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The role of the patient in the multidisciplinary team

Pete Moore

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5th meeting June 2011

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The CHANGE PAIN group is committed to develop solutions to improve patient outcomes. In June 2011, the International CHANGE PAIN Advisory Panel held its 5th meeting, with the aim of understanding chronic pain from different perspectives and ultimately leading to the implementation of a more effective approach to the management of chronic pain.

At this meeting the results from the period 2009-2010 of the international Physician survey were analysed. This survey was undertaken to understand how physicians from different disciplines perceive chronic non-cancer pain and to examine their opinions on current treatment options. The results of this survey clearly showed that pain reduction and improvement in quality of life are the major goals to be achieved. However, at present there seems to be little consensus on the best approach to the treatment of chronic pain and there are some differences among primary care physicians and specialists.

No doubt, multidisciplinary management of chronic pain offers benefits to patients by involving a core team of individual healthcare professionals capable of assessing and treating all the different aspects and consequences of chronic pain. But availability and general access to optimum pain treatment options also strongly depend on the given structures and patient pathways within the respective public health system. Various legislative procedures are changing the way in which public health systems function. Proposed changes in the National Health Service in the UK, for example, will give greater responsibility to General Practitioners who will be required to take a more active role in commissioning treatment for chronic pain patients. Finally, decisions for secondary care should become more evidence-based resulting ultimately in better pain management and outcome for patients.

Last but not least, as outlined in this issue, patients who are in chronic pain may further benefit from taking an active part in their own referral and treatment. Tools like the Pain toolkit, which was developed by Pete Moore and has been supported by the CHANGE PAIN® initiative, are designed to improve the management of chronic pain by taking into account the patients’ perspective of the treatment process.

FOREWORD

Professor Hans Georg Kress
President of the European Federation of IASP Chapters (EFIC)
Traditionally, the definition of chronic pain was solely based on duration, generally referring to pain which has persisted for more than 12 weeks or beyond the expected period of healing after trauma or surgery. Although duration is an important element of chronic pain, this definition fails to take into account the multidimensional nature of chronic pain, which may include both nociceptive and neuropathic components. Chronic pain sufferers frequently have an increased prevalence of comorbidities such as anxiety, depression and decreased physical and mental functioning, profoundly impacting on the quality of patient’s social and working lives.

The biopsychosocial model of chronic pain recognises the condition as a combination of physical dysfunction, beliefs and coping strategies, distress, illness behaviour and social interactions. Hence long-term management of chronic pain requires the use of a range of specialist treatments, not only aimed at effectively reducing pain, but also improving psychological wellbeing and preventing secondary dysfunction. This is best achieved through the use of an integrated pain management strategy combining multiple treatment modalities.

The core multidisciplinary team
Effective multidisciplinary management of chronic pain requires a core team of individual health professionals capable of assessing and treating all the conditions which arise as a consequence of chronic pain. The primary care physician will be the first point of contact for most patients. It is important that there is an effective communication between the physician and patient so that the physician can fully understand the patient’s condition and refer the patient for further assessment and treatment if necessary. The CHANGE PAIN® Scale, a user-friendly communication tool designed to assess pain more holistically, may be employed in this instance to help the physician appreciate the patient’s expectations of pain relief and quality of life improvement. Following referral for specialist care, typically the core members of the team will come from a range of medical specialities related to either the cause of the pain or the associated conditions which arise as a consequence of the pain.

The primary care provider will need accurate feedback from the specialists as he will be responsible for the ongoing management of the patient’s overall care.

Secondary pain care referral
Not all patients with chronic pain conditions will require multidisciplinary care, however if a patient has failed to respond to conventional treatment or the diagnosis is unclear a referral to specialist care will normally be made. At present a lack of good clinical prediction rules means that primary care physicians are often unclear as to whether a patient should be referred. Under-referral may result in patients being diagnosed too late for effective treatment, whereas over-referral places a strain on secondary care resources.

Once a decision for referral to secondary care has been made the patient will be entered into a pain programme model offering specialist treatment approaches tailored for the management of chronic pain. The type of model implemented will depend on the specific needs of the patient, and the available resources. Syndrome-orientated clinics may also be available for certain conditions such as headaches.
or low back pain. Requiring the fewest resources, unidisciplinary pain practices are most commonly used involving a single consultant in an outpatient clinic setting. The focus of treatment and management of pain in this setting will be according to the discipline chosen. If further issues arise patients may then be forwarded to a multidisciplinary program where the goal will not only be pain relief but also the treatment of any associated conditions, either physical or psychological.

**Benefits for the patient**

Being included within a team of healthcare professionals with a wide range of medical specialities gives the patient access to different treatment modalities. An individualised pain management plan is normally initiated more rapidly than it would be in a primary care situation and any failure in treatment is also more likely to be recognised at an early stage. Specialist physicians are able to suggest more up to date, evidence based treatment and may be able to enrol patients in on-going research programmes and trials. Chronic pain multidisciplinary programs have been shown to reduce the negative impact on pain on work productivity. Patients being treated in this way were found to be two-fold more likely to return to work than untreated patients or single-discipline patients³.

**Achieving integrated patient care**

There are a number of factors that may restrict referral to multidisciplinary pain management team and there is a clear need for guidelines to be developed to aid in this process. Continuing medical education (CME) can increase healthcare professionals’ knowledge of chronic pain and the underlying pain mechanisms allowing them to make a more informed decision. A wide range of CME materials are available as part of the CHANGE PAIN® initiative to help in this respect. There may also be budgetary and waiting time factors that need to be considered. A greater awareness among relevant authorities, budget-holders and policy makers is needed if we are to progress to integrated patient care. Although there will be considerable set-up costs in the short term, wider adoption of integrated care should bring long term economic benefits in reducing the high number of work disability days caused by chronic pain.

**References**


**COMMENTARY**

Professor Bart Morlion, Leuven Centre of Algology and Pain Management, University Hospitals Leuven, Belgium

The multifactorial nature of chronic pain indicates that a multidisciplinary approach is required in order to achieve effective pain management. The success of this approach is dependent on effective three-way communication between the patient, primary care physician and specialist so that all are fully aware of the progress of the pain management plan that has been implemented. The CHANGE PAIN® international advisory board has developed “Towards a multidisciplinary team approach in chronic pain management” which is now available online at www.change-pain.com. This practical pocket guide aims to introduce the complexity of the topic from an international perspective and gives guidance on important aspects to consider in setting up a multidisciplinary team.
Many national and international guidelines have been developed for the treatment of chronic pain, the more recent ones taking into account the importance of considering the underlying pain mechanisms involved. However, there remains a lack of consensus as to what constitutes the best practice in the management of chronic pain. Lack of knowledge, shortage of time, and disagreement or confusion with guidelines, are all factors which influence treatment choice. This lack of consensus is shown by the huge variations seen in the consumption of analgesics in different European countries, both in terms of the quantity and the specific agents prescribed. This indicates that the chosen therapy is highly dependent on geographical location and may be influenced by cultural and legislative considerations.

In order to understand how physicians from different disciplines perceive chronic non-cancer pain and to examine their opinions on current treatment options, the CHANGE PAIN® initiative began an international survey. Started in September 2009, one relevant part of the survey was to investigate if different groups of healthcare professionals – pain specialists, primary care physicians and other specialists (such as neurologists, palliative care specialist, and rheumatologists) differ in their approach to treating chronic pain.

The CHANGE PAIN® survey
This computer-based survey takes the form of a questionnaire which is completed by participants mostly at professional conferences, but also online at www.change-pain.com and other local CHANGE PAIN® websites. Between September 2009 and December 2010 a total of 2,919 physicians, of whom 2,683 were from Europe, have participated. Of these, 1,398 (48%) were pain specialists, 629 (22%) were primary care physicians, and 892 (31%) were other specialists.

Treatment goals
When participants were asked to identify above which point on an 11-point Numerical Rating Scale (NRS; 0 = no pain, 10 = worst pain imaginable) pain should be regarded as severe, answers differed however, with a large majority (86%) considering the threshold to be between 5 and 8. When questioned, 66.2% of physicians in this survey aimed to reduce the intensity of pain to an NRS score of 2 to 4, the percentage varying only slightly between the physician groups. There was a tendency for primary care physicians to aim for lower scores than the other two groups; 25.1% aimed for a score of 2, compared to 18.5% of pain specialists and 17% of other specialists.

Choice of analgesic agent
Questions regarding the choice of analgesic for a patient with severe, chronic non-cancer pain revealed that efficacy was the main consideration being chosen by 57.1% of the participants, with efficacy/side effect balance chosen by 26.5% and quality of life by 7.8%. Tolerability and quality of life were most frequently ranked second and third respectively. Of note was the fact that efficacy/side effect balance of an analgesic was considered more

COMMENTARY
Dr Gerhard H.H. Müller-Schwefe, President of the German Association for Pain Therapy (DGS), Germany

These results are based on a first analysis of the survey sample of already close to 3000 physicians. As the number of participants increases the results should provide further clarification of physicians’ clinical practice and opinions. Ultimately, the goal is to be able to draw firm conclusions as to what constitutes best practice in pain management, and to disseminate this knowledge as widely as possible throughout the medical community. A higher number of participants will also allow us to compare country-specific differences.
FACTORS LIMITING TREATMENT WITH OPIOIDS CITED BY THE DIFFERENT PHYSICIAN GROUPS

<table>
<thead>
<tr>
<th>Pain Specialists</th>
<th>Primary Care Physicians</th>
<th>Other Specialists</th>
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</thead>
<tbody>
<tr>
<td><strong>Lack of Efficacy</strong></td>
<td>7.8%</td>
<td>11.1%</td>
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<tr>
<td><strong>Tolerance Development</strong></td>
<td>16.8%</td>
<td>21.5%</td>
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<tr>
<td><strong>Nausea / Vomiting</strong></td>
<td>39.8%</td>
<td>27.7%</td>
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<td><strong>Dysfunction</strong></td>
<td>28.8%</td>
<td>31.2%</td>
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<td><strong>Dizziness</strong></td>
<td>29.8%</td>
<td>33.8%</td>
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The use of combination therapy
As chronic pain often involves more than one causative mechanism it is seldom controlled by a single agent. 93.2% of the survey participants reported using combination treatment rather than monotherapy, with a total of 176 different combinations being used. Primary care physicians were least likely to include antidepressants and more likely to use NSAIDs than the other two groups. Classical strong opioids were used more extensively by the specialist groups, not just in combination therapy but also in the case of monotherapy.

Opinion of current pain treatment
Only about half the primary care physicians (56.0%) agreed that there was little knowledge of the pharmacological characteristics of different analgesic therapies within the broad medical community, whereas this figure rose to 79.2% for other specialists and 90.0% for pain specialists. Similarly, both groups of specialists felt more strongly that there is a limited awareness of the physiological difference between nociceptive and neuropathic pain. However, there was broad agreement in all three groups that a neuropathic component is often not clearly diagnosed in patients with severe, chronic low back pain.

Conclusions
The CHANGE PAIN® Physician Survey has demonstrated that pain reduction and improvement in the quality of life are the major goals in the treatment of patients with severe, chronic non-cancer pain. The wide variation in prescribed analgesics suggests that no drug is particularly effective and generally treatment is not evidence based. The treatment of neuropathic pain poses a particular problem. The use of opioids is curtailed by the difficulty of achieving an efficacy/side effect balance, particularly among primary care physicians who tend to use more conservative first-line treatment. Primary care physicians also place more emphasis on improving social functioning and the ability to work probably due to their broader, less focused clinical approach.

References

See also: Wieczorek S, Schwartz H-J. Results of the CHANGE PAIN® survey on physician’s perception about the management of severe chronic non-cancer pain. EFIC Congress 2011, Hamburg, Germany.
Dr Pamela Bell

THE CHANGING ROLE OF THE GENERAL PRACTITIONER IN THE NATIONAL HEALTH SYSTEM

Following the acceptance of the UK Government white paper “Liberating the NHS” and the health and social care bill early in 2011, the NHS in England is about to undergo wide ranging cultural and managerial changes which will dramatically alter the way in which the service operates\(^1\). Previously under the control of the Strategic Health Authority and Primary care Trusts, by 2013 the decision making process will have completely transferred to the NHS Commissioning Board and Consortia. All GP practices will be required to belong to a consortium and they will subsequently assume more responsibility. It is visualised that this system will bring benefits to the patient who will be encouraged to be more involved with decision making about their care and how and where they want it delivered.

Two recent studies have focused on the current management of chronic pain in both the primary and secondary care setting across England, Scotland, Wales and Northern Ireland.

NHS management of chronic pain associated with osteoarthritis and low back pain\(^2\)

This study investigated a total of 264 adult patients suffering from either osteoarthritis (OA) (n=168), or low back pain (LBP) (n=96), all of whom had received 3 or more prescriptions for pain medication. Data on pain management was collected retrospectively for 3 years from diagnosis (newly diagnosed patients, n=53) or from the most recent 3 years (established patients).

Analysis of the data showed that most patients received up to 5 medications during the 3 year study period, almost all of them at some time being prescribed an opioid analgesic. Over half the patients received an adjuvant analgesic such as amitriptyline. Over half the patients were given medicines to manage the side effects of pain medication. Newly diagnosed patient were more likely to be receive non-drug...
treatments, mostly commonly physiotherapy. Referral to a specialist service occurred in most cases with the mean time from diagnosis to referral being 9.4 months. Only 8% of patients were referred to a pain specialist.

These results indicate the wide range of pain medications used, there being no overall prescribing pattern of treatment pathway. A high proportion of patients were referred for specialist treatment fairly early on, although many were not referred until relatively late in their clinical course leading to a delay in providing optimal treatment. Only a small number were referred to a pain specialist.

**NHS management of chronic pain in secondary care pain clinics**

This study looked at the patient pathways and NHS resource use associated with the management of chronic pain from LBP or OA in four specialist secondary care pain clinics across the UK. A total of 227 patients with a mean age of 55 years were involved, the median time from first symptoms to referral was 5.2 years.

It was found that 60% of referrals to the specialist pain clinics were from hospital consultants and 37% were direct from GPs. Most patients (75%) were referred for specialist opinion.

There was wide range of variation between the centres with regards to non-drug treatments, investigations requested and the time the patients were registered with the clinic, reflecting the difference in local policies and structures within each service. There was widespread prescribing of medicines such as corticosteroid injection, strong opioids and antiepileptics, which GPs at the primary care level may be reluctant to prescribe.

The results indicate the need for specific expertise in the management of chronic and also highlight the fact that at present there is no clearly defined model of practice for chronic pain specialist clinics.

**What will be the effect of the proposed changes to the NHS?**

Under the new system, responsibility for public health will be held by the Local Authority who will institute Health and Well-being Boards to commission NHS services, social services and health improvement teams. GPs will hold 80% of funding and use an “Any Willing Provider” model to commission care. Common chronic conditions relevant to commission will include Chronic Obstructive Pulmonary Disease (COPD), diabetes, and CVD including stroke. Other chronic conditions that may require GPs to engage secondary providers include musculoskeletal-arthropathies including degenerative and inflammatory conditions. The burden of chronic pain, either singularly or as a result of co-morbidities will also fall within this category. With the system redesign, changes will occur in referral management and hospital pain clinics may be decommissioned. Decisions for secondary care will become evidence based in order to improve quality of care and hopefully provide a better outcome for the patient.

**Conclusions**

At present, there is a lack of consensus regarding the best practice for chronic pain management. Even within the secondary care setting there is a wide variation in referral and treatment practices. The results suggest the need for specific expertise in the management of chronic pain. The redesigning of the NHS means that GPs will face an increased challenge in treating patients with chronic pain and will be required to make more informed decisions about their further treatment.

**References**

Persistent pain can have a debilitating effect on peoples’ lives and affect relationships with family, friends and work colleagues. Data from the Chronic Pain Policy Coalition has estimated that in the United Kingdom 7.8 million people of all ages are affected by pain, 70% of these being under the age of 60. It is easy for people who live with persistent pain to become trapped in a persistent pain cycle with diminished quality of life leading to depression and negative thoughts, which ultimately may result in higher pain intensity.

It has been estimated that on average people with persistent pain have just 3 hours a year contact with a healthcare professional. This indicates that pain self-management is vital and patients need to learn pain management skills and incorporate them into their daily lives. As with all the other participants in multidisciplinary pain management, the patient has a vital role to play and teamwork is essential.

**The CHANGE PAIN® toolkit**

As someone who lives with persistent pain, asthma and osteoarthritis, I have developed the toolkit as a guide for others to learn simple pain self-management skills. This informative booklet which is endorsed by the CHANGE PAIN® Initiative outlines tips and skills designed to encourage patients to keep a positive focus on their condition and helping them to manage pain in their daily activities.

**Acceptance and support**

Patients need to accept their pain and conditions and recognise that they need to take more control with regards to how their pain is managed and be willing to try out new ideas, learn simple skills and do things differently. In order to prevent feelings of isolation, a support team will be required, the health care professional, family, friends and work colleagues, or perhaps a support group which may already be operating in the community. Numerous associations exist worldwide to provide patients with information on the cause of chronic pain, prevention and treatment. These may be run in conjunction with pain clinics or through chari-
ties e.g. the German Pain League, the British Pain Society, Arthritis Care. Patients who are better informed work with their health care professional as a team are able to make more rational choices about their care. Some communities offer self-management programmes (SMPs) that focus on approaches to self-managing pain, fatigue and the emotional aspects of pain. There are also many useful website links for available information and support.

Self-managing and daily activities
Pacing daily activities becomes vital in order to prevent overexertion or under activity whilst maintaining a level of fitness. Prioritising and planning will ensure that the essential activities of the day are carried whilst leaving time for relaxation and socialising with friends. Setting goals and making action plans are ways in which patients can chose realistic targets which will give a sense of achievement when goals are reached. Learning relaxation skills is important for tense muscles and for unwinding the mind. Regular stretching and exercising can not only decrease pain and discomfort, but can also strengthen weak muscles and induce a feeling of well-being. Physiotherapists or fitness instructors can individually tailor exercise routines that can include low impact exercises for people with joint problems. Looking after the whole body is very important which means that pain sufferers should eat healthily, and ensure that they get enough sleep at night. Keeping a diary enables patients to see how far they have come and how much they have achieved promoting confidence and positive thoughts.

The importance of team work
Team work between the patient and the healthcare professional is essential for self-help pain management to be successful. Together they can develop an action plan that can help both the patient and the healthcare professional to track progress. As part of multidisciplinary pain management team, the patient has a vital role to play. Patients may assist in the referral process from the primary physician to more specialist care by openly discussing their symptoms, attending diagnostic tests and completing questionnaires to the best of their ability. Patients may also be able to facilitate and speed up the communication process between primary physicians and pain care centres and clinics.

Conclusions
By putting into operation the suggestions in the Pain Toolkit people with pain can do much to improve their quality of life. Through acceptance of their condition and moderating their everyday activities accordingly they can continue to live a fulfilling life. Seeing an improvement in their quality of life promotes psychological well-being which helps patients to escape from the persistent pain cycle. Through teamwork involving healthcare professionals, friends and family, patients can take more control of their pain and their lives.

COMMENTARY
Pete Moore, Pain Patient, UK
Since 2009, over 200,000 copies of the Pain Toolkit have been circulated by the Department of Health in the UK. Translations are becoming available in a number of other European countries; adapted versions are available in Australia, New Zealand and Canada. The Pain Toolkit Team has also devised a one-day Pain Toolkit workshop seminar for primary and acute physicians to provide more training around learning extra pain self-management skills. Patients can also attend a half-day workshop to ignite their interest in pain self-management. Feedback from both health care professionals and patients regarding the Pain Toolkit workshop has been excellent!

References
1. www.paincoalition.org.uk
Proceedings of the CHANGE PAIN® Expert Summit in Rome 2010

Varrassi G et al.

Becoming recognised as a disease in its own right, chronic non-cancer pain has a severe impact on individual sufferers both in terms of physical and social functioning. The CHANGE PAIN® Expert Summit in Rome 2010 featured presentations focusing on ways to better understand and improve chronic pain management. These included an overview of current treatment in Europe incorporating a physician survey which demonstrated the wide range of approaches in use and highlighted a lack of knowledge of the pharmacology of analgesics in the general medical community.

At present, chronic pain treatment is often ineffective due to the difficulty in maintaining a balance between analgesia and adverse effects, which often results in the Vicious Circle of pain relief. In addition, chronic pain frequently includes a neuropathic component which may be especially difficult to assess and to treat. The negative financial implications of chronic pain include an increased burden on healthcare resources and a decrease in work productivity. Moving from symptom control to mechanism-based treatment should represent a significant improvement in the pharmacological treatment of chronic pain. Evidence suggests that medical training of pain management both at the undergraduate and postgraduate level is insufficient. With this in mind, healthcare professionals can now obtain support from a newly devised modular PAIN EDUCATION course accredited by the UEMS.

European survey of chronic pain patients: results for Germany

Müller-Schwefe GH

The Pan-European patient survey has been designed to provide insight into the way in which chronic pain patients perceive and cope with their pain. Recruiting 6435 patients currently treated by GPs, pain specialist or orthopaedists, this questionnaire survey focused on pain experience, therapy, and coping strategies, and explored possible areas in which these could be improved. Chronic back pain was found to be the most common complaint (61%). A diverse range of both monotherapies and combination therapies were in use, combination therapy being used most frequently in patients with more intense pain. Two out of three patients were also receiving non-pharmacological treatment. The overall level of dissatisfaction with treatment was 30%, the more severe the pain the higher the level of dissatisfaction. Insufficient pain relief was cited as the main cause of dissatisfaction, with the side effects of the medication being another major reason. More patients with severe and extreme pain were more satisfied by specialist treatment then by a GP. Coping strategies included reading, sport and listening to music. About half the patients identified a medium to high need for improvement in their quality of life. Overall 35% of patients were reported to be taking pain medication not prescribed by their doctor. The high levels of dissatisfaction demonstrated by the survey could adversely affect the outcome of pain management.

Healthcare utilization of back pain patients – results of a claims data analysis

Müller-Schwefe GH, et al
Journal of Medical Economics Vol. 14, No. 6, 2011, 816–823

The high lifetime prevalence of back pain (estimated to be 25-30% of the population) imposes a major cost both in terms of healthcare and to society in general. The cost of this care has been examined using a retrospective claims analysis using data gathered in 2006 which focused on 5.2 million beneficiaries of a German statutory health insurance fund. Pain was identified and classified using a diagnosis-based algorithm based on the same database. Of all the back pain patients (with either specific back pain, spinal disc disease or non-specific back pain) only 2.6% were detected to have chronic back pain, whereas 25.8% were identified to be at risk to develop chronic back pain. The patients having chronic pain used significantly more resources and had higher related healthcare costs than those with a risk of developing chronic pain. This included costs for outpatient analgesic prescriptions, in-hospital multi-modal pain therapy, in-hospital general care, and direct cost of care.

When considering the total spent on all the beneficiaries, pain related costs accounted for 21-29% of this total. Since the number at risk of developing chronic pain was ten times higher than those currently experiencing chronic pain, this indicates the importance of early detection of patients with risk factors for chronic pain both in terms of improving quality of life as well as reducing the financial burden placed on healthcare systems and work production costs.
Also including a CD with interviews with Bart Morlion, Peter van Wambcke, Eline Coppens from a Pain Clinic, Chris Monella from a General Practice and Pete Moore, a patient suffering from chronic pain

“TOWARDS A MULTIDISCIPLINARY TEAM APPROACH IN CHRONIC PAIN MANAGEMENT
Editor-in-Chief
Joseph Pergolizzi

“This new guide towards a multidisciplinary team approach in chronic pain management provides cutting-edge insight into how to improve your chronic pain management skills through a multidisciplinary team approach.

We hope you enjoy it.”

Prof. Joseph Pergolizzi,
Editor-in-Chief

Available under: www.change-pain.com