

I am pleased to appear before you as a practicing physician at the Veterans Affairs (VA) Medical Center in Iowa City to discuss my involvement in the Department's ongoing activities with regard to end of life, pain management initiatives. Pain is a significant health care problem in the United States and a substantial portion of the population is afflicted with pain each year. Recent surveys and studies have determined that 20% to 30% of the population annually suffers from acute pain and/or chronic pain syndromes. Further, the incidence and severity of pain increase with increasing age resulting in a disproportionately large amount of chronic pain occurring in individuals over 60 years of age, 20% of whom require continual pain medication.

Control of cancer pain remains a substantial unresolved problem in the U.S. Fifty percent of all deaths in the U.S. are caused by cancer with 75% of advanced cancer patients experiencing "moderate" to "very severe" pain. Although methods to relieve pain can be effective in over 95% of patients when utilized, pain in most cancer patients is inadequately controlled because of low priorities, limited education of providers, and inappropriate attitudes towards opiate therapy. Traumatic injuries and surgical procedures result in 75 million episodes of acute pain each year, the majority of which are inadequately treated. Reducing frequency and controlling the level of pain is a health care challenge for all medical specialties.

The knowledge and techniques to control most pain are known, but they often are not applied effectively. Proactive, aggressive management of both acute and chronic pain is universally recognized as an essential component of health care; however, substantial evidence indicates that neither acute nor chronic pain is managed adequately within most U.S. health care systems. This is due to a number of factors including:

- lack of knowledge regarding the availability of pain treatment by patients and their families,
- lack of knowledge regarding their rights as a patient,
- inappropriate fear of addiction on the part of patients, families and health care providers,
- lack of knowledge on the part of health care providers,
- failure to routinely assess pain and the effectiveness of therapy, and
- unavailability of state-of-the-art pain treatments on a consistent basis at all health care institutions.

Since the root of this problem exists largely as an issue of education, it is critical that patients be informed of their right to pain relief and their fears of living and dying with severe suffering due to pain be allayed. Healthcare providers must learn about the importance of pain assessment and treatment during their education, and ongoing educational programs regarding pain should be a part of the continuing education process.

The importance of this issue has been recognized by the Veterans Health Administration (VHA) and we are now on the forefront of developing systematic solutions to this problem. As early as 1996, a VHA Multidisciplinary Pain Committee was appointed to develop a national pain management strategy to ensure that appropriate acute and chronic pain care would be provided to veterans. Preliminary work included an assessment of the current status of pain management in VHA and a review of the available literature including surveys, studies, reports and literature reviews/book chapters. No generally applicable studies have been performed to determine types or incidence of pain in veterans. However, a conservative assumption can be made that veterans have at least the same amount of pain as the general U.S. population. A greater incidence of pain in veterans may be expected due to the higher prevalence of trauma and psychological problems, both known to increase the incidence of pain and confound therapies. Applying the pain incidence in the U.S. population to current VHA patients, it is projected that there are 0.8 million acute pain episodes annually and 0.75 million patients with chronic pain. For the entire veteran population, we estimate 6 million acute pain episodes and 5.6 million patients with

chronic pain. This represents the largest group of current and potential patients experiencing pain within any single health care organization.

As a result of the preliminary work of the National Pain Management Strategy Committee, a recommendation was made to appoint a permanent VHA Pain Advisory Committee to advance a pain management strategy. Former Under Secretary for Health, Dr. Kenneth W. Kizer, approved a comprehensive action plan, and the importance of treating pain within the VHA was thus recognized in a formal way. Since that time, a tremendous effort has been put forth to address the issue of pain in a systematic way throughout the VHA that in many respects is in advance of efforts being made at private institutions in response to changing JCAHO guidelines.

The first major initiative was to address Pain as the 5th Vital Sign™. This was formally announced and implemented in VHA in February 1999. It was the first step in recognizing that unless pain is assessed on a routine basis, it is not validated and is not treated in an adequate way. This initiative has mandated that pain be assessed at the same time that routine vital signs such as heart rate, blood pressure, pulse and temperature are taken and recorded in the patient record. The routine assessment of pain, along with ongoing development of guidelines regarding a response to the pain score recorded at the time of assessment, will help drive improved treatment.

A subcommittee of the National Pain Management Strategy Committee has been charged with developing evidence-based guidelines to standardize and improve treatment of acute pain, cancer pain and chronic pain. Concurrently, we have also begun to collaborate with the Institute for Healthcare Improvement (IHI) to improve the delivery of pain and end of life care throughout the VHA. This collaborative effort will enable VA facilities to strengthen their use of Pain as the 5th Vital Sign™, and utilize VHA resources to ensure that pain is assessed, treated, and monitored to achieve maximum patient comfort and enhance patient recovery.

The importance of education in making a change of this magnitude was immediately recognized by VHA. A toolkit has been developed as a means of helping the Veterans Integrated Service Networks (VISNs) implement Pain as a 5th Vital Sign™, establish procedures for pain assessment in all sites of care, provide education for healthcare providers on pain assessment, and provide for the education of patients and families. Further, in November 1999, a VA National Leadership Conference on Pain Management and End of Life Care was held. It served to highlight the importance of these issues, provided a forum for leaders from throughout the VHA to see the types of treatment programs and research currently in place throughout the system, and served to educate attendees about state-of-the-art pain management and end of life care. Finally, VHA recently funded 10 new pain residency positions to advance training in pain management and improve delivery of pain management services within our healthcare system.

I would like to make this more personal and share with you some of my own experiences at the VA Medical Center in Iowa City, Iowa. Since arriving in Iowa City in January 1998, to assume the position of Director of the Pain Medicine Division at the University of Iowa, I have had the opportunity to make a number of changes and to expand the available services. When I arrived, the pain clinic, which had been operating at the VA Medical Center in Iowa City, had been closed and some patients were being cared for at the University Pain Medicine Clinic. I have had strong support from the Chief of Staff and the Chief of Anesthesia at the VA Medical Center in Iowa City. As a result, I have been able to reopen the outpatient pain clinic and organize an inpatient acute pain service providing epidural analgesia for postoperative pain control with specialty call coverage 24 hours/day, 7 days per week. There remains a significant demand for pain services and I hope that future expansion of services will allow us to meet a greater proportion of that demand. I would like to share with you a recent example of the type of patient

encounter by our pain medicine team.

A 74 year old man recently presented to the pain medicine clinic with a chief complaint of severe left chest wall pain due to a tumor that was eroding through his ribs. At the time of his presentation he was taking only 10 mg of Oxycontin every 12 hours and had no medications available for breakthrough pain. He expressed concern about the use of narcotic pain medications and what they might do to him. His wife and daughter, who were with him, shared his concern. He made it clear that he had no misconceptions about what the future held for him, but that he did not want to suffer with pain for the remainder of his life. I explained to both the patient and his family the available options including oral pain medications, nerve blocks and delivery of pain medication within the spinal fluid. I also emphasized the fact that the narcotic pain medications were a tool that was appropriate to use in his current situation and that he should not fear addiction or a stain on his character for their use. After some relatively minor dose adjustments, he returned for a follow-up visit and reported that he had excellent pain control without any significant side effects. This could have been done earlier and he could have experienced less pain overall. However, it would have required better knowledge on the part of the referring physician and an understanding of the issue of pain and its treatment in cancer by the patient. This is only one story, but it is repeated over and over again.

In conclusion, I would like to thank you for the opportunity to highlight an area of medical care that I believe to be vital but often ignored. I would also like to emphasize the importance of your continued interest and support for:

- education for the public at large regarding issues of pain management,
- increasing education regarding pain during healthcare training and continuing medical education,
- research to improve treatments and document their outcome.

Improvements in these areas will have a significant impact on the delivery of healthcare and outcome throughout the United States.

Mr. Chairman, this concludes my opening remarks and I would be pleased to answer any questions you or the members of the Committee might have.