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Pain management in palliative care: a modified Delphi consultation study

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KEY POINTS
- A lack of best practice guidelines for GPs managing chronic pain was identified
- Chronic pain management aims to prevent over- or under-prescribing of analgesics
- A high degree of consensus between New Zealand GPs for the recommendations was demonstrated
- A step-wise approach of analgesic drugs (from weak to strong) is recommended
- Morphine (with dose titration) remains the mainstay agent.

ABSTRACT

Background: A need was identified to provide GPs and palliative care specialists with best practice guidance for chronic pain management, including minimising the under- or over-prescribing of analgesia.
Aim: Identify existing guidelines and determine degree of New Zealand consensus for these.
Method: A summary based on the Expert Working Group of European Association for Palliative Care recommendations was produced. A modified two-round Delphi consultation was conducted with anonymous panel of palliative care specialists and GPs with a special interest in palliative care selected to represent a wide range of possible opinions and experience. Respondents graded their degree of agreement/disagreement with each recommendation section against a five-point scale.
Results: All five specialists and four out of five GPs completed the first round. Further attrition resulted in a 70 per cent response rate. By the completion of the second round, there was a high level of agreement to all the statements. The final version of the recommendations are given in the article on page 7.
Conclusion: Morphine remains the mainstay agent for pain relief, with dose titration achieved using immediate release formulations and maintenance treatment with controlled release products. Inadequate pain control reduces the pain threshold, hence the aim is to provide sufficient analgesia to prevent pain recurring. The optimal route for morphine administration is oral, with subcutaneous continuous infusion when parenteral administration is required. Regimens using adjuvant analgesics can be individually tailored to provide maximum pain control. Use of these recommendations in palliative care should provide the relief of chronic pain in the vast majority of patients.

INTRODUCTION

A lack of specific guidelines for the management of chronic pain in palliative care by New

Zealand GPs and palliative care specialists was identified. It was felt of value to provide these practitioners with some guides towards best practice, in particular to prevent possible under- or over-prescribing of analgesic agents.
A literature search of Medline 1966 to 1999 and Embase 1980 to 1999 was conducted and existing guidelines identified. The Cochrane Library databases of Systematic Reviews, Abstracts of Reviews of Effectiveness and the Controlled Trials Register, CCTR, were searched for relevant documents.
It was considered that the recommendations provided by the Expert Working Group of the European Association for Palliative Care1 offered a concise and useful summary of advice to practitioners in chronic pain management. These recommendations formed the basis of a draft document which was adapted to a New Zealand context and took into account new developments highlighted in the literature. It was decided to determine the degree of New Zealand consensus for this outline using a Delphi consultation process.

METHOD

The Delphi process derives its name from Greek mythology. Delphi was the major oracle of Apollo, from where he made most of his prophecies. The Delphi technique was developed by the RAND Corporation in the late 1960s as a forecasting methodology. It is a tool based on the three characteristics of anonymity, statistical analysis and feedback of reasoning, which allows a group of experts to come to some consensus of opinion. Now widely used in research, the Delphi technique is a consensus method used to determine the extent of agreement on an issue. The technique involves asking a panel of experts to take part in a series of rounds to clarify, refine, and gain consensus on the particular issue. As the panel does not meet, individuals can express their opinion without being influenced by others.
Five palliative care specialists and five GPs with a special interest in palliative care agreed to participate in a modified two-round Delphi consultation. While traditionally the panel would be used to identify the initial issues, in our case we used a modified Delphi technique in which the preliminary statements were generated from the literature rather than from an initial round. Participating doctors were selected to represent a wide range of possible opinions and experience. The process was anonymous, and none of the invited doctors were informed as to the identity of others participating in the study.
Respondents were asked to grade each of 38 sections of the draft recommendations against a five-point scale (Strongly disagree; Disagree; Neutral; Agree; Strongly agree) and were invited to comment on each of the 38 sections.
Responses were collated and sections of the draft document rewritten in accordance with the opinions and evidence-based comments submitted at the first round. Participants who were sent the revised second round were asked to repeat the exercise.

RESULTS

All five specialists and four out of five GPs completed the first round. One GP failed to return the first round despite verbal assurances on two occasions. One specialist and one GP who had completed the first round failed to complete the second round, giving a 70 per cent response rate.
Even in the first round there was a high degree of consensus for most of the 38 sections. While individual doctors occasionally disagreed with a particular point, the median response for each section ranged from "Agree" to "Strongly agree". There was even stronger consensus in response to the second round, with the vast majority of responses being in agreement to the statements, and an overall movement of the median of responses towards "Strongly agree".
These recommendations have undergone a further revision in response to comments submitted at the second round. The recommendations are given in the article on
page 7.

DISCUSSION

A summary of the key recommendations in the literature with respect to chronic pain management in palliative care was prepared. Palliative care specialists and GPs with a special

interest in the field were selected to represent a range of opinions and experience, and their degree of agreement or disagreement with the summary points was elicited in a modified Delphi process. By the completion of the second round, there was a high level of agreement in the recommendations for managing chronic pain. While the sample size was small, the panel represented GPs and palliative care specialists from different regions and with different experiences. The degree of consensus reached between them suggests that their opinions may be generalisable for New Zealand contexts.

While a stepwise approach to pain management with progression from non-opioids through weak opioids to strong opioids is still advocated, morphine remains the mainstay agent for pain relief in chronic pain. The risk of morphine addiction is minimal when used in patients with chronic pain.

Dose titration is usually achieved through the use of an immediate release formulation with controlled release products used for maintenance treatment, with immediate release morphine available for breakthrough pain. Inadequate pain control leads to a reduced pain threshold, hence the aim is to provide sufficient analgesia to prevent pain recurring.

The optimal route for morphine administration is oral. Where circumstances require parenteral administration, morphine is usually best give subcutaneously by continuous infusion.

Not all pain will respond to morphine, and regimens using adjuvant analgesics including non-steroidal anti-inflammatory, antidepressant and anticonvulsant drugs can be individually tailored to provide maximum pain control.

Use of the recommendations in palliative care should provide relief of chronic pain in the vast majority of patients.2

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