CLINICAL Viewpoint

Assessment and Management of Chronic Pain and the Potential Role of Narrative Medicine

Chronic non-cancer pain (CNCP) is a common and growing problem in our society; a new comprehensive population survey has revealed that one in three (33%) Canadians now lives with moderate-to-severe pain as an ongoing part of their life. One in six lives with constant pain, and 20% experience pain daily.[1] The impact of chronic pain on the individual, plus the economic burden on society, is staggering. Effective management of chronic pain involves careful assessment of the mechanism(s) and severity of the pain and its impact on the patient's ability to function. Opioid therapy has a proven role in managing many patients with chronic pain. Detailed appropriate assessment and screening for risk factors for substance abuse help guide appropriate therapy.

Narrative medicine is a new modality that aids the physician in gaining an appreciation of the impact of chronic pain on the patient's life; it also helps build a therapeutic alliance between patient and physician.

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This article reviews the assessment and screening of patients who are candidates for opioid therapy, and introduces the concepts behind narrative medicine and how it can be applied to clinical practice.

Chronic Pain: Definitions, Epidemiology and Current Treatment

Chronic pain is often defined as pain lasting six months or more. The Canadian Chronic Pain Study II found that 25% of Canadians suffer from chronic pain. Among Canadians age 55 and older, 33% had pain lasting at least six months. The average duration of chronic pain in this study was 9.8 years.[2]

Behind the statistics, each patient with chronic pain has a story to tell. Severe chronic pain has been described as "our contemporary, central dilemma – it stands for our most impenetrable dilemmas of unnamable and unfixable and unwarranted suffering."[3]

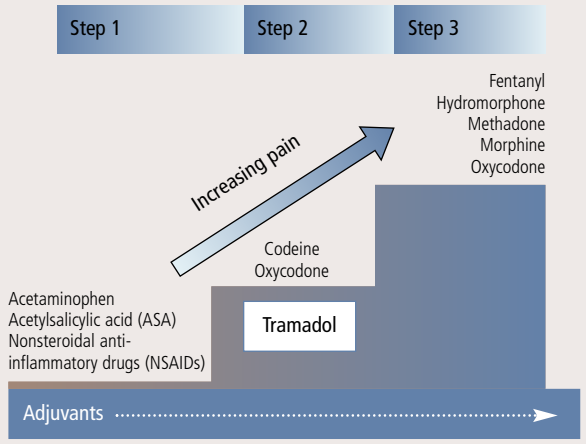
There are numerous pharmacological and non-pharmacological therapeutic modalities that have been shown to be effective in the management of CNCP. Non-pharmacological modalities include cognitive behavioural therapy, education, exercise, surgery, spinal-cord stimulation, and interdisciplinary rehabilitation. Pharmacological approaches include acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), tricyclic antidepressants, anti-epileptic drugs, and opioid analgesics.

The World Health Organization analgesic ladder (Figure 1) shows the integrated pharmacological armamentarium for managing pain.[4] The ladder has three steps, with each step representing a different severity of pain. Step 1 is for patients with mild pain, Step 2 is for patients with moderate

pain, and Step 3 is for patients with severe pain. Adjuvants such as tricyclics and anti-epileptic drugs may be prescribed when appropriate for pain of any severity. Recently, some authors have suggested adding tramadol to the list of analgesics recommended to patients with Step 2 or moderate CNCP.

Figure 1

World Health Organization Analgesic Ladder



Adapted from World Health Organization, 1996.

Controlled clinical trials have demonstrated that opioids can be effective in properly selected patients. A recent meta-analysis found that both weak and strong opioids outperformed placebo for pain and function in all types of CNCP. Other drugs produced better functional outcomes than opioids, whereas for pain relief they were outperformed only by strong opioids.[5] In contrast to many other therapeutic modalities, opioid therapy does not cause end-organ toxicity. In addition, unlike other medications, the adverse effects that opioids do possess tend to be predictable.

When prescribing opioid therapy, physicians must be vigilant in monitoring for the possibility of substance abuse and substance dependence, known more colloquially by the term 'addiction.' The Canadian Society of Addiction Medicine has defined addiction as a "primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour."[6] It is critical to understand that addiction is defined by behaviours, not by symptoms such as physical dependence or tolerance. Addiction is characterized by having at least one of the Four Cs (Table 1).

Table 1

Four Cs of Addiction

- Craving
- Compulsive use
- Loss of Control over use
- Continued use despite consequences (also known as use despite harm)

It is important to distinguish addiction from physical dependence (withdrawal symptoms when the drug is removed) and tolerance (the need to increase dosage to get the same effect over time). We expect the physical effects, but screen for risk and are constantly vigilant for evidence of the behavioural disorder.

A recent review of the literature found that the prevalence of addiction in chronic pain patients treated with opioids varied between 0% to 50% in patients with CNCP, and between 0% and 7.7% in patients with chronic cancer-related pain.[7] Thus, it is important to screen patients for addiction risk factors before starting opioid therapy, and monitor patients for indications of addiction during therapy.

The Opioid Risk Tool (ORT) is a five-question patient questionnaire that is easy to administer in the office setting (Table 2). Its aim is to predict the risk that the patient will exhibit aberrant drug-related behaviours once opioid therapy is initiated. Ideally, it should be administered to patients before opioid therapy begins. The ORT has been validated in preliminary studies.[8]

For guidelines on appropriate therapy for chronic pain, consult the Canadian Pain Society and your provincial College of Physicians and Surgeons.[9]

Documenting Appropriate Care

Good documentation is a cornerstone of appropriate care in all areas of clinical medicine, and pain management is certainly no exception. Poor documentation does not imply substandard care, but it does make it more difficult to prove that acceptable care was provided.

A good initial pain assessment includes taking a thorough history of the pain problem, previous

Table 2

Opioid Risk Tool

		Female	Male
1. Family history of substance abuse	Alcohol	[ ] 1	[ ] 3
	Illegal drugs	[ ] 2	[ ] 3
	Other	[ ] 4	[ ] 4
2. Personal history of substance abuse	Alcohol	[ ] 3	[ ] 3
	Illegal drugs	[ ] 4	[ ] 4
	Prescription drugs	[ ] 5	[ ] 5
3. Age (if between 16 and 45)		[ ] 1	[ ] 1
4. History of pre-adolescent sexual abuse		[ ] 3	[ ] 0
5. Psychological disease	ADD, OCD, Bipolar, Schizophrenia,	[ ] 2	[ ] 2
	Depression	[ ] 1	[ ] 1
Low (0-3) Moderate (4-7) High (8+)	**Total**	**[ ]**	**[ ]**

Webster LR, Webster RM. Pain Med 2005; 6:432-42.

investigations and consultations, previous treatments and their effectiveness, current medications, allergies, and other medical problems. Next, document how the pain has affected the patient's ability to function through the patient's work history, as well as the patient's ability to set realistic and achievable goals for opioid therapy. Finally, search for addiction comorbidities through the use of screening tests such as the ORT.

Documentation at follow-up visits includes the Six As, a convenient mnemonic (Table 3).

Narrative Medicine: The Power of Stories to Help Patients with Chronic Pain

In 2000, Dr. Rita Charon coined the phrase "narrative medicine" as "the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness."[10] Narrative medicine is an acquired skill practiced by someone who knows what to do with stories. Dr. Charon and colleagues have developed a program at Columbia University in New York City that provides rigorous training in close reading, attentive listening, reflective writing, and bearing witness to suffering.

Narrative competence requires rigorous training. However, the benefits may well be worth the effort. According to Charon, healthcare providers trained in this technique are able to understand more accurately and with more empathy what patients tell them. It may also strengthen the cohesion of the healthcare team, and increase patient satisfaction.

Clinicians who undertake training in narrative medicine are better able to strengthen the therapeutic alliance between doctor and patient by adopting or identifying with the patient's perspective.[11] Storytelling has become integral to the teaching of medical ethics.[12] Pediatricians have begun to use the power of storytelling to help forge alliances between physicians and children with illnesses.[13] It has been suggested that narrative therapeutic approaches can be helpful in supporting both terminally ill patients and their families.

Narrative medicine could well play an important role in the diagnosis and management of chronic pain.

Stories are very important to the experience of chronic pain. Such stories are often reflected in religious beliefs, literature and cultural references.

Table 3

The Six As of Documentation for CNCP

Analgesia	
What is the current level of pain?	
Activity level	
What is the current level of function? What can be done now that could not be done before?	
Adverse effects	
What adverse effects have arisen from opioid therapy? How are they being managed?	
Adherence or Ambiguous drug-related behaviours:	
Is the patient complying with the treatment plan? Are there any behaviours that might suggest misuse or abuse of the medication?	
Accurate medication log	
Are changes in the drug prescribed and dosage changes and the rationale for making those changes documented clearly? Does the documentation comply with controlled substance regulations?	
Affect	
What is the patient's mood? Has there been any change?	

In the distant past, physicians would listen intently as patients described their subjective symptoms in exhausting detail. More recently, as physicians focused on objective data gathering, there was a decline in valuing the patient's subjective storytelling.

Narrative medicine is an enhancement, not a replacement for a history taking and physical. The physician invites the patient to tell the story of his or her pain as if telling the story of his or her life, first love, or most frightening memory. The telling should be as unstructured and unhurried as is practical, with the physician maintaining eye contact and making as few notes as possible.

The experience is often cathartic to the patient. As well, the physician is able to appreciate the depths of the patient's suffering and the impact of the pain on the patient's life, occupation, relationships, as well as the patient's hopes and dreams.

More research is needed to demonstrate its efficacy in CNCP, and to validate and to develop further methods used to teach physicians and medical students.

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