Primary care for chronic pain patients

I am an anesthesiologist and Director of a chronic pain clinic in an academic centre in southwestern Ontario. Over the past 4 years, I have seen our waiting lists grow to 6 to 9 months and longer. In some pain clinics across Canada, the waiting list is 2 years. Understandably, this is causing widespread dissatisfaction. The longer someone suffers from pain, the less likely it is that they will have a successful return to work and function.

Two years ago I was able to see six new patients a week; now it is down to three, with almost no time available for urgent requests. Although there are several reasons for burgeoning waiting lists, including the increased demands of an aging population and the retirement of pain specialists, an important part of the problem is the unwillingness of family doctors to take patients suffering from chronic pain into their practices.

At our clinic, we no longer accept patients who do not have family doctors. But of the approximately 270 patients on my active roster, 40 do not have family doctors. How has this happened? It has become an almost weekly occurrence to hear of a family doctor quitting practice for such reasons as retirement, illness, moving, or changing to a less stressful type of practice. My heart sinks when patients divulge this, knowing that I have become de facto the family doctor. If they are lucky enough to locate a physician who is considering taking on new patients, they will usually fail the “screening interview.” In this process, anyone with fibromyalgia or back pain is turned down, especially if they are taking opioids. I have even had a young patient taking acetaminophen with codeine (Tylenol 3) for a first-time acute disk herniation who was refused by three family doctors. Another serious problem is that some patients who are lucky enough to have family doctors continue to need follow up at the pain clinic because their doctors refuse to prescribe opioids, even when sanctioned by a pain specialist.

Recently, the Ontario Liberal government has focused on decreasing waiting lists for cancer care, joint replacements, and cardiac surgery. This type of work requires highly trained specialist teams, and it is, therefore, difficult to reduce waiting times quickly. In chronic pain management, however, with a modest amount of education, family doctors could develop the skills to continue on with prescribed medications. This would have a direct effect in reducing waiting times for pain clinics across the province.

I understand that these patients are very time-consuming and have many complaints and comorbidities. As yet, there is no fee code for complex chronic pain, and this needs to be addressed. My Clinical Research Assistant, Jana Moulin, and I would welcome hearing proposed solutions to the problem of insufficient primary care for chronic pain patients.

—Pat Morley-Forster, MD, FRCPC
London, Ont by e-mail

Correction

Dans le numéro d’avril du Médecin de famille canadien, une erreur s’est glissée dans l’éditorial sur la sensibilité culturelle (Can Fam Physician 2005;51:478-80 [ang], 483-5 [fr]). Dans la note biographique à la page 485, la deuxième phrase aurait dû se lire comme suit: «Il est professeur adjoint à l’Unité d’éthique biomédicale de l’Université McGill à Montréal, au Québec, et éthicien clinique à l’Hôpital général de Montréal.»

Le Médecin de famille canadien s’excuse de cette erreur et de tout embarras qu’elle ait pu causer à l’auteur, Dr Leigh Turner.