantify the pain management abilities of graduating DPharm students. It is hoped that the findings will help guide the development of expanded curricular offerings about pain and its management throughout schools of pharmacy in the US.

It is also incumbent upon individual pharmacists to enhance their skills in the area of pain management via participation in continuing pharmacy education programming, which may include completion of self-study modules and attendance at live symposia. The American Society of Health-System Pharmacists has formed a Pain Management Network where practitioners with a common interest in pain management can convene and share information and

'war stories' arising from their practice environments.<sup>12</sup>

Importantly, professional pharmacy organizations and individual pharmacists are encouraged to enter into the public policy debate and enhance their legislative lobbying efforts on behalf of pain management issues. Focusing one's efforts on behalf of persons with pain can be professionally rewarding. Taking the hurt out of pain is a noble cause, and warrants continued support. ■

*This article represents an updated version of a guest editorial that appeared in the July/August 2001 issue of Practical Pain Management.*

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8. Lebovits AH, Florence I, Bathina R, et al., "Pain knowledge and attitudes of healthcare providers: practice characteristic differences", *Clin J Pain* (1997);13: pp. 237-243.
9. Furstenberg CT, Ahles TA, Whedon MB, et al., "Knowledge and attitudes of health-care providers toward cancer pain management: a comparison of physicians, nurses, and pharmacists in the state of New Hampshire", *J Pain Symptom Manage* (1998);15: pp. 335-349.
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11. Singh RM, Wyant SL, "Pain management content in curricula of U.S. schools of pharmacy", *J Am Pharm Assoc* (2003);43: pp. 34-40.
12. Rule AM, "American society of health-system pharmacists' pain management network", *J Pain Palliat Care Pharmacother* (2004);18: pp. 59-62.