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Pain Management Skills for Minority Breast Cancer Patients

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Approximately 60% of outpatients with metastatic breast cancer have pain and one-third have pain that restrict their ability to function. Compared with middle class patients those from underserved populations are three times as likely to be undermedicated with analgesics: Over 60% of African-American and over 80% of Hispanic patients get inadequate analgesic prescriptions. They have typical concerns that limit their reporting of pain and their use of analgesics.

We are assessing the needs of minority breast cancer outpatients for information and skills needed to manage pain. In Phase II we will develop multi-media education and training materials that are linguistically and culturally appropriate for Hispanic and African-American populations. To accomplish these tasks we have (a) formed a network of three urban public hospitals that treat these patients and (b) established a multi-disciplinary team to meet project goals. We will evaluate the effectiveness of this training program in a randomized, controlled clinical trial for minority outpatients with metastatic breast cancer and disease-related pain. If this program is effective, it can easily be introduced by other care centers where these patients are treated.

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Introduction

Strategies for improving pain control for patients with metastatic breast cancer will have a significant impact on reducing the morbidity of this disease. It is estimated that there are 182,000 new cases of breast cancer in the US each year (American Cancer Society, 1993). Approximately 70% of these women are diagnosed in the early stages of the disease, attributable in large part to progress in screening and diagnosis. Despite improvements in cancer care for patients with early stage disease, a large number of patients will still develop metastatic disease, and mortality rates for these patient remain relatively constant. Minority women are more likely than white women to have advanced disease at diagnosis, and treatment outcomes are worse for minority women (Freeman & Wasfie, 1989). Improving the quality of life of patients who will die of their disease, especially controlling their pain, should become a priority for these patients at the same time that efforts are directed at improving therapeutic approaches for their disease.

Women with metastatic breast cancer, especially those from minority populations, are not receiving optimum pain control. While it is estimated that pain could be well controlled in over 90% of patients with cancer (Foley, 1985), data from a recent national study indicate that 43% of women with metastatic breast cancer and pain are not adequately treated by the standards of the World Health Organization (Cleeland, et al, 1994). Compared with other patients who have pain due to metastatic disease, women are more likely to be undertreated, and minorities (Hispanics and African-Americans) are three times as likely to receive inadequate analgesics. Minority patients recognize that they are undertreated; they more frequently report that they need more medication for pain, and report less relief from pain treatment and shorter duration of pain relief from their medications. They also report more pain-related impairment of function.

Poor cancer pain control is a function of many factors, including those related to the inadequate pain management given by health care professionals and those related to barriers created by the health care system in general. Patient concerns, expectations and behaviors also contribute to poor pain management (Cleeland, 1984; Ward, et al, 1993). These patient-related factors include the belief that pain is inevitable and fears of addiction to analgesics, of building tolerance to analgesics, and of reporting pain to providers. Minority breast cancer patients need additional skills to cope with their pain, including how to get reimbursement for pain medications, how to find pharmacies that will dispense opioids, and how to find providers who will manage their pain.

Informing patients about pain control and teaching them the skills they need to get pain relief should reduce the numbers of patients who have inadequate pain management. Patients who expect pain relief and are able to communicate their distress are liable to promote more responsive pain management from their health care providers. Identifying patient concerns and behaviors that limit effective pain management and providing information and skills training to modify these concerns and behaviors may present the most effective way, at least in the short term, to reduce the percentages of patients whose functioning is impaired by pain. Training for minority patients will need to be predicated on an assessment of the specific information and skills they will need to manage their pain.

Body

Approximately 60% of outpatients with metastatic breast cancer have pain and one-third have pain that restricts their ability to function. Compared with middle class patients, those from underserved populations are three times as likely to be undermedicated with analgesics: Over 60% of African-American and over 80% of Hispanic patients get inadequate analgesic prescriptions. They have typical concerns that limit their reporting of pain and their use of analgesics. Additionally, they have limited contact with providers, difficulty paying for medications, and face greater health provider concern about addiction. They report that they need more pain medication and need more information about pain management. Educating these patients about pain and its management and training them with the skills they need to obtain pain relief should improve their pain control and increase their ability to function.

The program funded by this award assesses the needs of minority breast cancer outpatients for information and skills needed to manage pain. It develops multi-media education and training materials that are linguistically and culturally appropriate for Hispanic and African American populations. To accomplish these tasks we have (a) formed a network of three urban public hospitals that treat these patients and (b) established a multi-disciplinary team to meet project goals. We will evaluate the effectiveness of this training program in a randomized, controlled clinical trial for African-American and Hispanic outpatients with metastatic breast cancer and disease-related pain. If this program is effective, it can be easily be introduced by other care centers where these patients are treated.

During the first year of this award the network of three urban hospitals was formed. These include University of Miami Hospitals and Clinics, John Peter Smith Hospital in Ft. Worth, TX, and Los Angeles County Medical Center. Research Nurses were recruited at each site by site investigators. Each nurse is bilingual and each brings special skills to this project. The nurses have backgrounds in community outreach, cancer research, and education for special populations. The nurses have completed a number of clinical exercises in order to develop skills and knowledge needed for this program. Over the last six months the nurses have been trained in presenting questionnaires to the target populations and identifying the special needs of the targeted population in filling our forms and providing medical information. The nurses have also been evaluating the pain management programs within their institution by conducting pharmacy audits and chart audits. This has allowed them to become familiar with the prescribing practices and chart information.

An investigators meeting was held in April 1995, with all key personnel attending. A review of the status of pain management, research resources, and institutional corporate culture was discussed. The Research Nurses and Site Investigators reviewed the information that had been gathered by the clinical exercises and how that information could be used in the development of studies and the implementation of studies. A number of descriptive studies were identified and subsequently drafted. It was felt that these studies needed to be done in order to establish a baseline at each institution before an intervention was introduced.

In order to assess the needs of minority breast cancer patients, two descriptive studies have been developed looking at the environment in which these patients are treated. Research Nurses have been hired and have completed a number of clinical exercises including form administration, chart audits, pharmacology audits, and patient observations. These exercises have been completed at each of the urban hospital sites (Los Angeles County Medical Center, John Peter Smith Hospital, and University of Miami Hospital and Clinics). The two studies that have been developed to begin the need assessment phase will be open for study accrual as soon as IRB approval has been granted at each site.

Study 001 - Outpatients Pain Needs Assessment Survey

The control of pain is an important aspect of patient management for specialists who deal with the spectrum of oncologic diseases. Experts have indicated that 30-40% of patients under active treatment and upwards of 60-90% of patients with terminal cancer will have experienced pain from their illness (Cleeland, 1986; Cleveland, 1984; Foley , 1987). It has been estimated that although pain could be adequately controlled in the majority of cases, only approximately 50% of the patients reported good (70% or better) pain relief (Cleveland, 1986; Bonica, 1978; McGivery, et al, 1984). Results of an Eastern Cooperative Oncology Group survey of outpatients with metastatic cancer from 54 treatment settings indicate that 42% of those with pain were not prescribed adequate analgesia according to WHO guidelines. This held true at University Cancer Centers and community-based settings, however, minority patients were 3 times as likely to be undermedicated (Cleveland, et al, 1994).

Various reasons have been proposed for this substandard management of cancer pain. A recent survey asked 1177 ECOG physicians to rank 12 barriers to adequate cancer pain management in their own practice setting (VonRoenn, et al, 1993). The barrier ranked as most important was lack of proper assessment, pointing to the need for greater communication about pain between patient and health care providers. Among the top 4 barriers were "patient reluctance to report pain" and " patient reluctance to take analgesics". Other barriers include over concern about addiction, lack of knowledge regarding proper use of narcotics, pain management having a low priority, lack of understanding about the pathophysiology of pain and limited availability and use of alternative pain management techniques (i.e., surgery, alternate modes of narcotic administration, or behavioral interventions (Cleveland, 1986; VonRoenn, et al, 1993; Bonica, 1980). Additionally, it has been suggested that patients themselves may contribute to poor pain control because of their resistance to taking narcotics, or difficulties in communicating the nature and extent of experienced pain (Cleveland, 1984). Data obtained from a survey of 270 cancer patients indicate that a majority of cancer patients have distorted ideas about addiction, side effects and tolerance, and experienced the belief that pain medications should be reserved for extreme pain (Cleveland, et al, 1994). Finally, because of its subjective nature, pain is difficult to measure, allowing for wide variety in interpretation.

An ECOG group-wide extension of the outpatient study reported above examined pain treatment in 127 Hispanic and 155 African American patients in order to determine what factors contribute

to the very high numbers of such patients who are undermedicated with analgesics. Data has now been obtained for patients from 25 treatment settings, and preliminary analysis confirms the findings of the previous study concerning the high percentages of minority patients who have pain and who are not receiving adequate analgesic drugs. Approximately 62% of patients reporting pain at institutions that enrolled predominantly African American patients were not prescribed adequate analgesia , while in predominantly Hispanic settings 82% met the criteria for undermedication. The fact that minority patients receive poor pain management is not surprising; it is well-established that minority patients (African-Americans) are also likely to receive less adequate treatment for their cancers (Gibbons, 1991). The most powerful predictor of whether or not patients would be given therapy appropriate to their reported pain severity was the extent of discrepancy between physician and patient in the estimate of the patient's pain severity. Accurate appraisal of pain severity may be more difficult for patients who are not of the same ethnic or racial background as the treating physician. Concerns about addiction and reluctance to report pain, as well as reluctance to take opioids, may be significant barriers to optimal pain relief in minority cancer patients and may further widen the gap between pain severity and physician perception of the minority patient's level of pain.

In an effort to offer better pain control services to all oncology patients, it is felt that a better understanding about the nature and extent of cancer pain is needed in diverse populations. This will allow for the future design of pain control studies for those areas which are in need of attention. This baseline of information will also be useful for the future assessment of pain control and methods of management at participating institutions. This study proposes to collect data on the pain of patients with recurrent or metastatic disease treated at participating institutions. The data will include the patients' subjective report of pain and its impact on function, the perception of the treating physician concerning the patients' pain, and the details of the pain treatment these patients are receiving. The ECOG experience with primarily non-minority patients, indicated that potent analgesics were under-utilized by World Health Organization (World Health Organization, 1986) standards, and that there were significant discrepancies between the patients' reports of the pain relief and their physicians' estimate of the pain control being achieved in these patients.

The survey instruments are based on ones used by Dr. Charles Cleeland and the Pain Research Group at the University of Wisconsin (Cleeland, 1986) and in the Eastern Cooperative Oncology Group. Patient and physician questionnaires for this study have been tested within the ECOG system (Cleeland, et al, 1994). The patient form is an adaptation of the Wisconsin Brief Pain Inventory (BPI)(Appendix A and B). It has been tested for reliability and validity on more than 1200 patients at the University of Wisconsin Comprehensive Cancer Center, Madison, Wisconsin (Daut, et al, 1983). The BPI demonstrated respectable test-retest item correlations over short time intervals. Evidence for validity comes from use of the BPI with cancer patients. Groups of patients who differed in presence or absence of metastases gave expected differences in rating of pain severity. As ratings of pain at its worst increased, so did ratings of pain interference with various activities. The proportion of patients receiving narcotic analgesics increased as pain ratings increased. Finally, the intercorrelations among the various pain measures differed in a logical way from one disease to another, suggesting that the BPI is sensitive to differences in pain characteristics associated with

different diseases.

The physician questionnaire is adapted from a similar survey that was administered to nurses. The survey was shortened and simplified. All changes were ones of form; no substantive changes were made. Patient self report using the BPI was correlated with the corresponding nurse assessments. The two were well correlated.

These forms have been validated in culturally-diverse groups and also in different language formats. The Spanish version, developed following a cross-translation method, has been validated in a multi-site study in Mexico and the Dominican Republic as part of a WHO demonstration project (Cleeland, 1989). The simple pain and interference scales of the BPI are robust across different language and cultural groups (Cleeland, 1988; Serlin, 1995).

The results of this study will be used in (a) the development of pain education programs tailored to minority patients at participating institutions, and (b) the examination of potential barriers to adequate minority pain treatment.

The objectives of this proposed study are: (a) To determine the proportions of patients with a cancer diagnosis who currently have pain, the types of pain control measures being utilized, and the physician and patient assessments as to the nature of the pain and whether it is in control.
(B) To assess the degree of discrepancy between minority patients and their physicians in estimates of pain and pain relief. and © To assess the adequacy of pain management in minority patients.

Study 002-Health Professionals' Attitudes Toward Cancer Pain Management

A previous study of pain management practice by Eastern Cooperative Oncology Group (ECOG) suggested some of the reasons that patients receive sub-standard pain treatment. In this group-wide study, 861 ECOG affiliated physicians completed a questionnaire designed to determine the knowledge of cancer pain management and methods of pain management they use (VonRoenn et al., 1993). Together, the responding physicians reported treating over 70,000 cancer patients in the last 6 months. Only 50% of these physicians felt that pain management was good or very good in their own practice setting. In addition, physicians treating cancer patients identified poor pain assessment as the primary barrier to optimal pain treatment in their own practice settings and patient reluctance to report pain as the second barrier (VonRoenn et al., 1993). A similar survey of nurses in the state of Wisconsin identified the top two barriers to optimal pain management as (1) patients' reluctance to report pain, and (2) inadequate assessment of pain (Vortherms et al., 1992). A survey of pharmacists in the state of North Carolina identified slightly different barriers to optimal pain management. The top two barriers identified by pharmacists were: (1) conservative prescribing patterns of physicians, and (2) conservative opioid administration patterns of nurses (Krick et al., 1994). Of the pharmacists surveyed, 29% frequently talk with cancer patients about their pain management, 54% frequently talk with families of cancer patients about pain management, and 48% have intervened when they believed a prescribed analgesic regimen was inappropriate. This strengthens the assertion that pharmacists have a large role in the management of cancer pain

Surveys of health professionals have identified barriers and provided insight into current pain management practice patterns. Since it has been documented that minority cancer patients are at a greater risk for undermanagement of pain, a survey of health professionals who treat this population should help in designing interventions specifically targeting minority cancer patients. We now propose to gather data on cancer pain management practice from a sample of physicians, nurses, and pharmacists who treat minority cancer patients of low socio-economic status (SES).

The overall objective of this current proposed study is aimed at determining the current pain management practice of physicians, nurses, and pharmacists treating minority cancer patients of low SES. The study will be a component of the sponsored project for the development of educational materials for African American and Hispanic cancer patients of low SES. It will document the current pain management practice at the three study sites, and will provide useful information for the development of these educational materials. Specific objectives include (a) To determine the knowledge of cancer pain and its treatment among physicians, nurses, and pharmacists treating minority patients with cancer of low SES at three sites. (b) To determine the methods of pain control being utilized at these three sites. © To determine the staff's perception of barriers to pain management at these three sites. and (d) To compare the knowledge and attitudes of staff at these three sites with the results of cancer pain treatment as reported by patients in the "Outpatient Needs Assessment Survey."

A shortened form of the Physician Cancer Pain Questionnaire developed by Charles S. Cleeland and the Pain Research Group at the University of Wisconsin will be utilized (Cleeland et al., 1986) (Appendix c). This questionnaire was the instrument used in a recent study of physicians in the Eastern Cooperative Oncology Group (VonRoenn et al., 1993). The questionnaire was designed to assess physicians' estimates of the magnitude of pain as a specific problem for cancer patients, physicians' attitudes about the adequacy of pain management for cancer pain, and their report of how they manage pain in their own practice setting. As a way of describing more specific pain management practice questions, they provided treatment recommendations for a patient presented in a scenario format. Information was also gathered on the physicians' practice setting, training, experience with caring for patients with cancer pain and personal experience with friends or family members with cancer, persistent pain or substance abuse. The shortened version of the survey takes about 10 minutes to complete.

Conclusions

The two studies that have been presented will be open for accrual in October 1995 and completed by December 1995. No data is yet available.

The control of pain is an important part of oncology patient management. In an effort to offer better pain control service to oncology patients a better understanding of the nature and extent of cancer pain is needed. The objective of Study 001 is to determine the current status of pain and pain management methods at participating institutions. In statistical terms one would want to obtain from the survey: (I) A reasonable assessment of patients and the control of their pain. (ii) An overall

assessment of patients with serious pain at participating institutions. and (iii) To identify the sites which may have unusual pain problems which are disproportionate to their numbers.

The analysis of the Study 001 will primarily be descriptive. Pain prevalence will be estimated using descriptive statistics. Prevalence according to gender, age and physician's estimation of cause of pain will be reported. Associations between physician and patient assessments of pain level, control and level of interference with the patients daily living will also be calculated.

Study 002 investigating staff knowledge will provide descriptive statistics (frequencies, percentages, means and ranges) for each response reported. Following VonRoenn, et al (1993), we will attempt to identify characteristics of physicians who may be more aggressive in cancer pain control. For the categorical variables, Fisher's exact test will be used to determine candidate variables that are significantly associated with time to start maximum tolerated opioid analgesic therapy (outcome). The association between continuous (c) predictors and outcome will be tested for significance by examining the log-likelihood ratio Chi-square statistic. Differences in mean rankings for barriers to pain control will be tested by means of the Mann-Whitney U-test. Univariate analyses (two-way associations will be used to initially scree out he predictors significantly associated with the outcome variable prognosis (less than 6 months vs greater that 6 months start maximum opioid analgesic therapy in the treatment of severe pain). The prognostic variables will be considered in a multiple logistic regression analysis using stepwise selection. For reporting purposes, data will be grouped so that no cell has fewer than five individuals to protect the anonymity of the respondents.

References

Bonica, J.J. Cancer Pain: A Major National Health Problem. Cancer Nursing J. 4:313-316, 1978.

Bonica, J.J. Cancer Pain. In: Bonica, J.J. ed. Pain, New York, Raven Press, 335-362, 1980.

Cleeland, C.S., Impact of Pain on the Patient with Cancer. Cancer 54:2635-2641, 1984.

Cleeland, C.S., *et al.* Factors Influencing Physician Management of Cancer Pain. Cancer 58:796-800, 1986.

Cleeland, C.S., Ladinsky, J., Serlin, R., Thuy, N. Multidimensional Measurement of Cancer Pain; Comparison of US and Vietnamese Patients. Journal of Pain and Symptom Management, 3:(1) 23-27, 1988.

Cleeland, C.S. Demonstration Projects for Cancer Pain Relief. In:Foley, K.M., Ventafredda V. (eds.), Proceedings of the Second International Congress on Cancer Pain, New York, Raven Press, 465-73, 1989.

Cleeland, C.S., Gonin, R., Hatfield, A.K., Pandya, K.J. Pain and its treatment in outpatients with matastatic cancer. New England Journal of Medicine, 330(9):592-596, 1994.

Daut, R.L., Cleeland, C.S., Flanery, R.C. Development of the Wisconsin Brief Pain Questionnaire to Assess Pain in Cancer and Other Diseases. Pain, 17:197-210, 1983.

Freeman H.P. and Wasfie T.J. Cancer of the breast in poor black women. Cancer, 63(12): 2562-2569.

Foley, K.M. The treatment of cancer pain. New England Journal of Medicine, 313(2): 84-95.

Foley, K.M. Cancer Pain Syndromes. Journal of Pain and Symptom Management, 2:13-17, 1987.

Krick S.E., Lindley C.M. and Bennet M. Pharmacy-perceived barriers to cancer pain control: results of the North Carolina Cancer Pain Initiative Pharmacist Survey. Annals of Pharmacotherapy, 28:121-126, 1993.

McGivrey, W.T., Crooks, G.M. The Care of Patients with Severe Chronic Pain in Terminal Illness. JAMA, 251:1182-1188, 1984.

Serlin R.C. Mendoza T.R., Nakamura Y., Edwards K.R. Cleeland C.S., When is Cancer Pain Mild, Moderate or Severe? Grading pain Severity by its Interference with Function, Pain 61:287-284, 1995.

VonRoenn, J.H., Cleeland, C.S., Gonin, R., Hatfield, A.K., Pandya, K.J. Physician attitudes and prictice in cancer pain management: A survey from the Eastern Cooperative Oncology Group. Annals of Internal Medicine 119(2):121-126, 1993.

Vortherms R., Ryan P. And Ward S.E. Knowledge of , attitudes toward, and barriers to pharmacologic managemnt of cancer pain in a statewide random sample of nurses. Research in Nursing and Health 15: 459-466, 1992.

World Health Organization. Cancer Pain Relief. Geneva, 1986.

The Brief Pain Inventory

Pain Research Group
Department of Neurology
University of Wisconsin - Madison
Medical School

Revised 7/95

PROTOCOL # _____ INSTITUTION _____

PATIENT SEQUENCE # _____ HOSPITAL CHART # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory

Date: ___/___/___

Name: _____ _____ _____

Last First Middle Initial

Phone: (___) _____ Sex: ☐ Female ☐ Male

Date of Birth: ___/___/___

1) Marital Status (at present)

1. ☐ Single
2. ☐ Married
3. ☐ Widowed
4. ☐ Separated/Divorced

2) Education (Circle only the highest grade or degree completed)

Grade	0	1	2	3	4	5	6	7	8	9
	10	11	12	13	14	15	16	M.A./M.S.		

Professional degree (please specify) _____

3) Current occupation _____

(specify titles; if you are not working, tell us your previous occupation)

4) Spouse's occupation _____

5) Which of the following best describes your current job status?

1. ☐ Employed outside the home, full-time
2. ☐ Employed outside the home, part-time
3. ☐ Homemaker
4. ☐ Retired
5. ☐ Unemployed
6. ☐ Other

6) How long has it been since you first learned your diagnosis? _____ months

7) Have you ever had pain due to your present disease?

1. ☐ Yes
2. ☐ No
3. ☐ Uncertain

8) When you first received your diagnosis, was pain one of your symptoms?

1. ☐ Yes 2. ☐ No 3. ☐ Uncertain

9) Have you had surgery in the past month? 1. ☐ Yes 2. ☐ No

If YES, what kind? _____

10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week?

1. ☐ Yes 2. ☐ No

10a) Did you take pain medications in the last 7 days?

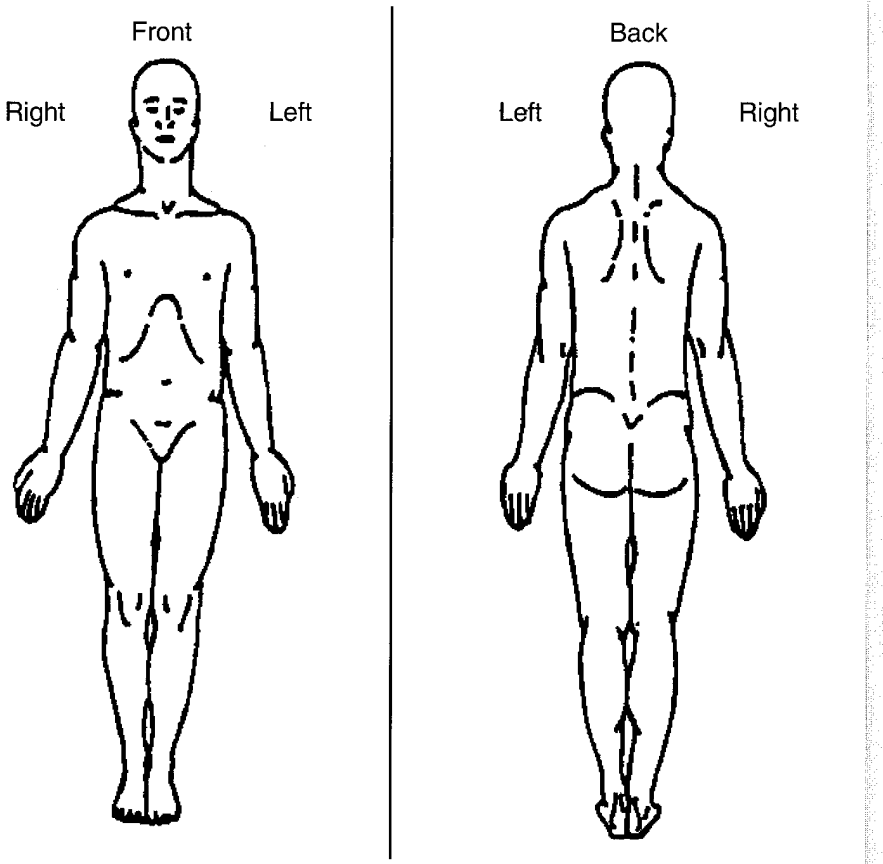
1. ☐ Yes 2. ☐ No

10b) I feel I have some form of pain now that requires medication each and every day.

1. ☐ Yes 2. ☐ No

IF YOUR ANSWERS TO 10, 10a, AND 10b WERE ALL NO, PLEASE STOP HERE AND GO TO THE LAST PAGE OF THE QUESTIONNAIRE AND SIGN WHERE INDICATED ON THE BOTTOM OF THE PAGE.
IF ANY OF YOUR ANSWERS TO 10, 10a, AND 10b WERE YES, PLEASE CONTINUE.

11) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



12) Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

13) Please rate your pain by circling the one number that best describes your pain at its least in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

14) Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

15) Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

16) What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

17) What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

18) What treatments or medications are you receiving for pain?

_____

_____

19) In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

20) If you take pain medication, how many hours does it take before the pain returns?

1. ☐ Pain medication doesn't help at all
2. ☐ One hour
3. ☐ Two hours
4. ☐ Three hours
5. ☐ Four hours
6. ☐ Five to twelve hours
7. ☐ More than twelve hours
8. ☐ I do not take pain medication

21) Check the appropriate answer for each item.
I believe my pain is due to:

☐ Yes ☐ No 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).
☐ Yes ☐ No 2. My primary disease (meaning the disease currently being treated and evaluated).
☐ Yes ☐ No 3. A medical condition unrelated to my primary disease (for example, arthritis).
Please describe condition: _____

22) For each of the following words, check Yes or No if that adjective applies to your pain.

Aching	☐ Yes	☐ No
Throbbing	☐ Yes	☐ No
Shooting	☐ Yes	☐ No
Stabbing	☐ Yes	☐ No
Gnawing	☐ Yes	☐ No
Sharp	☐ Yes	☐ No
Tender	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Exhausting	☐ Yes	☐ No
Tiring	☐ Yes	☐ No
Penetrating	☐ Yes	☐ No
Nagging	☐ Yes	☐ No
Numb	☐ Yes	☐ No
Miserable	☐ Yes	☐ No
Unbearable	☐ Yes	☐ No

23) Circle the one number that describes how, during the past week, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

24) I prefer to take my pain medicine:

1. ☐ On a regular basis
2. ☐ Only when necessary
3. ☐ Do not take pain medicine

25) I take my pain medicine (in a 24 hour period):

1. ☐ Not every day
2. ☐ 1 to 2 times per day
3. ☐ 3 to 4 times per day
4. ☐ 5 to 6 times per day
5. ☐ More than 6 times per day

26) Do you feel you need a stronger type of pain medication?

1. ☐ Yes
2. ☐ No
3. ☐ Uncertain

27) Do you feel you need to take more of the pain medication than your doctor has prescribed?

1. ☐ Yes
2. ☐ No
3. ☐ Uncertain

28) Are you concerned that you use too much pain medication?

1. ☐ Yes
2. ☐ No
3. ☐ Uncertain

If Yes, why? _____

_____

29) Are you having problems with side effects from your pain medication?

1. ☐ Yes
2. ☐ No

Which side effects? _____

30) Do you feel you need to receive further information about your pain medication?

1. ☐ Yes
2. ☐ No

31) Other methods I use to relieve my pain include: (Please check all that apply)

Warm compresses ☐ Cold compresses ☐ Relaxation techniques ☐

Distraction ☐ Biofeedback ☐ Hypnosis ☐

Other ☐ Please specify _____

32) Medications not prescribed by my doctor that I take for pain are:

_____

_____

33) During the past week, have you made any unplanned or emergency visits to a health care facility or other facility specifically due to unrelieved pain?

1. ☐ Yes 2. ☐ No

33a) If YES, please list the number of times you sought care at each of the facilities listed below:

Hospital Emergency Room _____
Hospital Clinic _____
Urgent Care or Walk-In Clinic _____
Doctor's Office _____
Pharmacy _____
Store (SuperMarket, etc.) _____
Other _____ (Please Specify:) _____

33b) Did these unplanned or emergency visits relieve your pain?

1. ☐ Yes 2. ☐ No

Patient's Signature _____

Thank you for your participation.

Cuestionario Breve Para La Evaluación Del Dolor

Pain Research Group
Department of Neurology
University of Wisconsin - Madison
Medical School

Revised 7/95

PROTOCOL # _____ INSTITUTION _____

PATIENT SEQUENCE # _____ HOSPITAL CHART # _____ _____

NO ESCRIBA SOBRE ESTA LINEA

Cuestionario Breve Para La Evaluación Del Dolor

Fecha: ___/___/___

Apellido: _____ **Nombre:** _____

Teléfono: ( ) _____ **Sexo:** ☐ Femenino ☐ Masculino

Fecha de Nacimiento: ___/___/___

1) Estado Civil (actual)

1. ☐ Soltero(a)
2. ☐ Casado(a)
3. ☐ Viudo(a)
4. ☐ Separado(a)/Divorciado(a)

2) Educación (Marque con un círculo el máximo nivel de estudios que haya alcanzado)

Grado/Curso Escolar 0 1 2 3 4 5 6 7 8 9

10 11 12 13 14 15 16 Maestría.

Título obtenido (por favor, especifique) _____

3) Ocupación actual
(Especifique la posición; si actualmente no trabaja, indique su última ocupación)

4) Actividad de su esposo(a) _____

5) ¿Cuál de las siguientes definiciones se adapta mejor a su ocupación actual?

1. ☐ Empleado fuera de casa de tiempo completo
2. ☐ Empleado fuera de casa de tiempo parcial
3. ☐ Labores de la casa
4. ☐ Jubilado(a)
5. ☐ Desempleado(a)
6. ☐ Otro

6) ¿Cuánto tiempo hace que sabe el diagnóstico de su enfermedad? _____ **meses**

7) ¿Ha tenido dolor a causa de su enfermedad actual?

1. ☐ Sí
2. ☐ No
3. ☐ No estoy seguro(a)

8) ¿Era el dolor uno de los síntomas cuando se hizo el diagnóstico de su enfermedad?

1. ☐ Sí 2. ☐ No 3. ☐ No estoy seguro(a)

9) ¿Tuvo alguna intervención quirúrgica en el mes pasado? 1. ☐ Sí 2. ☐ No

Si su respuesta fue Sí, ¿qué clase de cirugía? _____

10) Todos hemos tenido dolor alguna vez en nuestra vida (por ejemplo, dolor de cabeza, contusiones, dolores de dientes). ¿En la última semana, ha sentido un dolor distinto a estos dolores comunes?

1. ☐ Sí 2. ☐ No

10a) ¿Ha tomado usted medicamentos en los últimos 7 días?

1. ☐ Sí 2. ☐ No

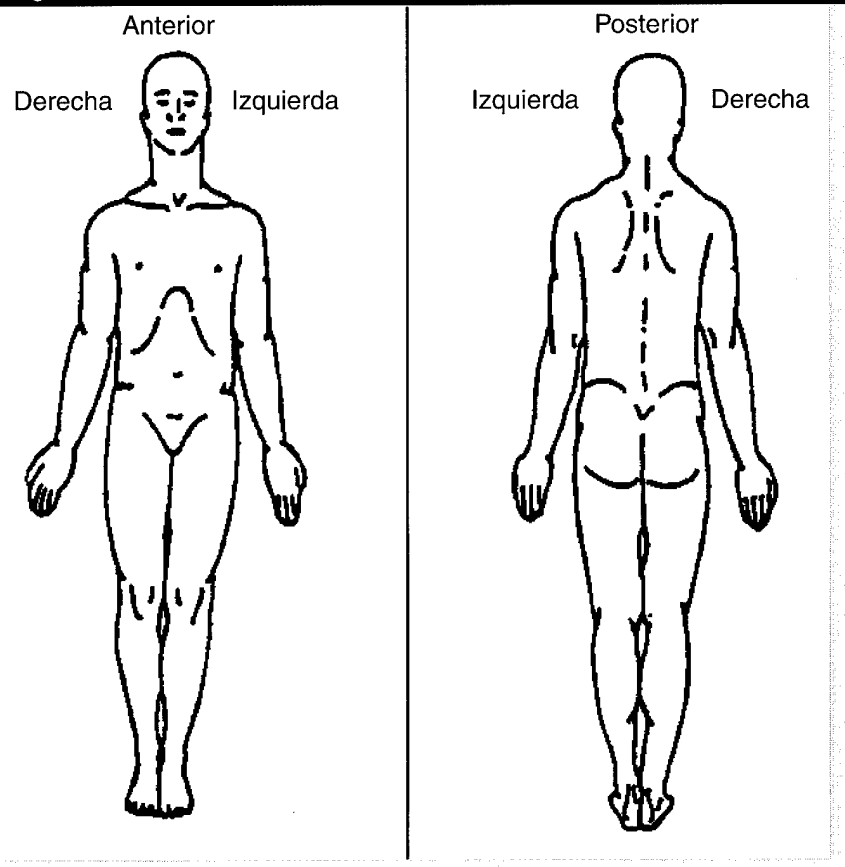
10b) Siento que ahora tengo alguna forma de dolor que requiere medicamentos cada día.

1. ☐ Sí 2. ☐ No

Si sus respuestas a las preguntas 10, 10a, y 10b fueron todas No, POR FAVOR PARE AQUI y pase a la última pagina del cuestionario y firme donde se indica, en la parte de abajo de la página.

Si alguna de sus respuestas a las preguntas 10, 10a, y 10b fue Sí, POR FAVOR, CONTINUE.

11) Indique en el dibujo, con un lápiz, donde siente el dolor. Indique con una "X" la parte del cuerpo en la cual el dolor es más grave.



12) Clasifique su dolor haciendo un círculo alrededor del número que mejor describe la intensidad máxima de dolor sentido en la última semana.

0	1	2	3	4	5	6	7	8	9	10
Ningún Dolor										El Peor Dolor Imaginable

13) Clasifique su dolor haciendo un círculo alrededor del número que mejor describe la intensidad mínima de dolor sentido en la última semana.

0	1	2	3	4	5	6	7	8	9	10
Ningún Dolor										El Peor Dolor Imaginable

14) Clasifique su dolor haciendo un círculo alrededor del número que mejor describe la intensidad media de dolor sentido en la última semana.

0	1	2	3	4	5	6	7	8	9	10
Ningún Dolor										El Peor Dolor Imaginable

15) Clasifique su dolor haciendo un círculo alrededor del número que mejor describe la intensidad de su dolor actual.

0	1	2	3	4	5	6	7	8	9	10
Ningún Dolor										El Peor Dolor Imaginable

16) ¿Qué cosas alivian su dolor (calor, reposo, medicamento, etc.)?

_____

_____

17) ¿Qué cosas empeoran su dolor (por ejemplo, caminar, estar de pie, levantar peso)?

_____

_____

18) ¿Qué tratamiento o medicamento recibe para su dolor?

_____

_____

19) En la última semana, ¿cuánto alivio ha sentido con el tratamiento o con el medicamento? Indique con un círculo el porcentaje que mejor se adapta a su alivio.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Ningún Alivio										Alivio Total

20) Si usted toma un medicamento, ¿cuántas horas pasan antes de que vuelve a sentir dolor?

1. ☐ El medicamento no alivia nada
2. ☐ Una hora
3. ☐ Dos horas
4. ☐ Tres horas
5. ☐ Cuatro horas
6. ☐ Cinco a doce horas
7. ☐ Más de doce horas
8. ☐ No tomo medicamentos para el dolor

21) Por favor, verifique la respuesta adecuada a cada una de las siguientes secciones. Creo que mi dolor se debe a:

☐ Sí ☐ No 1. Los efectos de tratamiento para mi cáncer (por ejemplo, medicamentos, cirugía, irradiación, dispositivo prostático)

☐ Sí ☐ No 2. Mi enfermedad principal (es decir, la enfermedad que en la actualidad está siendo tratada y evaluada

☐ Sí ☐ No 3. Una condición médica no relacionada a la enfermedad principal (por ejemplo, artritis).
Describa dicha condición: _____

22) Para cada una de la siguientes palabras, marque Sí o No si el adjectivo describe su dolor.

Continuo	☐ Sí	☐ No
Palpitante	☐ Sí	☐ No
Difuso	☐ Sí	☐ No
Punzante	☐ Sí	☐ No
Como Calambre	☐ Sí	☐ No
Agudo	☐ Sí	☐ No
Sensible al Tacto	☐ Sí	☐ No
Quemante	☐ Sí	☐ No
Agotador	☐ Sí	☐ No
Fatigador	☐ Sí	☐ No
Penetrante	☐ Sí	☐ No
Fastidioso	☐ Sí	☐ No
Sordo	☐ Sí	☐ No
Miserable	☐ Sí	☐ No
Insoportable	☐ Sí	☐ No

23) Haga un círculo alrededor del número que mejor describe la manera en que el dolor ha interferido, durante la última semana, con su:

A. Actividad en general

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

B. Estado de ánimo

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

C. Capacidad de caminar

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

D. Trabajo normal (ya sea en casa o afuera)

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

E. Relaciones con otras personas

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

F. Sueño

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

G.Capacidad de diversión

0	1	2	3	4	5	6	7	8	9	10
No Interfiere										Interfiere por Completo

24) Prefiero tomar mi medicamento para el dolor:

1. ☐ Regularmente
2. ☐ Sólo cuando es necesario
3. ☐ No tomo medicamento para el dolor

25) Tomo mi medicamento para el dolor (en un período de 24 horas):

1. ☐ No todos los días
2. ☐ 1 a 2 veces al día
3. ☐ 3 a 4 veces al día
4. ☐ 5 a 6 veces al día
5. ☐ Más de 6 veces al día

26) ¿Cree usted que necesita un tipo de medicamento más fuerte?

1. ☐ Sí
2. ☐ No
3. ☐ Inseguro(a)

27) ¿Cree usted que necesita tomar más medicamentos para el dolor de los que su médico le ha recetado?

1. ☐ Sí
2. ☐ No
3. ☐ Inseguro(a)

28) ¿Le preocupa estar usando demasiados medicamentos para el dolor?

1. ☐ Sí
2. ☐ No
3. ☐ Inseguro(a)

Si su respuesta fue Sí, explique por qué _____

_____

29) ¿Tiene usted problemas con los efectos secundarios derivados de sus medicamentos para el dolor?

1. ☐ Sí
2. ☐ No

¿Cuáles efectos secundarios? _____

30) ¿Cree usted que necesita recibir información adicional sobre sus medicamentos para el dolor?

1. ☐ Sí
2. ☐ No

31) Otros métodos que uso para aliviar mi dolor incluyen: (por favor, marque todos los que correspondan)

Compresas calientes ☐ Compresas frías ☐ Técnicas de relajamiento

Distracción ☐ Retroalimentación biológica ☐ Hipnosis

Si hay otra causa ☐ Especifique _____

32) Los medicamentos que tomo que no son recetados por mi médico, son:

_____

_____

33) ¿En la última semana, ha tenido usted que acudir a un centro de salud o algún otro sitio de forma no planeada o de emergencia debido especificamente a algún dolor no aliviado?

1. ☐ Sí 2. ☐ No

33a) Si su respuesta fue Sí, indique por favor cuántas veces solicitó atención en cada uno de los lugares mencionados a continuación:

Sala de emergencia de un hospital _____
Clínica hospitalaria _____
Tratamiento clínico inmediato
o clínica ambulatoria (no se requiere cita) _____
Consultario médico _____
Farmacia _____
Tienda (Supermercado, etc.) _____
Otro _____
(Especifique por favor:) _____
_____
_____

33b) ¿Encontró alivio a su dolor mediante estas visitas no planeadas o emergencias?

1. ☐ Sí 2. ☐ No

Firma del Paciente _____

Gracias por su participación.

UNIVERSITY OF
WISCONSIN
MADISON

PAIN RESEARCH GROUP

Clinic Staff Survey of Cancer Pain Management

We hope that you will take a few minutes to complete this survey.

The Pain Research Group (PRG) at the University of Wisconsin is currently serving as the Coordinating Center for a four year collaborative project with your hospital. The focus of this project is to develop educational materials about cancer pain and its management for minority patients of low socio-economic status. In order to achieve this goal, it is important to know the current status of cancer pain management in your setting from your perspective.

The Clinic Staff Survey of Cancer Pain Management questionnaire takes approximately 10 minutes to complete. We realize that it is impossible for multiple choice responses to accurately reflect the complexity of the questions being asked. However, to ensure concise statistical analysis, we are asking you to select the option that most closely approaches your response. All data collected will be used solely for PRG pain research. All information will remain ANONYMOUS AND STRICTLY CONFIDENTIAL during and following this project.

Please return the completed survey to the Pain Research Group using the postage-paid envelope provided.

Thank you for your support of this research.

Clinic Staff Survey of Cancer Pain Management

UNIVERSITY OF
WISCONSIN
MADISON

PAIN RESEARCH GROUP

Date this form completed _____/____/____

Please circle your responses to the following questions:

1. What percentage of cancer patients do you think suffer pain at some point during their illness?

   0 10 20 30 40 50 60 70 80 90 100%

2. What percentage of cancer patients do you think suffer pain for longer than one month?

   0 10 20 30 40 50 60 70 80 90 100%

3. In comparisons to your professional peers as a group, how conservative or liberal are you concerning the use of analgesic medications for cancer patients?

   a) MUCH MORE CONSERVATIVE
   b) SOMEWHAT MORE CONSERVATIVE
   c) NO MORE CONSERVATIVE OR LIBERAL
   d) SOMEWHAT MORE LIBERAL
   e) MUCH MORE LIBERAL

4. How good a job do you think staff in your setting do in relieving cancer pain?

   a) A VERY POOR JOB
   b) A POOR JOB
   c) A FAIR JOB
   d) A GOOD JOB
   e) A VERY GOOD JOB

Please circle your responses to the following questions:

5. The degree of all but one of the following side effects will decrease after repeated administration of narcotic pain-relieving medication. Which side effect will not decrease?

   a) SEDATION
   b) NAUSEA
   c) CONSTIPATION
   d) RESPIRATORY DISTRESS
   e) I DON'T KNOW

6. The most likely explanation for why a terminal cancer patient would request greatly increased doses of pain medication is:

   a) THE PATIENT IS EXPERIENCING INCREASED PAIN
   b) THE PATIENT IS EXPERIENCING INCREASED ANXIETY
   c) THE PATIENT IS EXPERIENCING INCREASED DEPRESSION
   d) THE PATIENT IS REQUESTING MORE STAFF ATTENTION
   e) THE PATIENT'S REQUESTS ARE RELATED TO ADDICTION
   f) OTHER, specify _____

7. Which of the following statements best describe the use of an analgesic medication for cancer pain in your practice setting?

   a) THE MAJORITY OF PATIENTS ARE OVER-MEDICATED
   b) MOST PATIENTS RECEIVE ADEQUATE TREATMENT FOR PAIN
   c) THE MAJORITY OF PATIENTS IN PAIN ARE UNDER-MEDICATED

Based upon your knowledge and experience, what analgesic medication do you recommend in the treatment of PROLONGED MODERATE TO SEVERE PAIN for cancer patients. Please **rank your top 5 recommendations** in order of preference with 1 being the most preferred.

_____a) ASPIRIN / ACETAMINOPHEN

_____b) BROMPTON'S COCKTAIL

_____c) CODEINE

_____d) HYDROMORPHONE (Dilaudid)

_____e) LEVORPHANOL (Levo Dromoran)

_____f) MEPERIDINE (Demerol)

_____g) METHADONE

_____h) MORPHINE SULFATE (immediate release)

_____I) MORPHINE SULFATE (sustained release tablets)

_____j) MORPHINE SULFATE SUPPOSITORIES

_____k) NUMORPHAN SUPPOSITORIES

_____l) HYDROMORPHONE SUPPOSITORIES

_____m) ASPIRIN / ACETAMINOPHEN OXYCODONE COMBINATION (Percodan, Percocet)

_____n) PENTAZOCINE (Talwin)

_____o) NSAIDS (Ibuprofen, Toradol)

_____p) FENTANYL (transdermal)

_____q) HYDROCODONE

_____r) BUPRENORPHINE

_____s) OXYCODONE

The following questions refer to your opinions and practices regarding the use of analgesic medications in treating cancer pain and nonmalignant chronic pain. Make your responses on the basis of your knowledge and experiences.

8. A 40-year old male cancer patient is hospitalized with severe untreated back pain of more than 1 month duration, attributable to bone metastases without vertebral collapse. He weighs 70 kg., has no cardiovascular or respiratory problems, and has a disease prognosis of more than 24 months. He has no history of medication allergies and is opiate naive. What would be your recommendation for initial pain management regimen for this patient?

DRUG	ROUTE	DOSAGE REGIMEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. It is noted that this cancer patient continues to report back pain after a course of radiation therapy. The patient's disease status remains stable. There are no signs of complication, and he is having no side effects from the medication. What is the most aggressive analgesic drug regimen that you would recommend?

DRUG	ROUTE	DOSAGE REGIMEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle your responses to the following questions:

10. The PRIMARY reason for not prescribing more medication than indicated in your previous answer (see question 10) is?

    a) THE POSSIBILITY OF ADDICTION

    b) THE POSSIBILITY OF SIDE EFFECTS (e.g. respiratory depression, sedation)

    c) LARGER DOSES ARE NO MORE EFFECTIVE

    d) CONCERN FOR BUILDING PATIENT'S TOLERANCE TOO RAPIDLY

11. At what stage in the disease of the patient previously described would you recommend maximum, tolerated narcotic analgesic therapy for treatment of severe pain? Assume that this patient desires to remain alert.

    a) PROGNOSIS OF LESS THAN 24 MONTHS

    b) PROGNOSIS OF LESS THAN 18 MONTHS

    c) PROGNOSIS OF LESS THAN 12 MONTHS

    d) PROGNOSIS OF LESS THAN 6 MONTHS

    e) PROGNOSIS OF LESS THAN 3 MONTHS

    f) PROGNOSIS OF LESS THAN 1 MONTH

    g) PROGNOSIS OF LESS THAN 1 WEEK

12. The following is a list of potential barriers to optimal cancer pain management. Please **rank** all of the following (1=greatest barrier, 13=least barrier) in terms of how they might impede cancer pain management in your setting.

_____a) PATIENT RELUCTANCE TO REPORT PAIN

_____b) PATIENT RELUCTANCE TO TAKE OPIATES

_____c) MEDICAL STAFF RELUCTANCE TO PRESCRIBE OPIATES

_____d) NURSING STAFF RELUCTANCE TO ADMINISTER OPIATES

_____e) EXCESSIVE STATE REGULATION OF PRESCRIBING ANALGESICS

_____f) INADEQUATE ASSESSMENT OF PAIN AND PAIN RELIEF

_____g) INADEQUATE STAFF KNOWLEDGE OF PAIN MANAGEMENT

_____h) LACK OF AVAILABLE NEURO DESTRUCTIVE PROCEDURES

_____I) LACK OF PSYCHOLOGICAL SUPPORT SERVICES

_____j) LACK OF ACCESS TO A WIDE RANGE OF ANALGESICS

_____k) LACK OF EQUIPMENT OR SKILLS

_____l) LACK OF ACCESS TO PROFESSIONALS WHO PRACTICE SPECIALIZED METHODS

_____m) PATIENT INABILITY TO PAY FOR SERVICES FOR ANALGESICS

_____n) LACK OF STAFF TIME TO ATTEND TO PATIENTS' PAIN NEEDS

_____o) TOO MUCH PAPER WORK

13. Please list any other potential barriers to optimal cancer pain management in your setting that you can think of:

_____

_____

_____

_____

PROFESSIONAL BACKGROUND

This final set of questions is directed toward collecting important background information on individuals completing this questionnaire and will remain completely confidential.

14. Adequacy of training in cancer pain management:

a) POOR
b) FAIR
c) GOOD
d) EXCELLENT

15. What is the total number of cancer patients that you have cared for during the past 6 months?

a) NONE
b) LESS THAN 20
c) 20 - 50
d) 50 - 100
e) MORE THAN 100

16. What percentage of these cancer patients have had pain that lasted more than one month?

0 10 20 30 40 50 60 70 80 90 100%

17. What percentage of the cancer patients that you have cared for in the past 6 months are members of an ethnic or racial minority group?

0 10 20 30 40 50 60 70 80 90 100%

PERSONAL DATA

18. Your age _____ (years)

19. Your gender

a) MALE
b) FEMALE

20. Your race

a) ASIAN OR PACIFIC ISLANDER
b) BLACK
c) NATIVE AMERICAN OR ALASKAN NATIVE
d) WHITE

21. Your ethnicity

a) HISPANIC ORIGIN
b) NOT OF HISPANIC ORIGIN

THANK YOU FOR YOUR PARTICIPATION