HAUTE AUTORITÉ DE SANTÉ

CLINICAL PRACTICE GUIDELINE

# Chronic pain: identification, assessment and referral of patient with chronic pain syndrome

Formal consensus

**GUIDELINE**

**December 2008**

The scientific report to this guidelinecan be downloaded from
www.has-sante.fr

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**Guidelines**

# 1 Introduction

## 1.1 Subject and aims of guidelines

### ► Subject of guidelines

This guideline was written by Haute Autorité de Santé (HAS, French National Authority for Health) following a request from the French Society for the Study of Pain Therapy (SFETD).
It is focused on the patient care pathway before and after treatment in pain clinics[1] for assessment and treatment of chronic pain. The guideline addresses the following points:

- definition of chronic pain, which is a multi-faceted syndrome;
- identification of chronic pain by healthcare professionals of all types;
- initial assessment within or outside a pain clinic;
- factors that make a patient suitable for referral to or follow-up by a pain clinic.

### ► Context of request

The French Ministry of Health issued its first set of regulations on chronic pain in 1991.
In 1998, the first “national pain programme” (“Plan Douleur” in French) was put in place countrywide, involving multidisciplinary teams to assess and manage intractable chronic pain[2], set up within healthcare organisations. The distinction was made between 3 types of pain clinics: multidisciplinary pain management consultation facilities, units and centres (see appendix 1).
The second “national pain programme” (2002-2005) saw several areas of progress, in particular the creation of 96 chronic pain clinics, which are still not well-known among the general public and doctors practising individually. Waiting times for initial consultation remained around 3-4 months, which is still the case today. New procedures were recommended for use in healthcare organisations and elsewhere (experimental network for assessment and treatment of chronic pain). In the same year, law 2002-303 dated 4 March 2002 concerning patient rights and healthcare quality was passed, which recognised that every person has a fundamental right to pain relief.
The third “national pain programme” is currently underway (2006-2010); it is based on four main principles, one of which is the restructuring of the care pathway, for which 5 priority measures are proposed:

- bringing up to date the principles underlying the management of chronic pain, as proposed in 1998;
- improving access to chronic pain management facilities;
- sharing experiences of the structures and policies that have been implemented, particularly in the regions;
- improving healthcare networks' policies in this field;
- defining and integrating objectives and indicators of improvement in pain management.

In 2007, in the "National Health programme to improve quality of life of patients with chronic diseases" it was shown that pain management is the primary expectation of patients with chronic diseases.

[1] In this document, "pain clinics" will be understood to refer to multidisciplinary facilities specialised in the assessment and treatment of chronic pain as defined in the circular dated 4 February 1998 concerning identification of facilities treating intractable chronic pain. Bull off [French Official Bulletin] 1998:98/9 (Directorate General for Health).
[2] The expression "intractable (=”rebelle" in French) chronic pain" is used in this guideline in the same way it is used in regulatory texts, and only in reference to these texts, since “rebelle” as too many meanings in French.

Against this background, SFETD approached HAS in 2007 with a request to produce guidelines for implementation of appropriate care pathways for patients with chronic pain. HAS embarked on two complementary projects:

- clinical practice guideline, focusing on clinical aspects (identification of chronic pain and clinical criteria for referral to pain clinics), which is the subject of the present document;
- public health guideline, focusing on organisational aspects (type and structure of facilities set up to assess and manage chronic pain). This guideline is contained in a separate document, which is being written by the HAS economic and public health evaluation department, and are based on a survey of current practice in these facilities[3].

### ► Aims of this clinical practice guideline

The issue of this guideline is to improve the quality of life of patients with chronic pain, starting from the principle that any complaint of pain must be listened to and responded to with appropriate treatment.

The objective of this guideline is to promote implementation of appropriate care pathways for patients with chronic pain and to promote exchanges between professionals from pain clinics and those who refer patients to these clinics.

The questions to which this guideline will provide a response are as follows:

- how can patients with chronic pain be identified?
- which patients should be referred to a pain clinic for assessment and treatment of chronic pain?
- what type of information should be sent to other professionals before and after the first consultation in a pain clinic?
- what should happen at an initial consultation in a pain clinic for assessment and treatment of chronic pain?
- which criteria should be used when deciding whether to refer a patient following initial assessment?

### ► Limitations of this document

The therapeutic aspects of pain management are not addressed.
Literature analysis is based on a search by symptom or syndrome, and not by pathology.
Situations in which specific management types or locations are required (for example people with disabilities, people with psychiatric disorders or elderly people with dementia) are not excluded from the present document, but are not subject to specific guidelines.

## 1.2 Patients concerned

Any person with chronic pain, of whatever age, apart from neonates. This age group is excluded as the concept of a care pathway is not relevant to children admitted to neonatal units. It is nevertheless essential to address pain in children during the neonatal period, and this must be done within the neonatal unit.

## 1.3 Professionals involved

This guideline is designed for all healthcare professionals who encounter patients with chronic pain, whether within healthcare establishments, in healthcare networks or at home, and in particular those doctors who co-ordinate patients' care pathways in general practice or hospitals and pain clinics (including but not limited to the following list):

[3] Data from the survey of patient clinical profiles and care pathways are given in appendix 2; the methods used in this survey and all results are detailed in the public health guidelines (Douleur chronique : les aspects organisationnels, in French).

- primary targets:
  - generalist or specialist physicians practising in outpatient clinics or within healthcare or medical and social welfare establishments,
  - physicians working in pain clinics (e.g. anaesthetists, rheumatologists, neurologists, psychiatrists);
- secondary targets: all healthcare professionals, psychologists.

### 1.4 Working method and grading of guidelines

This guideline has been written using the formal consensus method, as described by HAS (appendix 3).

Given the lack of intervention studies in this field of care's pathway, this guideline is not graded by quality of evidence, but is based on formal professional agreement of the assessment group formed by HAS, following consultation with the peer review group (the results of this formal agreement can be consulted in appendices 9 and 10 of the scientific report).

A lack of grading does not mean that this guideline is not relevant and useful. Indeed, if there is no grading, this should encourage further studies.

If new clinical studies evaluating the impact of interdisciplinary teams working in pain clinics are published, plans may be made to update this guideline.

## 2 Chronic pain: definition and epidemiology

### 2.1 Definition of chronic pain

The definition of pain proposed by the International Association for the Study of Pain, which is most often cited, shows that pain is subjective as well as complex: pain is " An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".

- Pain is therefore what the affected person says it is. This symptom exists when the patient claims to experience it, regardless of whether a cause has been identified.

- Chronic pain as included in this guideline is a multi-faceted syndrome[4] described by the person affected by it. Chronic pain, regardless of topography and intensity, is present when the pain has several of the following features:
  - persistence or recurrence beyond what is usual for the initial presumed cause, particularly if the pain has been present for more than 3 months;
  - insufficient response to treatment;
  - significant and progressive deterioration in the patient's everyday functional and relationship capacity because of the pain, at home, in education or at work.

- Chronic pain may be accompanied by:
  - psychopathological manifestations;
  - an insistent demand on the part of the patient for medicines or medical procedures (that are often invasive), which the patient declares to be ineffective in easing the pain;
  - by difficulty for the patient in adapting to the situation.

[4] This syndrome is commonly known as "chronic pain syndrome".

The term "intractable" which is used in the administrative definition concerning identification of pain clinics for management of chronic pain is not used in this guideline. Its meaning, which is ambiguous[5] and about which there is no consensus, is not useful in medical decision-making.

## 2.2 Epidemiology

With the caveat that it is difficult to evaluate prevalence of chronic pain in the general population, because of variable definitions of chronic pain, varied data collection methods, and possible under-declaration by patients, the prevalence of chronic pain is between 10.1% to 55.2% according to studies done in France and internationally. Prevalence is higher in women than in men, with a mean of 39.6% [13.4-55.5] versus 31% [9.1-54.9], and increases with age, particularly in those over 65.
The prevalence of severe chronic pain, i.e. very frequent and intense pain, is evaluated at 11% in adults and 8% in children.

# 3 Identification and initial assessment of chronic pain

## 3.1 Identification of chronic pain

If chronic pain is to be identified, the healthcare professional must know how to look for and recognise the patient's pain as the patient experiences and expresses it, regardless of the type of pain and the mechanisms underlying it.

It is recommended that all healthcare professionals consider chronic pain when the criteria in the above definition are met[6] (§ 2.1). Professionals should be alert to certain clinical signs:
- pain with anxiety or depression component or other psychopathological manifestations;
- pain that is resistant to clinical analysis and to treatment that in principle seems properly designed and is carried out in line with current guidelines;
- pain in which the patient's interpretation or beliefs are different from the doctor's interpretation of the pain, its causes, effects and treatments.

## 3.2 Initial assessment of a patient presenting with chronic pain

The aim of the initial assessment, regardless of the area of practice or medical discipline in which it is carried out, is to provide a precise description of the pain, which can be understood by any professional who consults the patient's record. In the course of their practice, various healthcare professionals, particularly nurses, physiotherapists and psychologists, have cause to identify patients with chronic pain syndrome; these professionals can play a role in assessment and can alert the patient's general practitioner.

This assessment requires a knowledge of the medical and surgical history of the patient him/herself and of the patient's family. This initial assessment can be a long process, requiring several consultations.

It is recommended that this assessment includes:

[5] French Directorate-General for Health Circular dated 4 February 1998 concerning identification of centres for management of intractable ("rebelle" in French) chronic pain. Bull off (French Official Bulletin) 1998;98/9. “Rebelle” in French has many meanings and is interpreted either as “intractable”, “resistant to treatment”, “difficult to analyze”, “fluctuant pain” or “pain associated with a rebellious comportment of patient”.
[6] The patient care pathway, from identification of chronic pain to referral of the patient following initial assessment in a specialised clinic for assessment and treatment of pain, is summarised in a diagram in appendix 4.

- evaluation of the characteristics of the pain: conditions and circumstances under which it arises, topography, intensity, factors that trigger or ease the pain, duration and variability over time, and whether it is nociceptive or neuropathic. This evaluation, which looks for the causes of the pain, includes an interview, which is at least in part semi-structured or uses validated tools or questionnaires, clinical examination and any necessary additional tests;
- self-evaluation of pain intensity, or in the absence of patient participation, an heteroevaluation appropriate to the patient, which can include assessment by family and friends, particularly in the case of children or those with severe communication difficulties;
- assessment of the social, educational, workplace and economic effects of the patient's chronic pain, including any procedures that are underway (e.g. signed off work, redeployment, litigation);
- analysis of results of previous drug and non-drug treatments (e.g. reaction to usual analgesics, compliance);
- systematic screen for anxiety, depression or psychopathological manifestations caused by or associated with the pain, and also the patient's interpretation of and beliefs concerning the pain and its causes, effects and treatments, which may be different from those of the doctor, and this difference could have an effect on the intensity of the pain and the effects of treatment.

It is recommended that the pain be monitored for changes at regular intervals, if it persists despite the management. Scales for the assessment of chronic pain or other validated tools that are specific to the underlying pathology can act as useful reference points when tracking the pain over time. These tools should not be expected to have any benefit in terms of intensity of pain.

# 4 Referring the patient to a pain clinic

## 4.1 Requirements

Referral of a patient to a pain clinic for assessment and management of chronic pain requires that the following conditions are met:

- initial clinical assessment, and specialist opinions and additional tests appropriate to the situation (particularly if the pain is suggestive of somatic disease) have been carried out. There can be no exceptions to this, unless there is a request with explanation from the general practitioner;
- a request for specialised management never means that outpatient management has been abandoned;
- the doctor who refers a patient to a pain clinic shall inform the patient of the multidisciplinary nature of the assessments carried out in these clinics;
- it is also desirable that the request for consultation corresponds to the objectives that the patient, his/her parents (if the patient is a child) and the general practitioner have discussed together.

## 4.2 Referral criteria

Referral to a pain clinic for assessment and management of chronic pain, if pain persists despite treatment, is recommended for the following priority indications:

- **additional diagnostic opinion** (in-depth and multi-faceted assessment of the causes and mechanisms underlying the pain), for example when the following appear to be major problems:
    - intensity and duration of pain in comparison with the presumed causal lesion, as identified on previous tests;
    - the effects of the pain on the patient's work, social and family life, or his/her psychological state;

- **additional therapeutic opinion**, for example if:
  - treatment is frequently changed because of inadequate pain control,
  - in-depth evaluation of the usefulness, efficacy and side-effects of current drug or non-drug management is required,
  - long-term step 3 analgesic treatment is planned for non-cancer cases;
  - treatment withdrawal is planned but has been difficult to implement;
- **initiation of assessment or management of the patient, facilitated by the pain clinic**, for example when:
  - an interdisciplinary approach is required, including at least one of the following aspects:
    - a psychological approach;
    - a social-work approach;
    - a specific physical approach;
    - therapeutic education;
  - a specific therapeutic procedure requiring referral to such a clinic.

## 4.3 Items to send to the pain clinic

It is recommended that a referral to a pain clinic be accompanied by a letter containing the following information:

- complete personal details of the patient:
  - administrative information; names and details of professionals to be included in correspondence, as proposed by or with the explicit agreement of the patient[7], conclusions of any assessment made;
  - any context that could be related to the pain (family, social, cultural educational or work circumstances);
  - history (patient's own and family);
- reason for referral (diagnostic, therapeutic, other);
- any additional tests that have been carried out and/or specialist opinions sought, and results of these;
- treatment(s) administered prior to referral (e.g. reaction to usual analgesics, responses to any drug or non-drug treatments given).

The letter should preferably also contain the most important details of the initial assessment of chronic pain carried out by the doctor who is referring the patient. If the patient is unable to communicate them him/herself, it is recommended that the following items appear in the letter:

- assessed characteristics of the chronic pain:
  - what the patient feels (self-evaluation), expectations and interpretations or beliefs concerning this pain;
  - a history of the pain: e.g. for how long has the patient experienced it, how did it start, under what circumstances does it appear or recur, how has it progressed, how does it change over time;
  - data from the doctor's examination (hetero-evaluation): topography, typology (nociceptive pain, neuropathic pain, other), intensity;
- effects of pain:
  - on daily life (particularly any functional impairment caused by the pain);
  - on relationships, and in particular parent/child relationships for children (changes in mood and behaviour, psychopathological manifestations);
  - on family, work, social and financial situations (including any litigation that may be in progress).

[7] (or legal representatives, particularly for children).

# 5 Assessing chronic pain in a pain clinic

## 5.1 Conditions under which assessments in pain clinics should take place

The objective for the clinic is to respond within the shortest possible period:
- confirming that the referral is appropriate, and in particular providing an opinion with reasons on previous assessment, current treatment and any changes to consider, if applicable;
- informing the referring doctor of the full results of the pain assessment carried out in the clinic, using the 1999 ANAES guideline[8] (appendix 4 of the background paper);
- offering, dependent on the situation, the most appropriate management and any additional management required (e.g. psychological, social or occupational support).

Before the initial consultation, particularly if the patient has requested the consultation spontaneously or if the referral is not accompanied by a letter from the general practitioner, it is desirable that the patient be given a self-administered questionnaire which will enable staff at the clinic better to organise the initial consultation.

It is recommended that initial assessment within a pain clinic be carried out by several professionals, either at the same time or separately. Several consultations may be required in order to carry out an initial assessment[9], if the complexity of the clinical situation requires it.

It is recommended that initial assessment within a pain clinic be followed by an interdisciplinary meeting including at least one physician and a psychiatrist or psychologist.

## 5.2 Assessing chronic pain in a pain clinic

The objectives of initial assessment of chronic pain in a pain clinic are given below.

### ► Summarising what has already been done

Recommendations:
- take into account the requests of the patient and doctor, according to the information that has been sent;
- check clinical and diagnostic information, if necessary making contact with the professionals involved;
- ensure that current treatment adheres to current guidelines and that the patient is complying with treatment.

### ► Completing a prior assessment of pain

It is recommended that for every patient a prior assessment of pain be completed, using validated scales, scores or tools. These tools should be appropriate to the patient's clinical situation (age, comprehension level, communication abilities, causal or associated pathologies: see appendix 4 of the scientific background paper). The following should be stated:
- the mechanism underlying the pain: nociceptive pain, neuropathic pain, idiopathic pain or psychogenic pain;

[8] http://www.has-sante.fr/portail/jcms/c_540915/evaluation-et-suivi-de-la-douleur-chronique-chez-l-adulte-en-medecine-ambulatoire

[9] In the text that follows, the expression "initial assessment" shall refer to all consultations required to perform this assessment, and not just to the first consultation.

- aspects of the patient's life that are affected by pain: physical, psychological, cognitive, social and workplace;
- any resistance or incoherence observed in what the patient says;
- secondary benefits, if applicable;
- effects of chronic pain on quality of life and daily activities, which could lead to a recognition of disability: for example limitation in completing educational work, daily tasks, journeys, household or family tasks, suffering in the workplace;
- factors that can help the patient to cope with the situation.

#### ► State, for patients in education or at work, the educational or occupational context of the pain

For all patients who are in education or working, it is recommended that the following information be collected:

- education or work pursued prior to the episode of pain: qualification, training, profession or career path, current post, type of employer, satisfaction at work;
- the effects of the pain on educational or work activities; if applicable, any cause within education or work for the pain: pain caused by work, accident at work or occupational disease, how the pain changes in response to levels of activity at work;
- the social and financial consequences, dependent on the patient's situation (e.g. signed off work, receiving disability benefits, unemployment, return at work).

#### ► Propose solutions or ensure that additional measures are carried out

After the initial assessment of chronic pain by the pain clinic, it is recommended that the clinic staff create plans in order to:

- confirm or alter current treatment, and offer further tests if appropriate;
- explain the proposed treatment strategy: objectives, proposed treatments, professionals who are likely to be involved, planned follow-up and revision of treatment, further referral;
- if necessary, propose a multidisciplinary management programme, and plan follow-up of this management (co-ordination of care with the general practitioner, and with other professionals);
- suggest further (non-medical) steps to take, for example a request to be registered as disabled, request for redeployment at work.

Some of these items are simple and can be collected as part of the self-administered questionnaires; others require several interviews with the patient, contact with the company doctor, medical adviser, the social worker involver, or specific facilities such as occupational health units (for difficult cases or where there is no company doctor). The objective is to prevent the social and workplace consequences of chronic pain.

## 5.3 Communicating the conclusions of the assessment

The objective when communicating information is to improve coherence of information held by the various professionals involved with the patient's care, while upholding patient confidentiality.

Conclusions from the initial assessment should be sent to the referring physician, as well as to other professionals involved in the patient's care, particularly the general practitioner if the latter did not refer the patient, as long as the patient explicitly agrees to this.

The information that is communicated must:

- respond to the reason for the referral, and in particular provide an well-argued opinion concerning current treatment and any changes to consider, if applicable;
- state the conclusions of the pain assessment, and in particular:

  - any new information concerning the chronic pain (history, context, mechanisms, identified or suspected causes) and its effect on the patient's daily life (functional, psychological, social and educational or workplace impact),
  - diagnostic hypotheses,
  - any request for additional information from the referring physician (for example any treatments given and their effects),
  - additional tests and opinions requested or to be requested;
- state proposed treatment, in particular:
  - objectives of the management plan , about which there is explicit agreement between the team in the pain clinic and the patient (for example: improving functional capacity, going back to work, reducing medicine consumption),
  - criteria using which various professionals can evaluate the extent to which these objectives have been reached (for example: an increase in walking test results over the next two weeks),
  - treatment plan designed together with the patient (the following list is indicative: psychological approach, social worker involvement, workplace or educational facility involvement, family and friend involvement, physical treatments, desirable changes to health and lifestyle, therapeutic education, for example in patients on opioid treatments, antidepressants, anticonvulsants, drug or non-drug treatments);
- suggested ways of implementing the management plan:
  - continued outpatient treatment, co-ordinated by the general practitioner, with or without occasional follow-up by the pain clinic,
  - continued outpatient treatment co-ordinated by the pain clinic or identified healthcare network,
  - implementation of a specific or multidisciplinary management plan by the pain clinic,
  - implementation of management by another specialised facility.

# 6 Referral of a patient following assessment in a specialised facility

Three possibilities can be considered, depending on the situation when this assessment is complete.

## 6.1 Refer patient back to referring physician

Following initial assessment in the pain clinic, it is recommended that patients be referred back to the referring physician under the following circumstances:

- if the current treatment is appropriate and the pain clinic cannot provide more help;
- if the referral was inappropriate (for example, if the patient refuses to be treated in the clinic or if the referral was made in error because of a requirement for specific treatment that cannot be provided in the clinic; in the latter case, it is recommended that the pain clinic informs the patient and the referring physician about existing facilities that are appropriate to the patient's clinical situation);
- appropriate management is possible on an outpatient basis now that a diagnostic or therapeutic hypothesis has been confirmed. Investigations or tests concerning treatments can be carried out elsewhere, if suggested or requested by the clinic;
- the referring physician can co-ordinate the management and the clinic can provide occasional additional input if required, for instance using alternate appointments, and psychological follow-up if this cannot easily be provided elsewhere.

## 6.2 Management within the pain clinic

### ► Because of the patient's clinical situation

Management within the pain clinic is recommended, if the patient agrees and in co-ordination with the general practitioner, in the following situations:

- diagnosis requiring repeated assessments;
- difficulties in adjusting drug treatment;
- severe and complex chronic pain syndrome, requiring specialised follow-up within the clinic;
- if the patient is requesting pain management but does not initially realise that his/her chronic pain has multiple causal factors;
- difficulties in accepting a previously planned outpatient treatment programme, or failure of implementation of such a programme;
- predicted negative effects on education or work and social life: assistance can be provided by the pain clinic with a view to rapid co-ordination of follow-up with school or company doctors or occupational health physicians or medical/social work management, in agreement with the general practitioner;
- on a case-by-case basis and in exceptional circumstances:
    - following the patient's express wish and if the patient refuses other types of management organised with the general practitioner,
    - for specific reasons, for example: geographical distance, social isolation, problems with health insurance coverage, work reasons.

### ► Because of the facilities offered by the pain clinic

Management within the pain clinic is recommended, if the patient agrees and in co-ordination with the general practitioner, in the following situations:

- treatments or management modalities that cannot be provided elsewhere (for example, if the patient needs multiple opinions or specific procedures, to be carried out in the clinic);
- if specific procedures that are essential to the treatment plan are not reimbursed if carried out in a location other than the clinic;
- complex medical records requiring multidisciplinary discussion (joint meeting with a psychologist, psychiatrist, social worker, relevant specialist, and the referring physician if possible);
- if the patient wishes to take part in a research project that has been authorised by the relevant regulatory bodies.

## 6.3 Referring the patient to a different pain clinic

Referring the patient to a different facility[10] that may be able to implement the recommended procedures requires the following:

- agreement with the general practitioner or referring physician;
- consent of the patient;
- ensuring that the other facility has availability and agrees to take on the patient's management.

[10] For example: healthcare network, multidisciplinary functional rehabilitation facility, other multidisciplinary facilities offering more specific management for the patient's particular clinical situation.

# Appendix 1. Typology of pain clinics

**Circular DGS/DH 94-3 regarding organisation of management of chronic pain defined four types of activity that take place in pain clinics:**

- assessment and management of therapy, requested by the general practitioner seeking a diagnostic and therapeutic opinion;
- long-term treatment and follow-up, in collaboration with the general practitioner and home care and treatment services;
- teaching delivered to other facilities and doctors;
- basic and applied scientific research.

This circular stated how these facilities were to be organised, in mobile multidisciplinary facilities, some with their own hospital beds or access to such beds, and contained within teaching referral hospitals with their three missions of care, research and teaching.

**First "National pain Programme" : Circular DGS/DH no. 98-47 concerning identification of centres for management of intractable ("rebelle" in French) chronic pain.[11]**

It draws the distinction between three types of facility:

- **Multidisciplinary consultation facilities** for the management of chronic pain, contained within public or private healthcare organisations. These are basic facilities that provide a holistic approach: prevention, care, rehabilitation, taking into account the patient's family, social and work context.
- **Multidisciplinary units** for the management of chronic pain, including, in addition to the consultation facilities described above, day case or admission beds and access to hospital diagnosis and treatment facilities when specific treatment plans require it.
- **Multidisciplinary centres** for management of chronic pain, contained within some university hospitals, which have, in addition to the above facilities, teaching capabilities (initial medical training, postgraduate medical studies, skills in evaluation and treatment of pain) and research into the issues surrounding pain.

**Second "National pain programme", 2002-2005**

In this programme, it was noted that there were 32 multidisciplinary consultation facilities for the management of chronic pain in France, along with 41 units and 23 centres, with regional disparities (49/98 French départements had no consultations facilities, and 8 had no centre). It was therefore proposed that 49 consultation facilities, 8 centres and 20 hospital physician posts be created, along with one experimental referral centre for migraine in children.
The programme published by the Ministry of Health in 2002 contained plans for the establishment of a Committee for the fight against pain (CLUD) within each public and private healthcare organisation, with the stated aim of offering medical staff and the nursing service "objectives and actions that should be part of the the medical and nursing plan of the healthcare organisation" (the CLUD is not directly involved in care).

**Third "National pain programme", 2006-2010**

Priority 4 involves organisational considerations more directly, with improvement of the skills of staff within clinics (100 junior doctors, 26 senior practitioners, 30 psychologists, 38 nurses) and in how patients are received into the service, in particularly elderly people (facilities, refurbishment and equipment within services).
Objective 10 contains plans for sharing experiences of those structures and activities that have been put in place, particularly in the regions, and for improvements in pain management within healthcare networks, and methods for monitoring the methods that have been put in place.

[11] The term "intractable chronic pain" is used here as it is in these official documents.

# Appendix 2. Results of HAS-SFETD current practice survey (extracts)

A current practice survey was carried out over two weeks in January 2008[12] and involved all pain clinics identified by the French Society for the Study of Pain Therapy (SFETD) regardless of organisation type (consultation facility, unit or centre[13]) or their ARH (regional hospital agency) registration status. A questionnaire had to be filled in for every patient visiting the facility for the first time. The overall response rate was 63%, with variation between regions. Three regions had a response rate of less than 50% (Auvergne: 43%, Haute-Normandie and Limousin: 40%), five regions had a response rate greater than or equal to 75% (Centre and Lorraine: 75 %, Provence-Alpes-Côte-d'azur: 81%, Nord-Pas-de-Calais and Picardie: 83%).

Of the 2953 new patients declared, in 183 different centres, 2896 patients being seen for the first time in such facilities were included in the analysis (40 new patients were excluded because they were seen in 3 facilities which did not meet the criteria in circular DGS/DH no. 94-3 concerning organisation of the management of chronic pain, and 17 records of children under 15 were excluded).
The patient records used came in fairly equal proportions from the different types of facility: 34% of patients were seen in a "consultation facility", 39.5% in a "unit" and 26.2% in a "centre".
The male-female ratio was not statistically different in the different types of facility. However, patient age differed significantly in the different facility types: the proportion of patients under 35 is higher in centres than in units and consultation facilities. The proportion of patients over 65 is higher in units (table 1).

**Table 1. Age and sex of patients by type of facility consulted (number of patients - percentage in a column)**

| Age - Sex | Type of facility | | |
|---|---|---|---|
| | Centre | Consultation facility | Unit |
| **Age** | | | |
| **under 35** | 130 | 149 | 182 |
| | 17.1% | 15.0% | 15.9% |
| **35-45 years** | 141 | 187 | 199 |
| | 18.6% | 18.8% | 17.4% |
| **45-55 years** | 195 | 225 | 297 |
| | 25.9% | 22.7% | 25.9% |
| **55-65 years** | 150 | 211 | 191 |
| | 19.8% | 21.3% | 16.7% |
| **over 65** | 143 | 220 | 278 |
| | 18.8% | 22.2% | 24.1% |
| **Total** | 759 | 992 | 1145 |
| **Gender** | | | |
| **men** | 31.8% | 32.9% | 35.3% |
| **women** | 68.2% | 67.1% | 64.7% |

In addition, statistically significant differences emerge between facilities in terms of breakdown by employment status. The proportion of patients who work is lower in units (with

[12] Because of this timetable, the results of this survey, which was carried out with a view to providing analysis of how facilities are organised within the Department for Economic and Public Health Evaluation, were sent after the peer review group opinions had been analysed. These results provide a perspective on the patient care pathway in France in 2008, and the pathway proposed in the guideline, but were not used in the development of the guideline.
[13] Facilities are identified using the typology created in circular DGS/DH no. 94-3 concerning organisation of management of chronic pain (see appendix 1).

a higher proportion of retired patients); the proportion of patients receiving disability benefits in centres (13%) is twice as high as among patients seen in units (7%) (table 2).

**Table 2. Breakdown of employment status by type of facility consulted (percentage by line)**

| | Employment status | | | | | | |
|---|---|---|---|---|---|---|---|
| **Facility** | **Student** | **Working** | **Looking for work** | **Receiving disability benefits** | **Retired** | **Off work for health reasons** | **Off work because of workplace accident** |
| **centre** | 3.6% | 31.4% | 4.0% | **13.4%** | 30.8% | 12.4% | 4.5% |
| **consultation facility** | 2.4% | 31.9% | 5.3% | 9.5% | 33.0% | 13.1% | 4.9% |
| **unit** | 2.9% | **26.9%** | 4.8% | 6.9% | **35.0%** | 16.5% | 7.0% |
| **Total (number of records)[§]** | 78 | 801 | 128 | 255 | 893 | 383 | 151 |

Statistically significant difference ($Chi^2$ test, $p<0.0001$)
[§] 2689 records used

Types of pain described at initial consultation in a pain clinic are primarily lower back pain (20% of patients), neuropathic pain (17% of patients) and headache (16% of patients) (table 3).
Duration of pain is greater than 2 years for 53% of patients, and is less than 6 months for 17%; the latter category primarily consists of patients with cancer pain or regional complex pain syndrome (table 3).

**Table 3. Breakdown of duration of pain by pain type (percentage by line)**

| | | Duration of pain | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **Less than 3 months** | **3-6 months** | **6 months-1 year** | **1-2 years** | **2-3 years** | **More than 3 years** | **All durations (number of patients)** |
| Type of pain | Lower back pain (19.8% of patients) | 3.0% | 6.5% | 15.6% | 16.6% | 10.9% | 47.4% | 566 |
| | Neuropathic pain (16.6% of patients) | 8.0% | 14.0% | 18.0% | 17.2% | 12.6% | 30.2% | 477 |
| | Headache (16.2% of patients) | 6.1% | 6.5% | 8.0% | 11.0% | 8.7% | 59.7% | 462 |
| | Rheumatological pain (not lower back pain or fibromyalgia) (9.8% of patients) | 5.4% | 11.3% | 14.2% | 17.8% | 21.4% | 29.8% | 275 |
| | Fibromyalgia (9.7% of patients) | 0.4% | 2.1 % | 7.9 % | 13.2% | 15.7% | 60.7% | 280 |
| | Multiple pain types (9.4% of patients) | 4.4% | 6.7% | 15.6% | 17.8% | 9.6% | 45.9% | 270 |
| | Regional complex pain syndrome (6.1% of patients) | 14.3% | 28.0% | 28.6% | 9.1% | 8.6% | 11.4% | 175 |
| | Other types of pain (4.1% of patients) | 12.1% | 10.3% | 13.8% | 24.1 | 7.8% | **31.9%** | 116 |
| | Cancer pain (3.7% of patients) | **37.1%** | 30.5% | 16.2% | 11.4% | 1.9% | 2.9% | 105 |
| | Visceral pain (2.5% of patients) | 4.3% | 4.3% | 17.1% | 17.1% | 17.1% | **40.0%** | 70 |
| | Not stated (2.1% of patients) | 3.6% | 18.2% | 12.7% | 9.1% | 12.7% | 43.6% | 55 |
| | All pain types (Number of patients) | 6.8% (194) | 10.3% (295) | 14.6% (416) | 15.2% (434) | 11.8% (336) | 41.2% (1176) | 100.0% (2851) |

Time to receiving an appointment in a pain clinic is less than or equal to 1 month for 56% of patients, and is greater than or equal to 3 months for 21% of patients.
Time to receipt of appointment is associated with duration of pain: time to obtain an appointment is longer as a proportion of the period during which the patient has suffered pain. For example, 72% of patients who have had lower back pain for more than 3 years have a waiting time of 1 month or longer, versus 26% of patients with a history of lower back pain of less than 3 months (the difference is statistically significant). Conversely, patients suffering from cancer pain, regardless of duration of pain, obtain an appointment within a week in the majority of cases.

In 549 cases (22%), the physical assessment sent by the referring physician to the specialised pain clinic was considered to be incomplete, of the 2869 records for which this information was collected. The rate of incomplete referrals is lower for patients referred by specialists than for those who refer themselves or are referred by a generalist physician (16.9%, 23.3% and 25.8% of records respectively, $p<0.0001$).

Referral to pain clinic is considered to be "appropriate" by a doctor within the pain clinic in 93% of cases. There is no significant difference between types of facility in rates of referrals that are considered to be appropriate (table 4). Conversely, significant differences were observed between regions ($p = 0.002$); the four regions in which fewer than 90% of referrals were considered to be appropriate were Burgundy (83%), Aquitaine, Champagne-Ardennes and Nord-Pas-de-Calais (89%).

**Table 4. Proportion of referrals considered to be justified by type of facility - percentages as columns**

| Appropriate referral | Facility | | |
|---|---|---|---|
| | Centre | Consultation facility | Unit |
| **Yes** | 92.6% | 93.3% | 92.0% |
| **No** | 7.4% | 6.7% | 8.0% |
| **Total (number of records)[§]** | 741 | 978 | 1122 |

[§] 2841 records used

Analysis using logistic regression was done in order to identify the variables that might explain rates of inappropriate referrals.
This analysis involved 2085 records, because of missing data in 811 records.
155 records showed an inappropriate referral, representing 7% of patients seen for the first time in a pain clinic.
Variables used in the model were: age, gender, occupational status, type of pain and duration, time to receipt of appointment, reason for referral to pain clinic (e.g. diagnostic advice, advice on treatment), whether there had been prior medical consultation, presence of a record of complete physical examination, and, finally, the person who referred the patient (patient him/herself or type of professional: general practitioner, specialist, another facility). Chosen comparators were the values of the variables that obtained the highest rates of appropriate referrals.
Three of the ten variables had a significant effect on rates of inappropriate referrals: type of pain (table 5), duration of pain and whether or not the patient had a prior consultation. All other things being equal, the only significant differences observed were as follows:

- patients suffering from other rheumatological pain, headache or lower back pain were between 3 and 6 times more likely to have an inappropriate referral[14] than a patient

[14] Odds ratio is the ratio between the probability of having an unjustified referral and the probability of having a justified referral. By "more likely to have an unjustified referral" we mean relatively to the probability of having a justified referral.

presenting with complex regional pain syndrome (OR = 4.5, 95% CI = 2.1;15.1]; OR = 2.8, 95% CI = [1.0;7.7]; OR = 3.5, 95% CI = [1.1;18.2]);
- a patient with pain that has lasted less than 3 months is 3 times more likely to have an inappropriate referral than a patient who has had pain for over 3 years (OR = 2.7, 95% CI = [1.0;4.5]);
- a patient who makes an appointment without prior medical consultation is twice as likely to have an unapproprate referral than a patient who made an appointment following prior medical consultation (regardless of whether the patient made the appointment him/herself or was referred by his/her doctor) (OR = 2.1; 95% CI = [1.5;3.0]); however, the proportion of unappropraite referrals remains low (15% of patients who were not seen previously). 24.3% of patients in this survey had not had prior medical consultation for their pain (n = 686).

**Table 5. Proportion of appropriate referrals, by type of pain**

| Type of pain | Justified referral | |
|---|---|---|
| | Yes | No |
| **Regional complex pain syndrome** | **97.1%** | 2.9 % |
| **Neuropathic pain** | **97.0%** | 3.0 % |
| **Multiple pain types (several types of pain ticked)** | **96.6%** | 3.4% |
| **Cancer pain** | **95.2%** | 4.8% |
| **Fibromyalgia** | 93.8% | 6.2% |
| **Lower back pain** | 92.0% | 8.0% |
| **Headache** | 91.4% | 8.6% |
| **Visceral pain** | 90.3% | 9.7% |
| **Diagnosis not stated** | 89.7% | 10.3% |
| **Other type of pain** | 87.2% | 12.8% |
| **Rheumatological pain (not lower back pain or fibromyalgia)** | *83.6%* | 16.4% |
| **Total (number of records)[§]** | 2632 | 209 |

[§] 2841 records used

Overall, doctors in pain clinics for assessment and management of pain considered that 209 patients had inappropriate referrals to specialist clinics. A reason for such a belief was stated for 138 cases. These reasons, in descending order of frequency, were as follows:
- required management differs from that provided by the pain facility;
- the facility is unable to provide an appropriate response (because of geographical distance, because the patient refuses to accept the diagnosis, because of lack of diagnostic and treatment progress, need for social, family or psychological support);
- prior treatment was insufficient or inappropriate (lack of prior assessment, usual drug treatments not prescribed, or inappropriate prescription);
- management by the general practitioner is possible;
- patient does not have chronic pain;
- prior treatment is appropriate, or has already been seen in a pain facility.

# Appendix 3. Method: formal consensus

Clinical practice guidelines (CPG) have been defined as proposals developed by an explicit method to help the practitioner and the patient to find the most appropriate care in a given clinical situation.
The formal consensus (FC) method is one of the methods used by the Haute Autorité de Santé (HAS - French National Authority for Health) to produce clinical guidelines. It is based on critical analysis and review of the available medical literature as well as on the opinion of a multidisciplinary group of professionals involved in the subject area of the guidelines.

## ► Choice of subject

The HAS Board chooses the topics for clinical guidelines. For this purpose the Board takes into account public health priorities and any requests from Ministry for health and national health insurance.The HAS Board may also consider topics proposed by learned societies, the French national cancer institute, the French Association of National Health insurance, the French national union of health professionals, organisations representing health care professionals or establishments, or registered user groups.

For each chosen topic, the working method follows the next steps. A HAS project manager coordinates the work as a whole and ensures that it conforms to HAS' methodological principles.

## ► Steering committee

HAS sets up a steering committee composed of representatives of the learned societies, professional or user organisations and, if need be, of the relevant health agencies and institutions. The steering committee specifies the exact subject area of the guidelines, the issues to be dealt with, the patient populations and the professionals for whom the guidelines are intended. It draws attention to relevant publications, notably guidelines. It proposes suitable professionals to take part in working and peer review groups. Finally it takes part in the peer review.

## ► Project group

A project group is formed by HAS. It is made up of healthcare professionals working in the public or private sectors, from various regions and schools of thought, and, if required, other professionals who are involved and representatives of patients' and users' associations. In the case of the present document, half the project group members work in a pain clinic for assessment and management of chronic pain (a consultation facility, unit or centre). A report author is also designated by HAS to select, analyse and summarise the relevant medical and scientific literature. The report author drafts the evidence report and specifies the level of evidence of the studies considered, under the supervision of the HAS project manager. The evidence is regularly updated until the end of the project.

The steering group then writes a list of recommendations' proposals, secondarily submitted to the rating panel.

When literature is available, proposals are graded based on the scientific evidence level (table1)

**Table1. Grading of guidelines**

| Grade | Scientific evidence level |
|---|---|
| A | trials of a high level of evidence (level of evidence 1), e.g. high-power randomised controlled trials (RCTs) free of major bias and/or meta-analyses of RCTs or decision analyses based on level 1 trials. |
| B | studies of an intermediate level of evidence (level of evidence 2), e.g. RCTs with some bias, meta-analyses based on questionable methodology, well-conducted non-randomised controlled trials or cohort studies; |
| C | studies of a lower level of evidence, e.g. case control studies (level of evidence 3) or case series (level of evidence 4). |

In the absence of reliable publications, the guidelines are based on professional agreement among rating panel members, after taking into account peer reviewers's comment.

If there are no studies, which is most often the case when the formal consensus method is used, guidelines are based on formal professional agreement within the rating panel formed by HAS, following consultation with the peer review group. In this text, ungraded guidelines are based on formal professional agreement. A lack of grading does not mean that the guidelines are not relevant and useful. Indeed, if there is no grading, this should encourage further studies.

### ► Rating panel

An rating panel is formed by HAS. It is made up of professionals who have daily involvement in the clinical situation that is being studied, who are selected using the criteria used to select members of the working group. Members of the rating panel receive a questionnaire in which they individually rate each proposition produced by the project group, using a numerical scale, taking into account the available information concerning quality of evidence and their practical experiences (1st individual rating). A meeting of the rating panel is organised, under the leadership of the HAS project manager, at which the 1st rating results are presented and discussed, and so that the professional experiences of the participants can be compared with the data in the literature. Depending on the results, the proposals may be changed or clarified. Soon after this meeting, the rating panel members are asked to individually grade the proposals resulting from the meeting (2nd individual rating). Members of the rating panel who do not return their individual ratings or who do not attend the meeting are excluded from the panel. Rated proposals, rating rules and analysis of responses are given as an appendix, as are the results of individual ratings.

### ► Writing the first version of the guideline

After the rating process, an initial version of the text of the guidelines is draft by the HAS project manager, based on the identified consensus. This is submitted to the project group, which checks it for consistency before it is sent to the peer review group.

### ► Peer review group

HAS appoints the peer reviewers using the same criteria as for project group members. The peer reviewers are consulted by e-mail and give an opinion on the content and structure of the evidence report and guideline, in particular on guideline's legibility and applicability.

### ► Final version of the guideline

The project group and the rating panel analyse the peer reviewers' comments, amend the evidence report if necessary, and drafts the final version of the guideline and a quick reference guide (QRG), during a working joint session. If recommendations' content is modified, a third rating by the rating panel is performed.
The final version of the evidence report and guideline and the development process are discussed by the *Committe of guidelines approval*. At its request, the evidence report and the guideline may be amended by the project group. The committee submits its opinion to the HAS Board

### ► Validation by the HAS Board

Acting on the proposal from the *Committe of guidelines approval*, the HAS Board validates the final documents and authorises their publication.

### ► Publication

HAS makes available on its website (www.has-sante.fr), free of charge, the evidence report, the guideline and the Quick Reference Guide (QRG). HAS may decide to print both the QRG and the guideline.

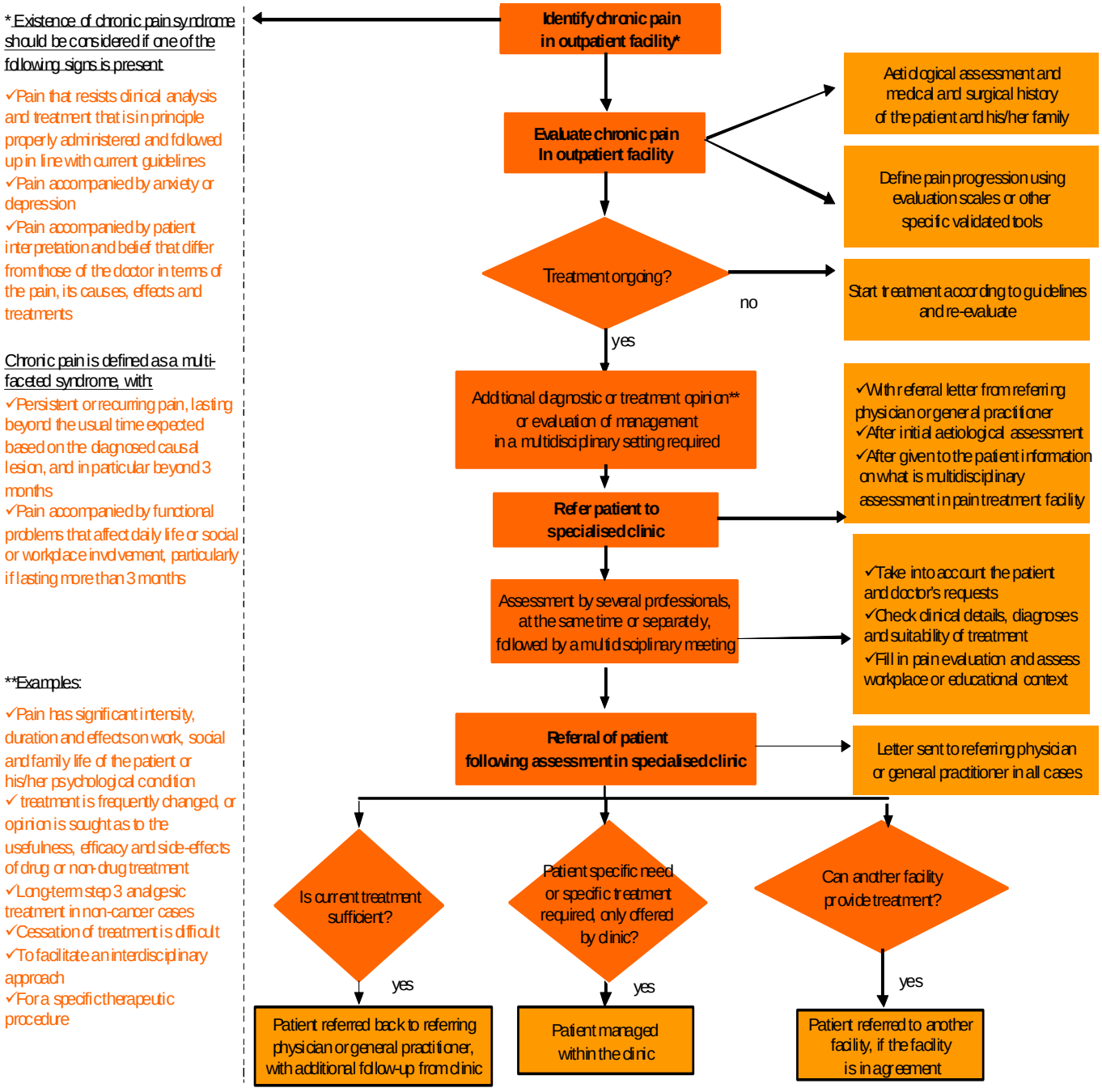
### ► Internal work at HAS

A HAS project manager ensures that the whole project conforms to HAS methodological principles and is properly co-ordinated.
An in-depth literature search is carried out, by systematically searching medical and scientific bibliographical databases over an appropriate period of time for each subject. Depending on the subject in question, this can be complemented by searches of other specific databases. For all studies, there is a systematic search of clinical practice guidelines, consensus conferences, medical decision-making articles, systematic reviews, meta-analyses and other evaluation studies that have

been published nationally and internationally. All useful websites (e.g. government agencies, learned societies) are explored. Documents that cannot be obtained by conventional means of information distribution (grey literature) are sought via all available means. In addition, legislative and regulatory texts that could be related to the subject are consulted. Initial searches are carried out at soon as the project starts and enable the scientific report to be written. They are updated regularly until the project ends. Examination of the references cited in the articles that are analysed enables the selection of articles that were not found in the various searches. Finally, participants in the project can send articles from their own libraries. The languages used are French and English.

For more information on the formal consensus method for creating professional guidelines, see the guide published by HAS in 2006: "Bases méthodologiques pour l'élaboration de recommandations professionnelles par consensus formalisé" This guide can be downloaded from the HAS website: www.has-sante.fr.

# Appendix 4. Care pathway - summary of guidelines




rehabilitation, Gilon

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# Descriptive leaflet

| | |
|---|---|
| **TITLE** | **Chronic pain: identification, assessment and referral of patient with chronic pain syndrome** |
| **Working method** | Clinical practice guideline by formalised consensus (FC) |
| **Date made available online** | January 2009 |
| **Date of publication** | Available in electronic format only |
| **Objective(s)** | • To promote implementation of appropriate care pathways for patients with chronic pain:<br>◗ define how patients with chronic pain can be identified<br>◗ define the situations in which referral to a pain clinic for assessment and management of chronic pain is required, using an evaluation by professionals outside such facilities<br>◗ define the content of the initial assessment within a pain clinic<br>◗ define the criteria to use when deciding whether to refer the patient following this initial assessment<br>• To promote exchanges between professionals in pain clinics and professionals who refer patients to such facilities:<br>◗ define the information that should be communicated between professionals when referring patients to pain clinics and following initial assessment in such facilities |
| **Professionals involved** | • generalist or specialist physicians, working with outpatients or within health or healthcare/social welfare establishments<br>• doctors in pain clinics (e.g. anaesthetists, rheumatologists, neurologists, psychiatrists)<br>• all healthcare professionals, psychologists |
| **Requested by** | French Society for the Study of Pain Therapy (SFETD) |
| **Sponsor** | Haute Autorité de Santé (HAS), good professional practices department |
| **Financing** | Public funds |
| **Steering of project** | Co-ordination: Ms Joëlle André-Vert, project manager, good professional practices department, HAS (head of department: Dr Patrice Dosquet)<br>Secretariat: Ms Laetitia Gourbail<br>Literature search: Mme Gaëlle Fanelli, with the assistance of Ms Julie Mokbhi and Ms Yasmine Lombry (head of documentation department: Ms Frédérique Pagès) |
| **Participants** | Learned societies, organisation committee, steering group, assessment group, reading group: see list of participants<br>Participants in the organisation committee and steering and assessment groups have provided a declaration of interests to HAS |
| **Literature search** | Covering January 1985 - December 2007<br>(see search strategy, documented in the scientific report) |
| **Authors of the scientific report** | Dr Jean-Pierre Vallée, MD, general practitioner, Colleville-Montgomery |
| **Validation** | Opinion of *Committe of guidelines approval*<br>Validated by HAS Board in December 2008 |
| **Other formats** | Quick reference guideline and evidence report [in French] can be downloaded from www.has-sante.fr |