Editorial

Chronic Pain Clinic in Kuwait: Are We Prepared?

Ibrahim Hadi[1,2]

[1]Department of Anesthesia and Perioperative Medicine, University of Western Ontario, St Joseph Health Care, London, Canada

[2]Department of Anesthesia and Intensive Care, Farwaniya Hospital, Ministry of Health, Kuwait

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Chronic pain is a common condition in adults with a median prevalence of 15% (2 - 40%) across different countries worldwide[1]. Although access to treatment for chronic pain is a compelling need, under treatment continues to be a major concern and has been clearly documented in those patient populations for which there is broad consensus about the nature of optimal care. A recent local survey reported a prevalence of 35.7% for musculoskeletal pain in females and 20.2% in males[2]. The authors concluded that musculoskeletal pain is a major health problem among Kuwaitis and deserves intense government attention.

Unfortunately until this day, an integrated, comprehensive pain management service for patients with chronic non-cancer pain condition does not exist and we are seriously behind other gulf states in the region who have established multidisciplinary pain services with demonstrated positive outcomes. Deficiencies in pain management still exist, but pain medicine is rapidly approaching responsibility and recognition, and we hope that in time, pain medicine will become an independent specialty. Nevertheless, the days of the omnipotent, omnipresent physician who "waves his hand" over a silent, awestruck patient are over. Therefore, are we prepared to establish such chronic pain clinics at our local hospitals in the ministry of health? Is it cost-effective? And how can we communicate with other various medical disciplines (*e.g.,* surgeons, internist and general practitioners) to provide their patients with professional chronic pain management?

Often, chronic pain syndrome reflects the endpoint in a sequence of events. Patients become aware of their initial symptoms and seek help from their primary care physician or treating surgeon. Should treatment or passage of time be unsuccessful in resolving their symptoms, they frequently are referred to specialists or seek out other medical opinions and treatment on their own. As patients continue through the medical system, they are subjected to multiple diagnostic studies, are treated with a variety of medications, and may be referred to physical therapy or biofeedback and counselling. Surgical interventions are sometimes attempted to resolve the problem. When pain continues, patients become frustrated and desperate. They increase pain behavior in an attempt to communicate their level of discomfort and its devastating impact on their lives. Frustrated as well, physicians or other health care professionals may begin to probe the impact of other factors such as stress level or lifestyle. Patients begin to fear abandonment because they perceive that the reality of their symptoms is being questioned or that their problems are being attributed to a psychological cause.

Chronic pain is increasingly recognized as a major health problem in many countries. It has been shown to affect psychological health, social and economic well-being, and health-related quality of life in different communities[3]. As a result, chronic pain and its consequences have been reported to cause considerable burden to the health care cost. In the United States and United Kingdom, the economic cost for back pain was estimated to exceed US$ 54-86 billion and US$ 20 billion a year, respectively[4]. Similarly in the Netherlands, neck pain alone was estimated to cost US$ 686 million[5].

In a study by Okifuji *et al*, they analyzed the cost benefits and cost-effectiveness of interdisciplinary pain management programs[6]. Cost savings were dramatic for persons who had been involved in interdisciplinary treatment programs. Patients treated in interdisciplinary programs would spend US$ 280 million less for medical costs in the year following treatment and additional surgery, than those treated conventionally. Similarly, annual savings for subsequent surgical costs would be approximately US$ 63 million when patients were treated in an interdisciplinary program rather than surgically. Cost savings were much more dramatic

Address correspondence to:
Dr. Ibrahim Hadi, MB ChB, FRCPC, 268 Grosvenor Street, St Joseph's Health Care Room E 147, London, Ontario, Canada N6A4L6. Tel: (519) 646-6000 - Ext: 64219, Fax: (519) 646-6116, E-mail: Ibrahim.hadi@gmail.com

when costs of lifetime disability benefits were included. Okifuji *et al* found that interdisciplinary treatment was nine times more cost-effective than conservative treatment and 3.5 times more effective than surgical treatment in helping patients return to work.

In 1990, the International Association for the Study of Pain (IASP) struck a task force to define desirable characteristics for pain treatment facilities[7]. The task force defined the structure of these facilities as follows:

Pain-treatment facility: a generic term used to describe all forms of pain-treatment facilities, without regard to personnel involved or types of patients served. Pain unit is a synonym for pain-treatment facility.

Multidisciplinary pain centre: an organization of healthcare professionals and basic scientists that includes research, teaching and patient care related to acute and chronic pain. A wide array of health-care specialists is required, such as physicians, psychologists, nurses, physiotherapist, occupational therapists, vocational counselors, social workers and other specialized health-care providers. The members of the team must communicate with each other on a regular basis, both about specific patients and about overall program development.

Multidisciplinary pain clinic: a health-care delivery facility staffed with physicians of different specialties and other non-physician health-care providers who specialize in the diagnosis and management of patients with chronic pain. It does not include research and teaching activities in its regular programs.

Pain clinic: a health-care delivery facility focusing on the diagnosis and management of patients with chronic pain. A pain clinic may specialize in a specific diagnosis or in pain related to a specific region of the body. A pain clinic may be large or small, but it should never be a label for an isolated solo practitioner. A single physician functioning within a complex health-care institution that offers appropriate consultative and therapeutic services could qualify as a pain clinic, if patients with chronic pain were suitably assessed and managed. It differs from a multidisciplinary pain centre or clinic due to the absence of interdisciplinary assessment and management of patients.

In conclusion, there are probably a large number of patients in our health care system who suffers daily from chronic pain as consequence of either trauma, surgical procedure or other causes. These patients are often inadequately treated not because of negligence, but due to lack of access to professional chronic non-cancer pain clinics that have the ability to diagnose and possibly treat such chronic conditions. I believe, the time has arrived to formally and materially acknowledge the essential need to establish a chronic pain facility center in Kuwait. Therefore, we need to initiate a strategic plan for the chronic pain service in our health care system that includes the process of determining our goals for the future and finding the best way to achieve them. This will be possible only through the continuous support and understanding of our medical colleagues and the health care system, besides financial support from our government. The ultimate aim is better improvement in health care provision with greater clinical effectiveness and efficiency.

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