Translating brain and pain science through brief GP education: The Time Efficient Management of Pain in the Office (TEMPO) road-trip

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TIME EFFICIENT MANAGEMENT OF PAIN IN THE OFFICE

Pain is raised in almost half of all GP consultations and most chronic pain is managed by GPs. GPs must balance full waiting rooms and a remuneration system promoting 5-minute medicine and quick scripts. Many of a GP's patient load involves multi-morbidities & polypharmacy, while their guidelines are developed by single-organ experts, leading to "guideline fatigue".

For two decades, most GP pain education has been commercially underwritten by pharmaceutical companies. Such teaching advises opioids must only be given after the failure of nonopioid methods and it highlights judicious risk precautions to avoid prescribing to addicts. However, Big Pharma knows that GPs rarely follow these caveats[1]. Pain education has not sought to upskill GPs on psychobehavioural care or the provision of opioids in dependency despite their evidence-base and relative safety.

In 2014-15, some of us (SH, CH) delivered brief training to GP registrars/ trainees on chronic noncancer pain guideline-concordant opioid care and undertook a dual evaluation. While theoretical management improved, training failed to change objective opioid prescribing rates[2,3].

During 2015 a group of seven clinicians formed a working group to develop the TEMPO programme. We comprised a clinical psychologist, a pain physiotherapist, a pain physician, a pain psychiatrist (and physician) and three private practice GPs. None of the GPs were specialised in pain management, two working in psychotherapy and one as a rural GP and addiction physician.

Content

Our learning objectives involved teaching clinicians about:

- multimodal, non-interventional, alternatives to pharmacological management.
- active self-management skills to optimise function and social reintegration.
- strategies for non-initiation and the de-prescribing of opioids.
- educating patients about the harms of opioids in chronic pain.
- the management of co-morbidities including depression, anxiety, family problems, sleep difficulties and dependency (e.g. take-home naloxone and opioid maintenance therapy).

Delivery

We used a mix of interactive and didactic styles situated within routine GP training days. Several groups and experts were consulted to comment on the project. Through 2016-2018, we presented at 9 or 10 venues ranging from a one-hour webinar to 1-6 hour workshops. One education organiser was approached by a sponsoring pharmaceutical company requesting they review our material. They were worried TEMPO wanted to stop GPs prescribing all opioids and wanted the conference to "keep a consistent message". We declined this invitation. After our presentation at the 2017 International Medicine in Addictions conference, we were approached by the editors of Australian Prescriber and commissioned to prepare a paper about managing pain in general practice[4].

Funding and Evaluation

We applied for funds or grants from about 20 public, professional or charitable organisations, but found no interest for evaluating GP education. During 2016, we initiated a Joint Venture grant application with regional Aboriginal Medical Services and the National Prescribing Service to deliver and objectively evaluate the programme for Aboriginal Medical Centre clinicians. This failed at the final round. Lack of funding prevented us using videos or developing web-based resources. We attempted in vain to have the programme auspiced by numerous professional organisations.

They loved Chris Hayes' jokes

We wanted to see if this education was feasible and, given our previous experience, effective. We applied for ethics approval via the RACGP, although evaluations were contingent on the venue and funding. We developed our own survey because all evaluations of GP pain education reflected their educational focus: how to better deliver opioid analgesics. The survey remained unvalidated both due to lack of funding and because there was no "gold standard."

We negotiated with both GP colleges to have TEMPO accredited with the highest value continuing education rating (an "ALM"). This required the 6-hour workshop to be 2/3 interactive. So we developed 16 "Learning Activities" for GP17 in Darling Harbour late 2017. Just before this, we finally gained funding via a Primary Healthcare Network grant for building capacity in the Alcohol and Drug treatment workforce. This facilitated the evaluation, but only a methodologically weak before-and-after workshop survey.

Feedback

We had great feedback from participants: "Transformative"; "It empowered me to think I can do it and gave me the tools to achieve this"; "Make it universally available, perhaps even consider a trial with university medical students."
We had wanted to focus on nonopioid care, but early feedback asked for more help on opioid negotiating. Despite increasing this section, discomfort remained about these conversations.

Dissemination of the Evaluation:

Our evaluation is being presented at this conference, but our paper has not yet been accepted for publication. Feedback indicates this is because a before-and-after survey is methodologically unsuitable to assess effectiveness (despite surveys being the most common method utilised[5]). We will continue to seek publication because of the potential value of this innovative and pragmatic educational project.

The Future

The nonpharmacological management of pain is important for GPs, junior hospital doctors, many medical specialists and those working in addictions. Given these skills do not require prescribing rights, there is no reason staff of residential aged care facilities could not also be introduced to holistic pain care. For malpractice indemnity insurers, a TEMPO programme may prevent or ameliorate prescriber impairment. Dealing with "legacy" or "inherited" pain patients on opioids requires pain care skills as well as those gleaned in addiction medicine. This would allow more tailored outcomes than the current blunt regulatory backlash to over-prescribing and overdose deaths which has seen reports of opioids being denied even to those requiring palliative care[6]. Opioids have an evidence-based medium-to-longer-term role in addictions and for palliative care. We hope programmes like TEMPO will assist clinicians manage the range of opioid-related cognitions and behaviours. A final bonus is that with the increasing Western burden of chronic diseases, the skills introduced by TEMPO programme may be utilised for multi-morbid patients.

The GP17 presenting team L to R: Lester Jones, Simon Holliday, Jill Gordon, Sarah Overton, Chris Hayes

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