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Letter to the Editor

Establishing pain service in Dharan, Nepal: overcoming the inertia

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Abstract: The letter describes the initial days of establishing pain management services in the eastern part of Nepal.

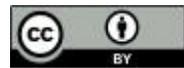
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Sir,

It was interesting to read the article titled 'Pain practice in Nepal thirty years ago: A practitioner's Quest'¹ in your journal which reveals a single individual's efforts and perseverance to start pain management in Kathmandu dating back to 30 years ago. It is not unsurprising that many of the beliefs, concepts and barriers are still the same; only some technological advancement has taken place and some complex concepts have been unravelled.

Starting pain service in Kathmandu by Dr Swar was at an individual level but starting pain service in BP Koirala Institute of Health Sciences (BPKIHS), Dharan, Nepal was at a departmental (institutional) level about 24 years ago. Since BPKIHS was initially supported by the Government of India, the concept of pain management clinic naturally seeped into the institute through the deputed faculty members from India in the Department of Anesthesiology and Critical Care.

Expectedly, the starting was quite challenging as several barriers (including system barriers, logistic barriers, clinician barriers and patient barriers) existed. In the beginning, the pain management service was limited to the administration of analgesic medications (opioids/non-opioids/adjuvants), simple interventions like peripheral nerve blocks and counselling; labour analgesia was provided occasionally. There was no identified space allocated for a pain clinic; part of the preoperative holding area was utilized for assessing and managing pain for OPD patients.

Prof. Abhijit Bhattacharya, deputed by Government of India, joined the department in 1998 and introduced acupuncture for pain management in selected patients; but, unfortunately, it could not be continued beyond his deputation tenure. On his initiatives, the department also organized the first 'International Conference on Pain' in BPKIHS in February 2000. The conference was attended by 200 delegates from Nepal and abroad.² The conference was an important sensitizer for many clinicians.

With the commissioning of the new hospital, the spectrum of clinical services expanded in BPKIHS and the pain management service was not an exception. In 2003, a study was carried out to assess the burden of chronic pain and its cost at the community level in Sunsari District.³ The study revealed a high prevalence of chronic or non-acute pain in our communities. By 2004 the capacity of the pain clinic expanded and a dedicated procedure day for pain intervention was allocated in the routine operation theatre by the hospital administration reflecting the recognition of the importance of chronic pain management.

Unavailability of oral morphine and proper neurolytic agents were still standing as hindrances. Some medications/gadgets had to be organized on additional personal efforts and initiatives. Despite these hindrances, a sizable number of interventions were possible.^{4,5} Oral morphine was made available with special permission, which further supported pain management in cancer patients.

With time some junior colleagues have shown interest in the subject and have pursued advanced training and are providing services to the increasing number of patients in the pain clinic. But barriers have not ceased to exist and much advocated a multidisciplinary approach of pain management in true sense is still a mirage in our context. In fact, barriers exist everywhere but the types and magnitude vary.⁶ But we can see a silver lining in the dark cloud; Nepal Association for Study of Pain (NASP) has been constituted with multidisciplinary involvement.⁷ We can hope that this organization can play a key role in bringing different disciplines involved in pain study and management together to address the complex issue better.

As such pain is a very complex and multidimensional issue. Patients with pain may primarily present to any of the myriad of practitioners including internists, neurologists, surgeons, orthopedic surgeons, rheumatologists, oncologists, physical medicine practitioners, psychiatrists, psychologists, alternative medicine practitioners (Ayurvedic, Homeopathic, Chinese traditional, Acupuncturists etc.) and many others to name before reaching the specialist pain practitioners. Undoubtedly, these primary practitioners have specific expertise in handling pain originating from the pathologies they routinely deal with. However, it would not be otherwise to speculate that most of the needy patients with chronic pain may not have been getting optimal pain management in our context. This is quite a difficult barrier to tackle and is unlikely to have an easy and quick solution. Forming multidisciplinary pain team, though not an easy task either, may be one step ahead to partially mitigate such a problem.

It is time to change our belief and practice. Traditionally, as anesthesiologists, many of us are keeping a belief that we are standing in the forefront of pain management (at least as a default) in our hospital settings without realizing our limitations; our focus has been mostly around interventional and pharmacological modalities ignoring other dimensions. If we believe we are at the forefront and we want more comprehensive pain management in our patients, it is our duty to take initiatives and extend our hands to other stakeholders to seek cooperation and coordination.

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