

and after any changeover.

In recent years, several other old, but therapeutically satisfactory, neurological drugs have also been withdrawn from the Australian market (oral neostigmine, several anticholinergic antiparkinsonian agents, ethosuximide and some phenytoin preparations, and the only ergotamine preparation not also containing caffeine).

Subject to safety issues, ethics committees usually will not approve a clinical trial of a new drug unless patients who benefit from it are guaranteed supplies until the drug is marketed. Surely similar considerations should apply for patients who have had completely satisfactory long-term responses to marketed drugs. If such drugs must be withdrawn, except for safety reasons, there should be extensive prior consultation with prescribers and patient groups, prescribers should know the situation before their patients discover it from other sources, and there should be a sufficient lead time for everyone receiving the drug to return for another prescription (and for advice) before the drug becomes unavailable (a minimum lead time of six months in the case of drugs subsidised under the Pharmaceutical Benefits Scheme).

The withdrawal of useful neurological drugs in Australia has reached the stage where therapeutic options are becoming limited. In the case of drugs required for

At a recent strategic planning meeting, the Australian Pain Society identified this group of people as a high priority for the development of pain management treatment strategies. These strategies are now well into the development process.

While it is appropriate for the Journal to focus on medical practitioners' care of these patients, it must be remembered that most direct care for people in aged-care facilities is delivered by nurses and nurse assistants/carers. The Australian Pain Society will be focusing its strategies on non-drug techniques that can be used by this group of healthcare workers. Assessment and documentation of pain-related behaviour, particularly in people with cognitive impairment, is critical if progress is to be made. It is also

## Pain management programs in residential aged care

Robert H Llewellyn-Jones,\* Karen A Baikie,† Heather E Smithers,‡ Philip D Funnell§

\*Lecturer, †Senior Research Psychologist, ‡Research Officer, Department of Psychological Medicine, University of Sydney, Sydney, NSW; §Rehabilitation Physician, Rehabilitation and Aged Care Department, Hornsby Ku-ring-gai Hospital, Hornsby, NSW  
rljones@mail.usyd.edu.au

**TO THE EDITOR:** The articles by Melding<sup>1</sup> and McClean and Higginbotham<sup>2</sup> highlight the important problem of chronic pain in residential care.

We have conducted two studies to investigate factors related to depression in

### Self-reported pain frequency and severity among residents of aged-care facilities

Study 1 (1994) (n = 513) Study 2 (2000–2001) (n = 148)

#### *Pain frequency*

Not at all	230 (44.8%)	54 (36.5%)
Rarely/occasionally	115 (22.4%)	52 (35.1%)
Frequently/constantly	168 (32.8%)	42 (28.4%)

#### *Pain severity\**

Minimal/mild	58 (20.5%)	27 (28.7%)
Moderate	98 (34.6%)	36 (38.3%)
Severe/bad as could be	127 (44.9%)	31 (33.0%)

\*Severity rated only for residents experiencing pain.

residential care. In our first study, in 1994, we approached a random one-in-two sample of the non-nursing-home population of a Sydney retirement village ( $n=1466$ ). We excluded residents who were under 65 years, had severe dementia, were away from the village at the time of the survey, or were too deaf or ill to participate. Of 610 eligible residents, 513 participated (response rate, 84%). Of these, 42.1% lived in hostels and 57.9% in independent living units. In a second, similar study, in 2000–2001, we surveyed residents of three Sydney aged-care hostels ( $n=205$ ). Of 159 eligible residents, 148 (93%) participated.

In both studies, residents were asked how often over the previous six months they had experienced recurring pain and asked to rate the severity of pain at its worst (see Box). Using the Geriatric Depression Scale (GDS),<sup>3</sup> Study 1 found that residents reporting frequent/constant pain were significantly more likely to be depressed (ie, to have a GDS score  $\geq 11$ ) than people reporting rare/occasional pain; similarly, people who felt rare/occasional pain were more likely to be depressed than those with no pain (odds ratio, 1.44; 95% CI, 1.13–1.83). In Study 2, there was a non-significant association between frequent pain and depression (odds ratio, 1.47; 95% CI, 0.96–2.24).

We implemented pain management programs at each facility. In Study 1, the program was part of a multifaceted intervention for depression,<sup>4</sup> but residents could attend whether depressed or not. Based on general practitioner referral, the program provided interdisciplinary assessments by a visiting rehabilitation specialist together with a physiotherapist, occupational therapist and registered nurse from the facility. Consultative psychiatric input was also available. Neuropathic and musculoskeletal pain were the most common reasons for referral. Recommended interventions included drug treatment, exercise and preventive measures. Our impression was that they were well received by residents and GPs.

In Study 2, residents with chronic pain were referred to a physiotherapist specialising in pain management and reported that this was beneficial. A clinical psychologist also offered to assist, but residents were reluctant to accept this form of help. Our impression was that psychological assistance would have been better received as part of an interdisciplinary pain management program.

Older people in residential care may find it difficult to travel to hospital-based pain management programs. Our experience indicates that it is feasible to conduct pain

management programs in residential care. However, improving pain management is not only a matter of pharmacological interventions. If we are serious about achieving adequate standards of pain management in residential-care facilities in Australia, resources should also be devoted to providing accessible interdisciplinary pain management programs and to changing the attitude that pain is an inevitable part of old age.

1. Melding PS. Can we improve pain management in nursing homes [editorial]? *Med J Aust* 2002; 177: 5-6.
2. McClean WJ, Higginbotham NH. Prevalence of pain among nursing home residents in rural New South Wales. *Med J Aust* 2002; 177: 17-20.
3. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res* 1983; 17: 37-49.
4. Llewellyn-Jones RH, Baikie KA, Castell S, et al. How to help depressed older people living in residential care: a multifaceted shared care intervention for late life depression. *Int Psychogeriatr* 2001; 13: 477-492. □

## Halting the growth in diagnostic testing

Michael J Murray

Group Manager, Aged Care, St Vincent's Health, St George's Hospital, 283 Cotham Road, Kew, VIC 3101  
michael.murray@stgeorges.org.au

**TO THE EDITOR:** As a geriatrician in the subacute sector with hospital medical officers (HMOs) rotating from a major teaching hospital, I am acutely aware of the cost to all concerned of inappropriate diagnostic testing. Discussion stimulated by Stuart et al<sup>1</sup> and the editorial by Hammett and Harris<sup>2</sup> may help elevate this issue into its rightful arena — quality care and clinical accountability.

Donabedian,<sup>3</sup> in looking at the assessment of quality care, describes “elements in the performance of practitioners”, with technical performance defined as “knowledge and judgement used in arriving at the appropriate strategies of care”. I believe that both these quality elements are deficient and that it is the responsibility of the senior clinicians to provide the necessary leadership in ensuring their acquisition.

While I agree with Hammett and Harris that there are systems failures and that, as an example, improved feedback of results (particularly given changing HMO work practices and shorter length of patient stays) will provide some of the answers, there appears little doubt that a significant knowledge deficit exists among junior doctors regarding the use and interpretation of common tests and how often they should be ordered. The unfortunate fact is that we have known about these issues for many years and have yet to develop a sustained response. At our hospital we have

attempted to modify the use of diagnostic tests by HMOs during their geriatrics rotation, with tutorials from biochemists and haematologists which are reinforced during consultant ward rounds and meetings. This is, however, doomed to failure unless the process is continued by all other clinicians who supervise HMOs.

Emanuel and Emanuel<sup>4</sup> define accountability in a number of domains. The least controversial of these, I suggest, is professional competence. It is incumbent on us as senior clinicians to “invoke, affirm and enforce professional standards”,<sup>4</sup> being accountable for the practices of those HMOs under our supervision. Appropriate use and understanding of diagnostic testing will reduce unnecessary patient discomfort while also reducing costs. As any geriatrician will tell you, additional years without insight simply provide grey hair, not improved clinical practice.

1. Stuart P, Crooks S, Porton M. An interventional program for diagnostic testing in the emergency department. *Med J Aust* 2002; 177: 131-134.
2. Hammett R, Harris R. Halting the growth in diagnostic testing [editorial]. *Med J Aust* 2002; 177: 124-125.
3. Donabedian A. The quality of care: how can it be assessed? *JAMA* 1988; 260: 1743-1748.
4. Emanuel E, Emanuel L. What is accountability in health care? *Ann Intern Med* 1996; 124: 229-239. □

Warwick J Carter

General practitioner, The Jamboree Centre, 50 Sumners Road, Sumner Park, QLD 4074  
wjcarter@ozemail.com.au

**TO THE EDITOR:** In their editorial,<sup>1</sup> Hammett and Harris have overlooked one of the most important contributory factors to the increased use of diagnostic tests by community-based practitioners (ie, GPs) — patient demand.

It is not unusual for a GP to be faced with a request by a patient to be “tested for everything”, or for a specific test that may be quite inappropriate (“I just want my hormones checked”).

It takes far longer to explain to the patient that the tests are inappropriate than to give in and sign the appropriate pathology form. And then, if the patient a year later does come down with some obscure syndrome, he or she can come back in the courts and say, “If only the doctor had listened to my request for tests I would be okay now”.

The frontline GP is in a lose-lose situation, stuck between the Health Insurance Commission and its demands for reasonable levels of testing, the expectations of patients that everything can be detected by a blood test, and the excessively perfectionist ideals of the legal system.

1. Hammett RJH, Harris, RD. Halting the growth in diagnostic testing [editorial]. *Med J Aust* 2002; 177: 124-125. □