Pain education in medical practice

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Pain is a common symptom among patients who seek help from a doctor. Examples of this include headache, facial pain, neck pain, knee pain and back pain. Apart from having an organic cause, there could be psychological component in the pain perception. However, the understanding of pain has been limited in the general public. Patients with pain complaint usually seek advice from a family doctor first, and some of them go to a specialist directly. However, it might not be easy for the patients to choose a doctor of an appropriate specialty as the cause of pain is sometimes multifactorial and across different disciplines. There have been many patients who have visited many doctors of different specialties without any improvement of pain. And they eventually end up in a psychiatrist's clinic with a psychiatric diagnosis given. Therefore, it would be beneficial to implement a pain education program for the general public and for patients, in order to increase the understanding of pain-related knowledge.

There has been a lot of misconception or myths about pain in the general public. Here are some examples.

Misconception:
People think all real pain has an identifiable cause.
Correction:
All pain is real and there could be psychogenic cause of pain.

Misconception:
People with prolonged period of pain should have a higher level of tolerance.
Correction:
Prolonged pain could lead to lower level of pain tolerance and could result in chronic pain. Stoicism does not help and the pain can lead to depressive disorder and anxiety disorder, which in turn affects the pain perception.

Misconception:
People who clock watch pain and request analgesia are usually addicted. The risk of addiction is very high.

Correction:
They are in severe pain and worry about the pain coming back. The risk of dependence is not high. In patients who require use of medication with potential of causing dependence, the prescription should be limited to a short period by the doctor.

Misconception:
In patients with depression or anxiety, the pain complaint is largely psychological and emotional in nature.
Correction:
The physical and psychological causes should not be separated and proper management of depression or anxiety is necessary.

Misconception:
Medication is the only treatment for pain.
Correction:
Apart from medication treatment, there are other modalities of treatment such as cognitive behavioural therapy, biofeedback and hypnotherapy. This could be introduced earlier in the management plan.

These pain-related misunderstanding, myths and stereotypes can act as barriers to patients seeking help for their pain problem. The patients' expectation and health practices regarding pain management would be affected. This could lead to negative consequences in pain management, such as delayed diagnosis, delayed treatment and reduced quality of life.

Therefore, there is a critical need for implementation of a pain education program for the general public and the patients in a clinic. For the general public, the aim of pain education is to counter the myths and misunderstanding and give the correct information to the public. This could be in the form of public lecture, publication of public educational materials and carrying out education in the electronic media. Pain education for individual patient with pain is also necessary. The purpose is to identify individual patient's stereotypes about pain, elicit patient's perspective about the expected treatment and give a positive direction to the patient. The discussion with the patient can be supplemented by some written educational materials. Apart from doctors, nurses and other allied health professionals such as physiotherapist and occupational therapist in the pain management pain should be recruited in the pain education program. This could give patients better understanding of pain from

different perspectives. Apart from targeting at patients, this kind of program could also involve family members and caregivers.

In the pain education program, some information should be included. This includes different types of pain, mechanism and causes of pain, self-monitoring of pain such as use of brief pain inventory and patient-reported improvement scales, different types of treatment including non-pharmacological and pharmacological approaches, efficacy and side effects of medication treatment, risk of tolerance and addiction to pain medication, psychological consequences of chronic pain, myths and misunderstanding. Effective education programs will also include different ways of communicating with health care professionals and enhance patients' pain-related coping skills such as self-monitoring, problem solving and adjusting maladaptive cognition about pain. The education program could be divided into different parts and delivered at different times. The effectiveness of the pain education program should be evaluated.

Despite the common occurrence of pain, there has been lack of a comprehensive pain education program in a daily busy clinic. The need of setting up and tailor-making a multidisciplinary pain education program for patients is recognized, alongside the provision of pain management. This could ensure early recognition, timely assessment and diagnosis, and effective intervention given as soon as possible. This is likely to avoid the long term consequences of chronic pain problem, such as depressive disorder, anxiety disorder, insomnia, frequent absences from school and work, and reduced quality of life.

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