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Challenges and paradigms in the teaching of pain in Colombia

Abstract

This article is a reflection, from the perspectives of both teachers and students, on the difficulties faced by the field of medical education in pain in Colombia. In this sense, a conceptual review is carried out, from the deficiencies in curricular structuring and time intensity, going through issues such as the positivist medical paradigm and its deleterious effects to educate in the approach to pain from a biopsychosocial perspective, to finally make an approach proposal to the current problem.

Keywords: Chronic pain, medical education, educational paradigms, positivist model, biopsychosocial model.

What do we know about this problem?

- The lack of or insufficient education in medical school in the subject of pain medicine, has been associated with poor pain management.
- Medical education for many years has been based on the traditional positivist model, centered on the disease.
- The biopsychosocial paradigm is centered on the patient, and this approach, is part of the answer to the problems noticed in pain education.
- IASP proposed to developed countries a global project for excellence in pain education. Currently, health education institutions in Colombia have not officially adopted this curriculum.

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Introduction

Pain as a public health problem

Pain is the most frequent cause of consultation in all emergency departments around the world, reaching 70% of patients, of which two thirds experience moderate to severe intensity pain, which is why it is considered the fifth vital sign.[1] In spite of the frequent reason for consultation, the treatment that produces pain relief is far from optimal since high rates of oligoanalgesia are reported in literature. We know that only between 42% and 60% of patients with pain receives pharmacological treatment, of which only 15% has pain relief. Furthermore, treatment takes up to 90 minutes to initiate.[2] To further cloud the picture, it is estimated that about 50% of patients is discharged from the emergency department even with moderate or severe pain, and without any type of analgesic.[3]

This results in patients suffering, significant alteration of their quality of life and increased incidence of chronic pain, since poor treatment of acute pain is the main risk factor for chronic pain, which ultimately translates into medical and occupational disability and high costs to the health system. The appearance of this one is the door of entrance to the indiscriminate use of medicines, perhaps not appropriate, that at the present time has taken North America to the epidemic of opioids, this currently being the first cause of death in minors of 50 years, and causing a marked diminution in the life expectancy.[4] Adequate pain relief in the emergency department is a requirement to meet the high-quality standards of the Joint Commission's Pain Standards,[5] but in Colombia there are no nationally coordinated measurement strategies, and our patients are possibly being discharged from the emergency department suffering moderate to severe pain.

Barriers to proper pain management

Factors associated with poor pain management have been attributed to multiple causes worldwide, the first of which being the lack of or insufficient education in medical school, inadequate use of measurement scales, misuse of pharmacological strategies, stigmatization of opioids, saturation of emergency departments, failure to reevaluate the patient, and ethnic, racial and social biases.[6]

Patients with painful crises commonly become frequent consultants, resulting in onerous expenses for the system. Additionally, they repeatedly report experiences of helplessness when they do not feel active subjects in therapeutic decisions, and when they perceive that their painful crisis is not perceived as a real urgency.[2,7] Another situation reported is the lack of a follow-up plan at discharge that is, the patient's painful crisis is calmed, but no management options are offered to face future crises or follow-up visits.[7]

Semi-structured patient interviews reveal that patients perceive barriers in dealing with service providers, such as: lack of interest and empathy, little knowledge in general practitioners about pain management, and communication failures.[2] In addition, patients suffer from long waiting times for appointments, short attention spans during medical consultation, and lack of a multidisciplinary approach.[8] The subjective and invisible nature of pain causes anxiety in patients, who feel that their symptom is underestimated, and treating physicians experience distrust about the true intensity of the symptom and the search for secondary gain. In addition, the possibility of facing cases of addiction or abuse of opioids breaks the relationship of trust between the doctor and the patient and makes the doctor afraid to provide this type of medication.[9] Physicians working in emergency departments report that facing patients with pain as a primary

symptom is seen as a challenge that often ends in frustration.[10] The physician perceives that the pain complaint cannot be resolved in an emergency service and considers that the patient should not use this service as a resource in the face of the painful crisis, generating a vicious circle of recurrent consultation that generates dissatisfaction for both patients and service providers. They also report a deep sense of failure when they perceive that they cannot solve the basic problem. In addition, they are aware that this type of patient requires emotional support, more than medication, which is difficult by the lack of time, due to the busy nature of the service and the lack of preparation of the medical personnel to provide this type of support.[11] Physicians are aware of the psychological and emotional factors involved in pain, but their intervention is limited to the pharmacological aspect.[12] Such findings were confirmed by a study carried out in an IV level hospital in Bogota, which found a tendency in physicians to underestimate the subjective and psychological aspects of pain, for the eagerness to obtain immediate results. A hierarchical positioning was also evidenced, a posture where medical personnel believe they have the truth about the patient's illness and pain and the patient's narrative is dismissed.[13]

Paradigm clash in pain education

At the bottom of the problematization of pain for the physician, it underlies an epistemological conflict around the meaning of pain, the disjunction between the traditional positivist paradigm and the critical social model. For the traditional positivist model, centered on the disease, pain is a minor symptom compared to the diagnosis and management of the basic pathology, and it is assumed that its intensity should be in correlation with the severity of the diagnosis. This paradigm emphasizes the objectification of the painful experience, isolating the patient's narrative and generating tools to recognize "true" pain, suggesting in the background that this experience must be validated by the medical authority in order to become an illness worthy of attention and care.[14,15] The positivist model promotes the discarding of critical diagnoses that could affect the survival of the patient, so that for the physician it is sufficient to discard serious illnesses as the cause of pain to assure the patient that "it is nothing serious to worry about". However, this approach rarely leaves the patient satisfied.[16]

In contrast to this perspective, the biopsychosocial model emerges, centered on the patient, which highly values the participation of the patient in his or her treatment, empowering him or her, understanding the therapeutic relationship as a negotiation between the patient and the physician to find together tools to confront the illness.[15] This approach, beyond the theoretical consideration, is perhaps the answer to a need felt by the patients, already reported in multiple studies, where the patients with a painful pathology report not feeling satisfied, since the doctors do not pay attention to the social and existential sphere of their life affected by the pain, even knowing that the emphasis made on such aspects is positively correlated with the functionality of the patient and his or her general satisfaction with the care.[17]

For the patient, to go to a physician who "does not believe in his pain," is a frightening, and unfortunately common, experience.[18] Therefore, it is vitally important in the therapeutic relationship that the patient's pain is taken seriously by the physician, and that despite its subjective nature it is not invalidated.

Current educational challenges

Although in the last three decades there has been an extraordinary expansion of knowledge in basic sciences, pain mechanisms and treatment, the study of pain remains a low priority in the world's medical curricula.[19] This low priority leads to pain being considered a secondary topic in the curriculum, without vital importance, similar to what happens with sleep medicine, sexual and reproductive health, among others.[20] When we are faced with a curriculum overfilled with contents, pain management is left aside, and its teaching is assumed to occur in a collateral manner to the rest of the primary clinical subjects. In this way, the responsibility for teaching pain is diluted among multiple specialties, without any of them taking the lead, finally resulting in professionals who are poorly prepared to deal with the subject.[21]

A recent systematic review showed that 383 medical schools in the developed world do not have exclusive pain modules in their curricula. 96% of the schools in the United Kingdom and the United States vs. 80% of European schools have these courses, but they are not mandatory, and they are part of other courses such as Anesthesiology and Pharmacology, with an average number of 12 to 20 hours in the entire career.[22] In 2018, the IASP proposed to developed countries a global project for excellence in pain education, and ensures that safe, efficient and compassionate pain treatment does not exist without education for all health professionals in undergraduate programs. This association is aware of the unknown state of pain education in low resource countries, and provides an open access curriculum, based on studies in higher resource countries, as a proposal to world education, in a way that avoids the informal curriculum that perpetuates a culture of inadequate practice.[23] Currently, health education institutions in Colombia have not officially adopted this curriculum. Initiatives to improve this approach have existed in the local environment for more than 25 years, led by the area of Anesthesiology, but it is admitted that there is still a long way to go.[24,25]

It is also worth asking whether the answer to the current problem lies in providing more hours of education on pain or rather in promoting a change in the paradigm of teaching pain in medical schools. Students adopt the traditional positivist paradigm in undergraduate programs; therefore, early intervention may be essential to avoid building a reductionist view of pain management.

Current evidence suggests that physicians' view of patients with pain becomes progressively negative as training progresses, with a progressive decline in empathy.[14] Given these findings, it is necessary to ask what the cause of this apparent loss of empathy with medical training is and what educational interventions can be done to avoid such desensitization and promote respectful pain management from a patient-centered perspective. In this sense, a concerted effort is required among the country's medical schools and representative academic associations in the area, to propose research that goes deeper into this problem, and interventions that strengthen pain curricula, while reflecting on the most effective pedagogical strategies to strengthen the teaching of the biopsychosocial model, and thus improve the quality of pain teaching in Colombia.

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None.

Conflicts of Interest

None.

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