

Global Year Against **Acute**

PAIN

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Why the Gaps between Evidence and Practice?

Ample evidence summarized in companion fact sheets shows that optimal treatment of acute pain:

- Improves patients' quality of life and satisfaction with care;
- Reduces the risk of many complications (e.g., venous thrombosis);
- Permits earlier discharge;
- Facilitates recovery through multiple mechanisms (e.g., reduced stress response);
- Can enhance clinical resource management (e.g., minimize disruptions to the smooth flow of patient care) and reduce short- and long-term costs of care.

Substantial high-quality evidence attests to the efficacy of multiple classes of medications and modes of their delivery (including regional anesthesia) and nondrug techniques for patients with acute pain from surgery, injury, or medical illness. Evidence also points to the importance of individualized care and consideration of the clinical context (e.g., available resources).

However, abundant evidence also indicates widespread underassessment and undertreatment of acute pain, and failure to provide proactive pain plans [8]. Gaps between evidence and practice are of several types. Some reflect general barriers to the implementation of evidence-based and outcomes-driven practice [3,9]. Another type of mismatch between evidence and practice is the uniform, rigid application of population-based evidence, such as a large randomized controlled trial (RCT), to individual patients without taking into account their variability, their preferences, or specifics of the clinical context [4]. Other barriers of particular relevance to optimal acute pain management reflect failure to address long-standing, prevalent myths about acute pain and the importance of its control [8,12].

Gaps in the quality of pain care delivery reflect:

- Problems related to health care professionals;
- Problems related to patients;
- Problems related to the health care system.

Problems related to health care professionals include:

- Out-of-date or inadequate attitudes and knowledge, e.g., mistaken ideas that:
 - Postoperative pain control interferes with prompt recognition of surgical complications;
 - Surgery has to be associated with pain;
 - Patients who speak up about pain are fussy.
- National differences with respect to professional societies' differences in interpreting the evidence
- "Clinical inertia" [10], i.e., slowness to update individual practice in light of evolving evidence [1];
- Inadequate staffing of an acute pain service, resulting in ad hoc efforts oriented toward treating pain rather than preventing it systematically [9,11];
- Incomplete, sporadic, or nonstandard pain assessment;
- Opiophobia;
- Exaggerated concerns about the side effects of pain treatment;
- Limited transferability of RCT-derived results into clinical practice.

Problems related to patients include:

- Out-of-date or mistaken ideas similar to those outlined above for health care professionals;
- Belief that "nice" patients do not complain about pain or do not show suffering (including cultural factors);
- A tendency to be satisfied with inadequate pain control, particularly when health care providers are perceived as supportive and caring [5];

- Reluctance to take pain medications because of side effects (e.g., nausea, vomiting) and other consequences (e.g., addiction, tolerance);
- Lack of awareness of the importance of pain control to optimize short- and long-term outcomes (e.g., chronic pain);
- Lack of an organized constituency such as arises among patients (and their families) affected by chronic diseases, including cancer.

Problems related to the health care system include:

- Low priority given to pain control education for health professionals;
- Low value accorded to patient preferences;
- Regulatory impediments to controlled substance use;
- Income derived from pain treatment is often inadequate to sustain a viable enterprise (often due to fragmented, flawed cost-effectiveness tracking);
- Cost-shifting to patients (e.g., by insurers);
- Inadequate infrastructure, including knowledgeable personnel to deliver medications and other interventions (e.g., patient-controlled analgesia, cognitive-behavioral techniques);
- Practice restrictions, such as regulations that permit nurses to administer injections only intramuscularly or subcutaneously injections, and not intravenously;
- Failure to capture short- and long-term quality outcomes that might be correlated with the adequacy of acute pain control [6,13];
- Relative to the burden of acute pain, expenditures for basic, translational, and clinical research funding are all disproportionately low [2,7].

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