Continuing methadone for pain in palliative care

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Abstract: ContextMethadone is one of the most important medications used for the treatment of refractory pain in the palliative care setting, and is usually initially prescribed by one of a limited number of physicians who have acquired authorization for its use. A lack of authorized physicians able to take over prescribing when the patient is stable is a barrier to accessing methadone for analgesia. **Objectives**. To determine the barriers to family physicians becoming authorized to prescribe methadone for pain in palliative care. Methods. A survey exploring the perceived barriers to continuing methadone for pain in palliative care following initial prescription by a specialist was mailed to a randomly selected group of 870 family physicians in British Columbia. Results. The response rate was 30.9%. Of the 204 responding physicians, 76.1% described themselves as positioned to provide ongoing palliative care to their patients. Within this group, 38 (18.6%) were already authorized to prescribe methadone for pain. The remaining 166 (81.4%) had significant knowledge deficits regarding methadone use in palliative care, but were largely aware of their deficits, and more than one-half were willing to learn more and to obtain an authorization if requested. Only 20.5% of the 166 respondents recalled having had any training or education on methadone for analgesia. Nearly one-half (45%) of respondents admitted they were not sure why methadone was useful for pai41% believed that methadone was dosed only once daily (as for prevention of withdrawal),Only 42% knew that methadone can be used for pain that is not responsive to other opioids, when this is, in fact, its main role. Even fewer (31%) were aware of the particular benefits of methadone for neuropathic pain. Only 16% of respondents knew that methadone is cleared almost entirely by the liver and is, thus, safe for use in patients with renal failure. Very few (8.4%) were aware that methadone can overcome tolerance when patients have been on high doses of other opioids. Only 21.7% of respondents were able to report that obtaining an exemption to prescribe methadone for analgesia was not similar to the process for addiction prescribing, Analysis of the ages of responders showed that the requirement for education has been better met for recent graduates, with the reporting of having received education regarding methadone for analgesia dropping offover the years since graduation from 38% for those younger than 40 years of age to 24% for 40 to 50 years of age, 18% for 51 to 60 years of age and only 6% for those older than 60 years of age. **Conclusion.**: Responding family physicians had mostly received little education regarding methadone for pain, but were aware of their need for education and were willing to learn.

Table 1

Factors influencing the decision whether to apply for methadone prescribing exemption

Barrier	**n**	**(%)**
Need for exemption	126	(75.9)
Lack of knowledge	125	(75.3)
'Too much hassle'	100	(60.2)
College scrutiny	65	(39.2)
Addiction risk	57	(34.3)
Side effects	54	(32.5)
Drug interactions	46	(27.7)
Electrocardiogram changes	23	13.9)

The selection of multiple barriers was allowed

Strengths: Relevant study to address the gap of awareness and knowledge .

Good response.

Detailed questionnaire.

Weaknesses: Reflects the case in only British Columbia.
National study will be required
Input from physicians who already prescribing methadone for pain could be a comparable group.

Relevance to palliative care: The awareness of the barriers influencing a decision to apply for methadone exemption,could change the way of communicating the plan to the primary care physicians in the community. Clear and detailed plan of methadone use could greatly assist the family physicians to handle use of methadone.Open door for feedback and re-consultation help delivery of better care.