



## Barriers to managing chronic pain: perspectives of Appalachian providers

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### KEYWORDS:

Appalachia;  
Barriers;  
Chronic pain;  
Pain management;  
Questionnaire

**OBJECTIVE:** Chronic pain is an important cause of morbidity among adults worldwide. Its management presents a greater challenge in the unique demographic of Appalachia. “Physician reluctance to prescribe opioids” has been identified as a major barrier to effective management of chronic pain nationally. The aim of this study was to determine whether prescribers in Appalachian Ohio encountered similar barriers as prescribers elsewhere.

**METHODS:** A 29-item questionnaire was distributed to all 1719 physicians practicing in 29 counties in Ohio designated as “Appalachia.” The questionnaire evaluated demographics, assessed aspects of pain management, and asked participants to rank a list of 11 perceived barriers to effective chronic pain management.

**RESULTS:** The overall survey return rate was 25.9%. The average respondent was male, 51 years old, with 20 years of experience practicing medicine, spending 86% of the working week with patients. Most participants (72.5%) reported being involved with chronic pain management “several times each week” or more. Of the potential barriers, those identified as important were (1) patient reluctance to make lifestyle or behavioral changes, (2) inadequate access to pain specialists, (3) inadequate access to health care because of financial burden, (4) lack of an objective measurement of pain, and (5) physician reluctance to prescribe opioids.

**CONCLUSION:** Prescribers in Appalachian Ohio identified issues of patient behaviors and health care accessibility as important barriers, in addition to top barriers previously described in the literature. Further research must be done to determine whether these results are unique to Appalachian populations.

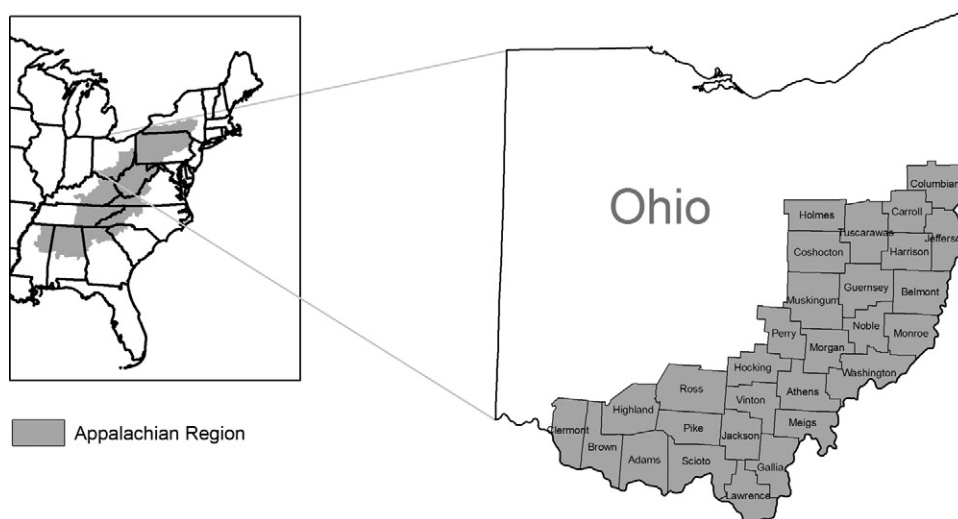
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With today’s remarkable medical advancements, why does chronic pain remain a significant issue for patients and health care providers? Chronic pain has been described as “pain without biological value that has persisted beyond the normal tissue healing time,”<sup>1</sup> usually recognized as lasting greater than three months. It causes substantial morbidity nationally, affecting the quality of life of at least 50 million

Americans who have disabling chronic pain<sup>2</sup> as well as those who live with and care for them. Chronic pain costs Americans more than \$100 billion annually for medical expenses, lost income, and lost productivity.<sup>3</sup> A diagnosis of chronic pain may stem from a wide variety of corresponding medical conditions including low back pain, osteoarthritis, headaches, peripheral neuropathy, sickle cell disease, neuralgias, myofascial pain, fibromyalgia, complex regional pain syndrome, and others.<sup>4</sup> Regardless of the underlying diagnosis (and in cases where a cause cannot be determined), many patients with chronic pain experience depression, hopelessness, social isolation, alterations in mobility, and altered sleep patterns.<sup>5</sup>

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**Figure 1** Appalachian region of the Eastern United States and counties of Appalachian Ohio. The Appalachian region consists of counties designated by the Appalachian Regional Commission, based on 2004 data.

Although the prevalence of chronic pain in Ohio mirrors estimates of the national average, Appalachian Ohio is a unique geographical area and home to a distinctive patient population (Fig. 1).<sup>6,7</sup> Twenty-nine of Ohio's 88 counties are included in the Appalachian region; this area includes 12% of Ohio's total population (almost 1.5 million people in Appalachian Ohio in 2006).<sup>8</sup> In 2007, the per capita income for Appalachian adults was \$29,274 (20% lower than the national average), and the 2009 unemployment rate reached 12.1%, superseding the national average by almost 3%.<sup>9</sup> This contributes to the fact that 14% of Appalachian Ohio adults are uninsured.<sup>10</sup> With the economic recession of the past two years, financial hardship has affected patients nationally, resulting in even higher unemployment rates and greater disparity in areas that were already economically depressed, such as Appalachia. Research has identified that adults living in Appalachian Ohio are more likely to be living with a chronic disease, to have limited access to health care, and to be in poorer health overall than those living in other parts of the state.<sup>11</sup> As a result, health care providers are required to manage sicker patients with limited resources.

Researchers worldwide have identified reasons chronic pain remains under-treated. Several studies have classified specific barriers related to physicians, patients, and existing health care infrastructure.<sup>3,12,13</sup> One major barrier to effective pain management identified by physicians in current literature is "physician reluctance to prescribe opioid medication."<sup>3,12,13</sup> Researchers postulate that this stems from prescribers' lack of training in assessment and treatment of chronic pain, fears about potential legal sanctions that may result from prescribing controlled substances, and negative attitudes regarding patients with chronic pain.<sup>12</sup> Ponte et al evaluated the attitudes of West Virginian family physicians regarding pain; the entire state of West Virginia is included in the designation of "Appalachia."<sup>14</sup> They discovered that a majority of primary care physicians surveyed had reser-

vations in prescribing opioid medications for noncancer pain, and reported that regulatory scrutiny influenced their prescribing behaviors.<sup>15</sup> Their study also supported previous data that identified a lack of knowledge in prescribing appropriate opioid medications and managing the side effects of opioids.<sup>12,15</sup>

Patient-related barriers reported in the literature include issues of communication, fears of opioid addiction and side effects, as well as patients' reluctance to report pain.<sup>16</sup> Health care infrastructure barriers such as long travel times to see a physician, inadequate transportation, and lack of social and psychological support resources add further complications.<sup>3</sup>

The investigators previously reported a pilot study examining barriers to effective chronic pain management in rural Appalachian Ohio.<sup>17</sup> The pilot study was a 30-item questionnaire distributed to physicians and nurse practitioners attending a continuing medical education conference on pain management. Results consisted of responses from 22 providers in Appalachian Ohio regarding chronic pain management, including identifying perceived barriers to chronic pain management. The top barriers identified in the pilot study were: "inadequate access to pain specialists," "physician reluctance to prescribe opioids," "inadequate access to health care due to financial burden," and "lack of an objective measurement of pain" as the most important barriers identified by the participants. Although limited by the small sample size, the pilot study suggested that barriers involving health care accessibility were important obstacles for this patient population.<sup>17</sup> Based on the results from the pilot study, the objective of the research presented here was to expand the sample to help identify specific barriers Appalachian prescribers encounter in managing chronic pain patients. By understanding these barriers, we can begin to identify ways to better prepare health care professionals to care for their patients with chronic pain.

## Methods

### Sample

The sample for this study consisted of a convenience sample of 1719 physicians from Ohio's Appalachian counties obtained from the Ohio State Medical Board in May 2007. All allopathic and osteopathic physicians who were in active practice at the time of the study and had a license to prescribe medication were included. A survey was mailed to listed addresses and, if returned, data were compiled and the participant removed from the mailing list. Three weeks after the initial questionnaire and cover letter were mailed, a second questionnaire was mailed to participants who had not responded.<sup>18</sup>

### Survey instrument

**Demographics.** The initial questionnaire consisted of 29 questions previously used and validated in the literature by researchers in other demographics (Appendix).<sup>3,12,13</sup> The questions were then piloted by the investigators among a small sample of Appalachian Ohio providers before querying the larger sample.<sup>17</sup> The participants voluntarily and anonymously answered questions regarding their demographics, prescribing behaviors, use of a pain contract, comfort levels in discussing chronic pain with their patients and other health care providers, familiarity with federal and state regulations, and how participants view their medical education in chronic pain management. All aspects of the study protocol were approved by the Institutional Review Board at Ohio University.

**Barriers to pain management.** Physicians' perceptions of the barriers to chronic pain management were measured using 11 items rated on a 5-point scale, with higher numbers indicating the item was perceived to be a "more significant" barrier. Figure 2 lists the potential barriers respondents ranked in this study. The scale used for the items ranged from "Not at all Significant" to "Extremely Significant." When the term *significant* is being used as it applies in relation to the survey scale, it will appear in quotation marks to differentiate from its use in the statistical context (i.e., statistically significant).

## Results

### Response

Forty-eight surveys (2.8%) were returned undeliverable and 77 surveys (4.5%) were returned blank for a variety of self-reported reasons (i.e., retired, not currently managing chronic pain patients, etc.). The final sample consisted of

- Federal/state regulations for prescribers
- Financial burden on patients
- Inadequate access to pain specialists
- Inadequate access to primary care
- Inadequate pain assessment
- Lack of objective measurement of pain
- Lack of transportation for patients
- Patient fear of addiction
- Patient reluctance due to adverse effects
- Patient reluctance to make lifestyle or behavioral changes
- Physician reluctance to prescribe opioids

**Figure 2** Potential barriers to effective chronic pain management.

413 usable questionnaires with an overall return rate of 25.9%.

### Demographics

Physicians practicing in 27 of Ohio's 29 (93.1%) Appalachian counties were represented in the sample. About three-quarters (74.0%) of the respondents were male and the majority of respondents (68.9%) were allopathic physicians. The average respondent was 51 years old (SD = 11.4), had 20 years of experience practicing medicine (SD = 11.9), and spent 86% of the working week with patients (SD = 23.3). More than one-third of participants ( $n = 169$ , 41.7%) reported being involved with chronic pain "daily" or "more than once each day."

### Ranking of potential barriers

Descriptive statistics were calculated to characterize responses for survey items that asked physicians to rate how "significant" they perceived 11 barriers to chronic pain management. In an effort to rank the items in order from "most significant" to "least significant," the following data reduction technique was used: the scale responses *not at all significant* and *minimally significant* were collapsed to form the category "Perceived as a Less Significant Barrier" and the scale responses *moderately significant* and *extremely significant* were collapsed to form the category "Perceived as a More Significant Barrier." The *no opinion/not applicable* responses remained unchanged to preserve the spirit and intent of the original survey. Survey items were placed in descending order based on the frequency of the physicians' responses collapsed into the category "Perceived as a More

**Table 1** Identified barriers to chronic pain management in descending order

Barrier	Perception as a More "Significant" barrier % (n)	Mean (SD)
Patient reluctance to make lifestyle or behavioral changes	87.9% (406)	4.35 (0.95)
Inadequate access to pain specialists	78.1% (406)	4.05 (1.21)
Financial burden (patient)	73.1% (409)	3.81 (1.24)
Lack of objective measurement of pain	72.3% (404)	3.77 (1.26)
Physician reluctance to prescribe opioids	71.0% (407)	3.69 (1.24)
Inadequate pain assessment	59.3% (408)	3.34 (1.30)
Lack of transportation (patient)	57.2% (409)	3.31 (1.30)
Federal/state regulations	52.9% (408)	3.23 (1.43)
Inadequate access to primary care	50.1% (405)	3.09 (1.41)
Patient fear of addiction	40.4% (408)	2.87 (1.21)
Patient reluctance due to adverse effects	35.5% (408)	2.72 (1.19)

Significant Barrier." To confirm the rank order of the items, means and standard deviations were calculated. The ranks derived from the frequency distributions and those derived using item means were identical (Table 1). It was hoped that two subscales could be extracted from these items: physician barriers and patient barriers. However, inter-item correlation matrices revealed that the correlations between the items for each potential subscale were weak and would not result in sound psychometric scales. It appears that the barriers to chronic pain management are very complex and should be treated individually rather than collectively.

The most important barrier identified was "patient reluctance to make lifestyle or behavioral changes," followed by "inadequate access to pain specialists," "inadequate access to health care due to financial burden," "lack of an objective measurement of pain," and "physician reluctance to prescribe opioids."

## Discussion

This study examined the perspectives physicians have regarding barriers to the effective management of chronic pain in Appalachian Ohio. It is clear that management of chronic pain provides challenges to health care providers as well as their patients. It was identified that prescribers in this demographic view elements of patient reluctance and health care inaccessibility, as well as physician barriers including reluctance to prescribe opioids, as important obstacles to

effective management of chronic pain. Each of these top barriers will be explored here.

Compared with the previous pilot study, the investigators identified the same top barriers among prescribers, with one exception: the larger sample identified "patient reluctance to make lifestyle or behavioral changes" as the most important barrier. This was not ranked highly in the pilot study. Reasons for this may include that the pilot study was done in one town at a conference specifically regarding chronic pain issues; participants in the pilot were essentially self-selected and represented only one narrow geographical location. The results of this larger survey indicate that physicians queried see patient-related barriers as being a very important component in solving the puzzle of chronic pain.

The existing literature suggests that the characteristics of chronic pain fall into physical, behavioral, and psychological dimensions.<sup>5</sup> Because pain is a wholly subjective experience, how an individual experiences pain and responds to it is complex and unique to the individual. Yet, theories suggest that pain is also a result of operant conditioning or learned behavior. Living with chronic pain adversely alters patients' day-to-day patterns, which results in negative physical, psychological, and social effects. These include disruptions in eating and sleeping and alterations in mobility. The psychological effects of these changes include depression, anger, anxiety, grief, hopelessness, and feelings of helplessness.<sup>5</sup> In short, chronic pain initiates learned behaviors that are often complicated by comorbid depression, requiring a holistic treatment approach that involves more than simply treating pain.

In some areas of Appalachia, poor health decisions have been identified as having a significant impact on communities.<sup>19</sup> In addition, many patients in Appalachian regions have difficulty accessing necessary medical care as a result of financial or transportation barriers. One can imagine that this arrangement can easily lead to missed appointments and lack of follow-through with physician recommendations. If responses to pain are also learned, we can understand how patients from specific demographics might share similar learned patterns of response to pain from family or other community members. As our current system functions, in Appalachia and elsewhere, there are many financial disincentives toward making health improvements for patients, including disability payments and supplementation of food and housing costs. Presently, there is little motivation for patients to return to work, and there is only a paucity of jobs available. Why should people want to improve their health when it costs more money to do so? This remains a challenge for providers and their patients nationally, and is closely intertwined within larger health care systems and state and federal programs.

The usefulness of self-management techniques in treating chronic pain has been identified.<sup>20</sup> These self-management tools focus on patient skill development and empower patients to actively manage their symptoms by developing effective strategies and communicating with their health care providers regarding their effectiveness.<sup>20</sup> Recent re-

search describes both inhibiting and facilitating factors to chronic pain self-management. Barriers included lack of social support, limited resources, and time constraints, depression, ineffective pain-relief strategies, as well as lack of individualized strategies for pain management and difficult patient-physician interactions. Facilitating factors included encouragement from the health care team, treatment of depression, improving social support and providing multiple strategies tailored to the patient's needs.<sup>20</sup> Although it cannot be determined by this research, incorporating self-management practices by eliminating identified barriers and making facilitating factors available may make it easier for patients to make lifestyle and behavior changes a part of their chronic pain management.

Participants in this study also identified issues of health care accessibility—"inadequate access to pain specialists" and "inadequate access to health care due to financial burden"—as important barriers to optimal pain management. For a patient in Appalachian Ohio, a visit to a pain specialist is more of a financial and logistical burden than a visit to a primary care provider, especially when these visits are complicated by pain. Of all 29 counties located in Appalachian Ohio, only 8 physicians identify themselves as "pain specialists": these physicians serve a population of more than 1.4 million people.<sup>7</sup> These statistics certainly indicate that chronic pain must be managed in primary care out of necessity.

The fourth ranked barrier identified in our study was "lack of an objective measurement of pain." This is a ubiquitous problem for health care providers, because pain is a subjective experience, with no concrete measurement tools. For this reason, a holistic—and often creative—approach to assessment and treatment of chronic pain patients is necessary. Medical professionals have an obligation to individualize patient treatment options, which is of utmost importance in dealing with chronic pain. By approaching each patient as a complete individual with inherent mechanisms for healing, providers can optimize treatment and improve the quality of life for most patients living with chronic pain.

"Physician reluctance to prescribe opioids" remains an important barrier to treating chronic pain, noted by 71% of prescribers in this study, echoing results of similar previous studies.<sup>3,12,13</sup> Although it cannot be determined from this study, perhaps with recent changes in medical education and the availability of continuing medical education in this area, physicians are becoming more confident in using opioid medications appropriately.

The major limitations of this study revolve around the fact that physicians were self-reporting, allowing us to evaluate their opinions and perceptions, but not being able to objectively measure their experience with and knowledge of chronic pain. Also, further research needs to be done to identify whether these barriers are unique to physicians practicing in Appalachia or to those practicing in Ohio, in both, or in neither. The return rate was lower than expected, with several likely contributing factors. Physician information was obtained using a database from the Ohio State

Medical Board. Addresses provided are self-reported and updated by physicians; some provided home addresses and others provided office addresses, which may have limited response rate based on how mail is reviewed at each. An electronic version of the survey was not used, but may have provided a greater response rate.

## Conclusion

Chronic pain management is a problem for patients and health care providers in Appalachian Ohio. Major barriers to effective pain management including patient behaviors, limited access to pain specialists, financial burden of accessing health care, lack of an objective measurement of pain, and physician reluctance to prescribe opioids were identified in this study. Future research addressing the complexity of chronic pain, especially for unique populations such as Appalachia, is necessary. Applying results from this study in Appalachian Ohio to other Appalachian counties in other states may shed light on barriers unique to all of Appalachia, or identify trends among rural populations. Many osteopathic physicians are actively working in the Appalachian region, both as clinicians and educators, and play an important role in solving the puzzle of chronic pain. The problem here is complex, and a solution must be multifaceted. A holistic approach is needed not only from prescribers and their patients, but from legislators, medical educators, and state agencies to best serve patients in pain.

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## References

1. International Association for the Study of Pain, Subcommittee on Taxonomy: Classification of chronic pain. Descriptions of chronic pain syndromes and definitions of pain terms. *Pain Suppl* 3:S1-S226, 1986
2. National Institutes of Health: National Institutes of Health guidelines: An Update of NIH Pain Research and Related Program Initiatives, December 8, 2005. Available at: <http://www.hhs.gov/asl/testify/t051208a.html>. Accessed August 17, 2010
3. Glajchen M: Chronic pain: treatment barriers and strategies for clinical practice. *J Am Board Fam Pract* 14:211-218, 2001
4. American Pain Society: Pain: current understanding of assessment, management and treatments. Available at: <http://www.scribd.com/doc/7563609/Pain-Current-Understanding-of-Assessment-Management-and-Treatments>. Accessed August 17, 2010

5. Breen J: Transitions in the concept of chronic pain. *ANS Adv Nurs Sci* 24:48-59, 2002
6. Verhaak PF, Kerssens JJ, Dekker J, et al: Prevalence of chronic benign pain disorder among adults: a review of the literature. *Pain* 77:231-239, 1998
7. Ohio Department of Health: *Report of the Ohio Compassionate Care Task Force*. Columbus, OH: Author, March 2004
8. Ohio Department of Development: Ohio County Profiles: Appalachia. 2006. Available at: <http://www.odod.state.oh.us/research/files/s0/appalachia.pdf>. Accessed January 10, 2010
9. Appalachian Regional Commission: Employment Report 2009q3. 2009. <http://www.arc.gov/images/appregion/AppalachianCountyEmploymentReport2009Q3.pdf>. Accessed February 10, 2010
10. Ohio Department of Health, Primary Care Office: *Ohio Primary Care—Health Professional Shortage Areas*. Columbus, OH: Ohio Department of Health, 2005
11. Mascarenhas A, Pathak D, Salsberry P: *Association Between Poor Health Care Access and Population Characteristics: The Center for Health Outcomes, Policy, and Evaluation Studies at The Ohio State University*, 2001
12. Weinstein SM, Laux LF, Thornby JI, et al: Physicians' attitudes toward pain and the use of opioid analgesics: results of a survey from the Texas Cancer Pain Initiative. *South Med J* 93:479-487, 2000
13. Furstenberg CT, Ahles TA, Whedon MB, et al: Knowledge and attitudes of health-care providers toward cancer pain management: a comparison of physicians, nurses, and pharmacists in the state of New Hampshire. *J Pain Symptom Manage* 15:335-349, 1998
14. Appalachian Regional Commission: Home page. Available at: <http://www.arc.gov/>. Accessed July 29, 2010
15. Ponte CD, Johnson-Tribino J: Attitudes and knowledge about pain: an assessment of West Virginia family physicians. *Fam Med* 37:477-480, 2005
16. Ward SE, Goldberg N, Miller-McCauley V, et al: Patient-related barriers to management of cancer pain. *Pain* 52:319-324, 1993
17. Remster EN, Marx TL: Barriers to managing chronic pain: a pilot of prescriber perceptions in rural Appalachia. *J Pain Symptom Manage* 36:e1-2, 2008
18. Dillman DA: *Mail and Internet Surveys: The Tailored Design Method*, 2nd ed. New York: John Wiley & Sons, 2000
19. Wewers ME, Katz M, Fickle D, et al: Risky behaviors among Ohio Appalachian adults. *Prev Chronic Dis* 3:A127, 2006
20. Bair MJ, Matthias MS, Nyland KA, et al: Barriers and facilitators to chronic pain self-management: a qualitative study of primary care patients with comorbid musculoskeletal pain and depression. *Pain Med* 10:1280-1290, 2009

**Appendix:**

**Managing Chronic Pain: Perceptions of Prescribers**

Instructions: Please mark answers like this: ●  1  9  1  1 Not like this: ☒ ☑  1  9  1  1

1. What is your age?   Years
2. What is your gender?  Male  Female
3. Which degree(s) do you hold?  D.O.  M.D.  J.D.  PhD
4. What is your specialty? \_\_\_\_\_
5. County of the location of your practice office: \_\_\_\_\_
6. How many years have you practiced medicine?   Years
7. What percentage of your working week is spent with patients?    %
8. How frequently are you involved in the management of chronic pain?  
 Almost never  Less than once per week  Several times each week  Daily  More than once each day
9. How often do you write prescriptions for non-narcotic (non-opioid) medications in the management of chronic pain?  
 Almost never  Less than once per week  Several times each week  Daily  More than once each day
10. How often do you write prescriptions for narcotic (opioid) medications in the management of chronic pain?  
 Almost never  Less than once per week  Several times each week  Daily  More than once each day
11. How often do you recommend or use the following non-pharmacologic treatments for patients with chronic pain? (Fill in the bubble that applies for each).

	Never	Sometimes	Frequently	Always
A. Acupuncture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Behavioral Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Psychophysiologic Techniques (e.g., biofeedback and relaxation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Osteopathic Manipulative Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Meditation/Spiritual/Religious Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Physical Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Therapeutic Modalities (e.g., ice, heat, massage)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12.	Extremely Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Extremely Comfortable
A. What level of comfort do you have in discussing chronic pain with your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. What level of comfort do you have in discussing chronic pain with a patient's family or caregivers (with the patient's permission)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. What level of comfort do you have in discussing a patient's chronic pain with other healthcare professionals also involved in their care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. How comfortable are you in your ability to manage each of the following aspects of pain?

	Extremely Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Extremely Comfortable
A. Assessment of the <u>cause</u> of pain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Assessment of the <u>severity</u> of pain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Use of non-opioid analgesics for pain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Selecting an opioid medication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Selecting a starting dose of opioid analgesics.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Titrating the opioid dose in patients with poor pain control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Use of "rescue" doses.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Dose calculation when switching between oral and parenteral routes of opioid administration.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Management of side effects from opioid medications.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
J. Management of opioid withdrawal symptoms.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
K. Use of combination of opioids and non-steroidal analgesic medications.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
L. Identifying behaviors associated with medication misuse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
M. Identifying co-morbid psychological issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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14. Do you currently use a "pain contract" or other tool to set ground rules when prescribing narcotic medications for your patients with chronic pain?

- No  Yes

If Yes, please mark all situations that apply.

- Always when prescribing a narcotic medication
- When the patient will be on the medication longer than 30 days
- If patient shows signs or symptoms of addiction potential
- For other reasons: \_\_\_\_\_

15. To what degree has a recent personal experience with pain influenced your decisions about pain management?

- No influence  Small influence  Moderate influence  Great influence

16. To what degree has a recent experience with a family member in pain influenced your decisions about pain management?

- No influence  Small influence  Moderate influence  Great influence

17. How familiar are you with the prescribing guidelines and regulations concerning controlled substances (e.g., opioid analgesics) in your state?

- Not familiar  Somewhat familiar  Fairly familiar  Very familiar

18. How often are your prescribing behaviors influenced by fears of potential legal sanctions?

- Never  Sometimes  Frequently  Always

19. How often are your prescribing behaviors influenced by your uncertainty about which medications might be appropriate for your patient?

- Never  Sometimes  Frequently  Always

Please continue on next page



20. How significant are each of the following potential barriers to chronic pain management?

	Not at All Significant	Minimally Significant	Moderately Significant	Extremely Significant	No Opinion/ NotApplicable
A. Federal/state regulations of opioid prescriptions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Inadequate access to health care due to financialburden	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Inadequate access to health care due to transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Inadequate access to pain specialists	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Inadequate access to primary care physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Inadequate pain assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Lack of objective measurement of pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Patient reluctance to make lifestyle or behavioralchanges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Patient reluctance to take prescribed opioidsduetoadverseeffects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
J. Patient reluctance to take prescribed opioidsduetofears ofaddiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
K. Physician reluctance to prescribe opioids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. Do you feel that most patients with chronic pain can be adequately assessed and managed in the primary caresetting?

Yes  No

Comments: \_\_\_\_\_

22. Do you feel that chronic pain is a greater problem in the area in which you practice than elsewhere?

Yes  No

Comments: \_\_\_\_\_

23. Do you feel that abuse of narcotic/opioid medications is a greater problem in your area than elsewhere?

Yes  No

Comments: \_\_\_\_\_

24. Please rate your medical school training for:

	Inadequate	Somewhat Comprehensive	Fairly Comprehensive	Very Comprehensive
A. Assessing chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Managing chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Pharmacology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. Please rate your post graduate (residency, fellowship) training for:

	Inadequate	Somewhat Comprehensive	Fairly Comprehensive	Very Comprehensive
A. Assessing chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Managing chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Pharmacology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. Do you participate in continuing education regarding management of chronic pain?

No  Yes

If Yes, mark all methods that apply.

- Through formal CME courses
- Through other courses, not for CME credit
- Through work-related literature
- Through social exchange
- Through online resources
- Other: \_\_\_\_\_



Thank you for completing this survey. We would appreciate any feedback you have about this survey or additionalcommentsyoumayhaveaboutthemanagementofchronicpain.Pleasewriteadditionalcomments here:

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