Consultation questions

1. Medication review

We recommend taking a holistic approach to manage pain, with medications being reviewed using a person-centred approach using the standardised Polypharmacy 7-Steps guidance.

Question 1a

Do you agree with this recommendation? (Yes/No/**Not sure**)

Question 1b

To what extent do you agree with this recommendation?

We do not give clinical advice or comment on the safety or appropriateness of treatments. However, taking a holistic, person-centred approach aligns with the professional standards that we set for doctors, PAs and AAs working in the UK. We describe these in more detail as part of our response below

Question 1c

Please tell us more about your views on our approach to review.

As mentioned in the previous response, we do not give clinical advice or comment on the safety or appropriateness of treatments. For this reason, we neither agree nor disagree with your recommendation.

That said, as the regulator for doctors, physician associates (PAs), and anaesthesia associates (AAs) is our role to ensure the effective regulation of their practice as we have a legal duty under the Medical Act 1983 and the Anaesthesia Associate and Physician Associate Order to protect the public. One of the ways we do this is by setting out the principles, values, and standards of professional behaviour expected of all doctors, PAs and AAs registered with us. These standards are known as: Good Medical Practice (GMP) and they are supported by more detailed guidance on distinct areas.

All doctors, PAs and AAs registered with us expected to be aware of and follow the professional standards to the extent that it is relevant to their practice. PAs and AAs cannot prescribe prescription-only medicines, but they may be involved in proposing medications or devices for an authorised prescriber to review and sign to the extent that this is within their competence, and their employer and supervising doctors have agreed that this is part of their scope of practice. More information about how PAs and AAs work with doctors under supervision can be found here: Supervision of physician associates and anaesthesia associates - GMC.

We would like to highlight the relevant areas of GMP and more detailed guidance that you may want to consider given your proposed recommendation of taking a holistic approach to manage pain, with medications being reviewed using a person-centred approach using the standardised Polypharmacy 7-Steps guidance.

What we say in GMP

In GMP we say that doctors, PAs and AAs must work in partnership with their patient and assess their needs and priorities (para 6) and that all patients have the right to be involved in decisions about their treatment and care, and be supported to make informed decisions if they are able to (para 24).

When providing clinical care and assessing a patient, doctors, PAs and AAs must take into account relevant psychological, spiritual, social, economic, and cultural factors as well as their patient's views, needs, and values (para 7a). Any treatment that a doctor, PA or AA proposes, provides or prescribes must be effective and based on the best available evidence (para 7e) and, where possible and provided it doesn't compromise care standards, the solution should be sustainable (para 15).

What we say about prescribing

In our guidance *Good practice in prescribing and managing medicines and devices* (prescribing guidance), we say that when prescribing or proposing a medication, whether it's a one-off or repeat prescription, doctors, PAs and AAs must make sure arrangements are in place to monitor, follow-up and review (para 92).

We also say that reviewing medication will be particularly important where the patient is prescribed a controlled drug or medicine that is commonly abused or misused (para 94c). At each review, a doctor, PA or AA should confirm that a patient is taking their medication properly and that it is still effective (para 100).

Things to consider

We would like to flag that you may want to be more explicit that sometimes a patient may request medicine that a doctor, PA or AA doesn't think will benefit them. For those that we regulate, we say that they should explore the reasons for the patient's request, their understanding of what it would involve and their expectations about the likely outcome. We're also clear that if after discussing the treatment or care with the patient the doctor, PA or AA is still of the opinion that it wouldn't benefit them, then they should not provide or propose this treatment (para 50-51).

2. Communication between practitioners and people experiencing chronic pain

We recommend that practitioners acknowledge that chronic pain is a long-term condition and people will be at different stages of their chronic pain journey. Practitioners should take a person-centred approach when communicating with individuals.

Question 2a

Do you agree with our recommendations around communication between practitioners and people experiencing chronic pain? (Yes/No/**Not sure**)

Question 2b

To what extent do you agree with these recommendations?

We agree that good communication between a practitioner and their patient is important; however, we hold no views on what tools are most effective in supporting effective communication.

Question 2c

Please tell us more about your views on our recommendations.

We agree that good communication between a practitioner and their patient is important.

What we say in GMP

In GMP we say that doctors, PAs and AAs must treat patients with kindness, courtesy and respect (para 23) which includes being sensitive and considerate when sharing potentially distressing issues about the patient's prognosis and care (para 23a) and being alert to signs of pain or distress, and taking steps to alleviate pain and distress whether or not a cure may be possible (para 23f).GMP sets out that it's important to listen to patients, encouraging an open dialogue about their health, asking questions to allow them to express what matters to them, and responding honestly to their questions (para 28). We say that they must not withhold relevant information just because it that may be upsetting or unwelcome (para 28).

To ensure the necessary information is communicated, doctors, PAs and AAs must take steps to meet patients' language and communication needs, so they can support them to engage in meaningful dialogue and make informed decisions about their care. The steps they take should be proportionate to the circumstances, including the patient's needs and the seriousness of their condition(s), the urgency of the situation and the availability of resources (para 32).

When giving information, doctors, PAs and AAs should check the patient has understood it and do their best to make sure the patient has the time and support to make an informed decision (para 31). This means that information must be given in a way so that the patient understands their condition (para 28a), the options available for managing their condition (para 28b) as well as the associated risks, benefits or uncertainties of each option (para 28c).

What we say about communication and prescribing

In our prescribing guidance, we say that doctors, PAs and AAs should work together with their patient to assess their condition before proposing or prescribing a course of action (para 34) and that the doctor, PA or AA must be satisfied that they can establish a dialogue and obtain consent (para 23). Doctors, PAs and AAs must also consider the patient's communication needs and make reasonable adjustments where necessary so that care meets the patient's needs.

Things to consider

You may want to consider whether the guidance should be more explicit about the need to make reasonable adjustments in line with equality legislation when thinking about whether communication is accessible for the following groups, but not limited to:

- Deaf or hard of hearing
- Blind
- Neurodivergent
- Learning disability
- Have limited literacy skills
- English as a second language

You may also want to think about whether you could provide more detail in the guidance about communicating with patients regarding the continuity of their care. In GMP we highlight the importance of continuity of care for patients, especially those that may struggle to advocate for themselves. Doctors, PAs and AAs must share information with patients about the progress of their care, who is responsible for which aspect of their care and which clinician or team has overall responsibility for their care (para 65). In this way, you can empower patients by keeping them informed about all aspects of their care.

3. Non-pharmacological approaches

We recommend that clinicians should:

- support individuals to explore non-pharmacological treatment options to manage their chronic pain, including self-management, physical activity, relaxation and psychological therapies
- support person-centred goal setting in management of chronic pain which are specific, measurable, achievable, realistic and timed (SMART)
- consider using local social prescribing and community resources.

Question 3a

Do you agree with our recommendations around using non-pharmacological approaches to managing chronic pain? (Yes/No/**Not sure**)

Question 3b

To what extent do you agree with these recommendations?

We agree that it's important to treat the whole person however, we hold no view on whether the biopsychosocial model is the best approach.

Question 3c

Please tell us more about your views on our recommendations.

We agree that it's important to care for the whole patient. As noted in our previous answer, in our guidance this means taking account of the relevant psychological, spiritual, social, economic, and cultural factors as well as their patient's views, needs, and values (GMP para 7a). We also say that doctors, PAs and AAs should support patients in caring for themselves and empower them to improve and maintain their health (GMP para 38).

In GMP, we set out that this means supporting and empowering patients to improve and manage their health (para 38).

4. Pharmacological management

We recommend that clinicians should:

- Review the indication and impact of medicines considering not only pain intensity levels, but also the effect on physical function, mental health and emotional factors. The risks of harm/adverse effects should be considered both actual and potential.
- Consider a two-to-four-week trial of regular paracetamol to assess efficacy
- Review treatment of all people on an opioid, prioritising individuals prescribed more than 50mg morphine equivalent dose (MED), who should be reviewed at least annually.
- Review efficacy and adverse effects within four weeks of starting opioid treatment or sooner if required.
- Review effectiveness of duloxetine after four weeks at 60-120mg and discontinue if there is no improvement in pain relief, physical function or subjective improvement. It is good practice to reduce gradually.
- Optimise antidepressant medication where possible in those with concomitant chronic pain and depression, rather than prescribe additional antidepressant medication

- Inform of significant risk of adverse effects with gabapentinoids, including drowsiness, dizziness, nausea, weight changes (abnormal appetite), cognition, speech problems and ataxia
- Review use of nefopam, lidocaine plasters, methocarbamol as there is limited clinical evidence.

Question 4a

Do you agree with our recommendation for the use and review of medicines used to treat chronic pain? (Yes/No/**Not sure**)

Question 4b

To what extent do you agree with these recommendations?

We agree that it's important to review medication, consider the risks and benefits, prescribe treatment that is based on the best available evidence, and inform patients about the side effects associated with a medication. However, we do not have a view on the efficacy of different treatments or the intervals at which they should be reviewed.

Question 4c

Please tell us more about your views on our recommendations.

We agree that it's important to review medication and reduce repeat prescribing where possible.

GMP and prescribing

In GMP we set out that when providing or proposing a repeat prescription, doctors, PAs and AAs must have adequate knowledge of the patient's health and be satisfied that the medication will meet their need (para 7) and that when prescribing or proposing a treatment it must be based on the best available evidence (para 7e).

Where a patient is taking multiple medications, doctors, PAs and AAs should discuss the importance of regular reviews with patients to check that the medication continues to meet their needs and that doctors, PAs and AAs should consider the overall impact of the patient's treatments, and whether the benefits outweigh any risk of harm (para 40)

Prescribing guidance and reviews

In our prescribing guidance we say that doctors, PAs and AAs must make sure that any repeat prescription they propose, or sign is safe and appropriate (para 97) and that they should agree with the patient how their condition will be managed, including a date for review (para 98).

At each review, doctors, PAs and AAs should confirm that the patient is taking the medication correctly and that it is still effective (para 98). We also say that where possible doctors, PAs and AAs should reduce repeat prescribing (para 97)

Things to consider

You may want to consider including advice in the guidance for healthcare professionals on responding to safety concerns. For example, what they should do when they receive referrals from individuals or organisations whose prescribing practices raise concerns. This would help safeguard patient safety and uphold professional integrity in complex care pathways

In GMP we say that doctors, PAs and AAs must act promptly if they think that patient safety or dignity is, or may be, seriously compromised (para 75). In our more detailed guidance, raising and acting on concerns about patient safety, we expand on this duty and outline that doctors, PAs and AAs have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work (para 7).

5. Opioid stewardship and deprescribing

We recommend that clinicians:

- **In partnership with the individual, consider managed reduction of opioids, as there is little evidence that they are effective for long-term pain but have many side effects and known long-term harms.**
- **Explain the importance of reducing opioids to the individual, providing chronic pain education, if necessary, and develop a tapering plan in agreement with the individual.**
- **Support the individual during the reduction, considering emotional impact and adverse effects.**
- **In secondary care, consider good opioid stewardship, ensuring effective communication between secondary care and primary care, noting that long-acting opioids are no longer recommended post-surgery.**

Question 5a

Do you agree with our recommendations for opioid stewardship and deprescribing for chronic pain? (Yes, No, **Not Sure)**

Question 5b

To what extent do you agree with these recommendations?

While we do not comment on the clinical appropriateness of opioid use, we agree on the importance of working in partnership with patients, prescribing based on the best available evidence, reducing repeat prescriptions where possible, explaining risks and benefits, and ensuring good communication between secondary and primary care.

Question 5c

Please tell us more about your views on our recommendations

We've outlined in previous responses the relevant parts of GMP and the prescribing guidance that highlight the importance of working in partnership with a patient, recommending treatment that's based on the best available evidence, reducing repeat prescriptions where possible, and explaining the risks and benefits of a medication to patients.

What we say about the continuity of care

In terms of ensuring effective communication between secondary care and primary care GMP is clear that doctors, PAs and AAs must promptly share all relevant information about patients (including any reasonable adjustments and communication support preferences) with others involved in their care, within and across teams, as required (para 65a).

What we say about prescribing controlled drugs

In our prescribing guidance, we set out to doctors, PAs and AAs that they should stay up to date on the drug safety updates on opioids (para 58). We also say that reviewing medicines will be particularly important where medicines have potentially serious or common side effects or where the patient is prescribed a controlled drug such as an opioid which is commonly abused or misused (para 94a-c).

6. Resources for practitioners and people with chronic pain

Question 6a

Are you aware of any other resources that practitioners or people with chronic pain or may find useful? (Yes/**No**/)

Question 6b

If your answer to question 6a was Yes, please list any other resources that you are aware of.

7. Implementation of this guidance

We have a few questions, which will help us implement the recommendations from this prescribing guide.

Question 7a

Do you feel there are any barriers to implementing the recommendations from this guidance? (**Yes**/No/Not sure)

Question 7b

If you answered yes, how do you feel these barriers could be addressed?

Effective implementation depends on clinicians having time and support to carry out regular medication reviews, and on systems that enable safe information-sharing between healthcare providers.

Question 7c

What do you feel are the key factors that will enable successful implementation of these recommendations?

Clear guidance, time and support for reviews, and IT systems that support continuity of care will be important enablers.

8. Finally

Question 8

Do you have any further comments on this prescribing guide?

We welcome the emphasis on safe, evidence-based prescribing and ensuring that patients are supported to manage their chronic pain holistically.