Guideline: Undertake safe pharmacological management of pain

EPA 2

Description

Undertaking safe pharmacological management of pain is a core requirement of safe patient care provided by the specialist pain medicine physician. This entrustable professional activity involves safe, evidence-informed pharmacological management of pain, including initiating, titrating, supervising, rotating, tapering and discontinuing medications and analgesic techniques used in the management of patients with pain, together with appropriate documentation, shared care coordination, risk mitigation and recognition of one's own limits. The physician integrates pain mechanisms, comorbidities, concurrent therapies, patient goals, risk stratification, cultural and social context, medicolegal requirements and coordinates shared care arrangements. This activity includes communication with patients, their families, carers and whānau (where relevant), pharmacists, primary care prescribers and other clinicians to ensure safe, coordinated and documented prescribing decisions.

Training stage to be completed in: Core Training Stage (quarter 2&3)

Details

Trainees entering pain medicine training are expected to be very familiar with prescribing in the Australian and New Zealand medicolegal contexts. They are expected to understand their responsibilities to prescribe in accordance with societal ethical standards using information from the patient assessment, evidence for the relevant drug or technique accounting for patient contextual factors and including patient wishes and preferences.

By the end of Q3, the trainee should be entrusted to undertake the pharmacological management of adult pain presentations with indirect supervision. This includes the safe initiation, monitoring, adjustment, tapering and cessation of analgesic medicines (and techniques) within standard protocols.

A summative entrustment decision for this EPA specifically excludes knowledge and skills related to pain management techniques and neuromodulation described in the Procedures in Pain Medicine program and the prescription, monitoring, tapering or discontinuation of pharmaceutical agents or analgesic techniques for children under the age of 16.

Related Graduate Outcomes

Clinician, Communicator, Scholar and Professional roles

Related roles in practice

Role in Practice	Related Learning Outcome
Clinician role	2.1.21 – Describe the pharmacokinetics of the following drugs and drug classes commonly used in pain medicine: paracetamol, NSAIDs, opioids, cannabinoids, clonidine, benzodiazepines, antidepressants, ketamine, local anaesthetics, anticonvulsants 2.1.22 – Describe the pharmacodynamic properties of the above drugs and drug classes commonly used in pain medicine 2.1.23 – Describe pharmacogenetic variability of drugs used in pain medicine 2.1.24 – Critically discuss the evidence base for the efficacy and adverse effects of drugs used in the management of pain 2.1.25 – Describe the withdrawal regimens for drugs commonly used in pain medicine 2.1.26 – With respect to opioids: compare and contrast rational use in acute, chronic non-cancer and cancer-associated pain; critically discuss commonly used dose-equivalents; discuss the rationale for opioid rotation,; describe the use and idiosyncrasies of methadone and buprenorphine; critically discuss opioid-induced hyperalgesia; and, discuss the long term effects of the use of opioids including but not

	limited to their immunomodulatory, endocrine and psycho-cognitive effects 2.1.27 – Critically discuss the evidence base for the efficacy and adverse effects of cannabinoids in the management of pain 2.1.30 – Critically discuss the use of complementary and alternative medicines (CAM) used in the treatment of pain 2.1.34 – Supervise and monitor patient progress through ongoing interdisciplinary consultation 2.1.36 – Demonstrate ability to rationalise and supervise complex pharmacotherapy in patients experiencing pain
Communicator role	2.4.1 – Establish therapeutic relationships with patients, their families and carers 2.4.2 – Communicate using a patient-centred approach that encourages patient trust and autonomy, and is characterised by empathy and respect 2.4.3 – Demonstrate effective communication skills such as active listening and attending to verbal and non-verbal cues 2.4.5 – Recognise and negotiate challenging communication situations, including conflict and emotionally charged situations 2.4.9 – Facilitate informed choices with respect to treatment options 2.4.10 – Encourage shared-decision making
Collaborator role	2.5.1 – Negotiate overlapping and shared responsibilities with interprofessional healthcare providers for episodic or ongoing patient care and safety
Manager leader role	2.6.8 – Demonstrate an ability to integrate the principles of opioid. And analgesic stewardship to the management of patients prescribed opioids
Health advocate role	2.7.8 – Promote the safe and appropriate use of controlled substances within the population
Scholar role	2.3.1 – Identify opportunities for further professional development and learning 2.3.2 – Participate in relevant professional and educational development in pain medicine and apply insights in practice 2.3.7 – Critically appraise scientific literature and translate evidence into decision-making about the care of patients with pain
Professional role	2.2.7 – Recognise and respond to ethical issues encountered in practice, including conflict of interest 2.2.8 – Demonstrate professional integrity and ethical conduct in response to industry marketing strategies 2.2.13 – Adhere to the regulatory and legal obligations required of practice in the relevant jurisdiction(s) 2.2.15 – Demonstrate detailed knowledge of regulations with respect to controlled substances in the relevant jurisdiction(s) 2.2.16 - Demonstrate detailed knowledge of regulations with regarding the use of cannabinoids in the relevant jurisdiction(s)

Related Essential Topic Areas

Role in Practice	Related Learning Outcome
Conceptual Basis of Pain	1.9 – Define and discuss: placebo, nocebo, placebo response and, placebo effect
Mechanisms in the Biomedical Dimensions of Pain	3.1.15 – Critically discuss the limitations of a mechanism-based approach to the pharmacological treatment of pain
Acute Pain	3.2.7 - Differentiate between causes of acute cognitive dysfunction and the effects this may have on the management of the patient with acute pain, including, but not limited to: delirium, withdrawal syndrome, unrecognised substance use disorder, poorly-controlled pain and, poorly-controlled mental illness 3.2.9 - Implement safe and effective multi-modal analgesia for patients experiencing acute pain. 3.2.10 Devise a plan to transition patients experiencing acute pain to oral analgesia from patient-controlled (PCA), regional or epidural analgesia. 3.2.11 Construct a post-discharge pain management plan tailored to the needs of the individual patient. 3.2.12 Critically appraise the evidence for efficacy and adverse effects in the management of acute pain with: conventional and atypical (multigesic) opioids, paracetamol and non-steroidal anti-inflammatory drugs. 3.2.13 - Critically appraise the evidence for the indications, efficacy and adverse reactions of the following drugs in the management of acute pain: NMDA-receptor

	antagonists, anticonvulsants, alpha-2 delta ligands, antidepressants, alpha-2 agonists, inhalational agents, calcitonin, corticosteroids and systemic lidocaine (lignocaine). 3.2.14 Assess and manage all adverse effects related to pharmacological therapies in acute pain management, including but not limited to: opioid-induced ventilatory impairment (OIVI), excessive sedation, nausea, vomiting and constipation, pruritus and cognitive dysfunction. 3.2.15 - Discuss the advantages, disadvantages and risks of delivering opioids for acute pain management via patient-controlled analgesia (PCA), continuous infusion, or intermittent boluses. 3.2.16 Describe the equipment, procedures, prescription and monitoring required when delivering opioids for acute pain management via patient-controlled analgesia (PCA) or continuous infusion. 3.2.17 - Discuss indications, risk-benefit analysis, safety and complications of the following analgesic techniques: major peripheral nerve analgesia, plexus analgesia (including patient-controlled regional analgesia), truncal analgesia (paravertebral, erector spinae and transversus abdominis plane), epidural analgesia (including patient-controlled epidural analgesia, PCEA) and intrathecal analgesia. 3.2.18 Describe the pharmacokinetics and pharmacodynamics of neuraxially administered opioids, local anaesthetics and adjuvants. 3.2.19 Describe the physiological consequences of opioids and local anaesthetics administered neuraxially, alone or in combination. 3.2.20 Critically discuss the benefits and risks of using adjuvant agents for enhancement of regional neuraxial or peripheral analgesia. 3.2.21 Respond to the complications of regional analgesic and neuraxial techniques. 3.2.22 Discuss the challenges of using neuraxial or major peripheral nerve regional analgesia in patients taking anticoagulants and/or anti-platelet agents.
Spinal pain	3.3.22 – Critically discuss the indications and evidence base for the efficacy for pharmacological treatment of spinal pain
Problematic substance use	3.4.3 – Discuss the current DSM V and ICD 11 criteria for diagnosis of substance use disorder 3.4.4 – Discuss how inappropriate prescribing behaviour may contribute to problematic substance use 3.4.6 – Discuss the contribution of benzodiazepines to problematic substance use encountered in pain medicine 3.4.7 – Recognise the spectrum of problematic substance use that may be comorbid with the experience of pain 3.4.8 - Recognise aberrant drug-taking behaviour 3.4.9 - Identify intoxication and withdrawal syndromes associated with: opioids, alcohol, benzodiazepines, amphetamines, cannabinoids, ketamine, gabapentinoids and atypical anti-psychotics and hypnotics 3.4.10 Identify people with or at risk of substance use disorders. 3.4.12 - Outline the factors that may help in the assessment of the suitability, including risk, of patients for opioid pharmacotherapy 3.4.14 - Compile a comprehensive medication record including: reconciliation of quantity prescribed and used and identification of any discordance between these, consultation with community prescribers and dispensing points and, identification of pharmacodynamic interactions. 3.4.15 Discuss strategies to minimise problematic substance use 3.4.16 Explain regulations regarding the prescription, restrictions and monitoring of controlled substances in the relevant jurisdiction(s) of practice. 3.4.17 Explain the operation of: prescription shopping information service (Australia) and, real-time, online monitoring of controlled drugs 3.4.18 Explain controlled opioid substitution therapy programs in the relevant jurisdiction 3.4.19 - Outline principles of withdrawal management from: opioids, benzodiazepines, alcohol, cannabinoids, caffeine, nicotine and, psychostimulants 3.4.20 - Outline the principles of collaborative management of patients with problematic substance use.
Visceral pain	3.5.11 – Demonstrate a patient-centred approach to pharmacotherapy for chronic pain conditions
Cancer pain	3.6.6 – Recognise interactions of medications, particularly the anti-cancer drugs with cytochrome P450 enzyme systems, and how this might influence analgesic treatments 3.6.16 – Critically discuss the use of other adjuvant analgesics in cancer pain, including but not limited to: bisphosphonates, denosumab, corticosteroids and ketamine

Headache & Orofacial pain	3.7.13 – Outline the evidence base for abortive and prophylactic pharmacological treatment of episodic migraine 3.7.14 – Discuss the rationale and evidence base for the use of the following in the management of chronic headache: botulinum toxin, (occipital nerve stimulation) and immunological therapy 3.7.15 – Critically appraise management of medication-overuse headache 3.7.16 - Discuss the rationale and evidence base for pharmacological (and surgical) treatments for trigeminal neuralgia

1. Knowledge expected to be demonstrated

Demonstrate a detailed knowledge of the neurophysiology of pain

Integrate knowledge of pain mechanisms, acute vs persistent pain neurobiology and pharmacology to justify analgesic choices and deprescribing decisions in different clinical contexts

Apply a detailed knowledge of pharmacokinetics and pharmacodynamics of analgesics and analgesic adjuvants to pain management across patients with co-morbidities and across the age spectrum.

Describe principles and guidelines of opioid stewardship (including initiation thresholds, dose ceilings, monitoring, tapering and deprescribing) and how these apply to acute, chronic non-cancer and cancer pain.

Discuss the DSM V and ICD 11 criteria for substance use disorder.

Explain how social determinants of health, health literacy, cultural beliefs and access to care influence adherence, diversion risk and harms from analgesic pharmacotherapy.

Demonstrate understanding of evidence for using opioids and cannabinoids in managing acute, chronic non-cancer and cancer pain.

Discuss jurisdictional medicolegal regulations for the prescription of controlled substances including cannabinoids, in the management of pain.

Demonstrate a detailed understanding of the use of opioid equivalence tables.

Outline ethical and legal considerations in off-label prescribing in pain medicine, including documentation, consent and post-marketing vigilance.

Develop understanding of Aboriginal and Torres Strait Islanders and Māori preferences for traditional medicines and cultural practices to aid in the treatment of pain

Critically appraise evidence for the efficacy of analgesics and adjuvant agents used in pain medicine across a range of clinical conditions.

Describe the role of regional analgesic techniques that are used in the management of pain – their indications and contraindications

Discuss the indications, contraindications and adverse effects of drugs that are administered epidurally or intrathecally for analgesia (including coadministration of anticoagulants).

2. Skills expected to be demonstrated

Trainees must demonstrate application of person-centric communication skills, professional behaviours including integrity, empathy and adherence to local medicolegal frameworks for the prescription of drugs used in pain medicine. They must educate and consent patients and their carers around the risks, benefits and alternatives to drug therapies and techniques used in the management of pain. They must collaborate with other healthcare practitioners to foster a coordinated shared-care model for prescribing, weaning, de-escalating and ceasing medications used for pain management.

Trainees must demonstrate:

- use of an evidence-based, person-centred approach to selecting, titrating and monitoring analgesic and adjuvant medications, explicitly weighing benefits, risks, patient goals and alternatives (including non-pharmacological options)
- systematic screening for and identification of risk factors for substance use disorders and aberrant use of analgesic agents using validated methodologies and tools supplemented by other patient information including, but not limited to, health records, prescription and dispensing records and screening for common comorbid psychiatric disorders, including suicidality, integrating the findings into prescribing and monitoring decisions
- adherence to the medicolegal requirements, in the relevant jurisdiction, of initiating, follow-up and continued prescription of analgesics, used in the treatment of pain
- the routine utilisation of prescription monitoring software (where available) to inform the commencement and continued prescribing of controlled substances and education of patients about compliance with prescription medications
- use of a shared care model. Consent is obtained for prescription of medications used in pain management, (especially for the prescription of medications that are 'off-label'), including discussion and documentation of risks of short- and long-term adverse effects and provision of information about alternative therapies,
- utilisation of communication strategies including motivational interviewing, interpreters and Aboriginal and Māori health-care workers where appropriate, to educate patients in the safe and evidence-based use of medications prescribed for pain management
- use of communication strategies to mitigate and/or resolve conflict with patients, their families and whanau or other prescribers regarding prescription therapies
- adaptation of prescribing and monitoring strategies for populations at higher risk of harm (e.g. older adults, patients with severe end organ impairment, pregnancy, Aboriginal, Torres Strait Islander and Māori patients, people with low health literacy).
- implementation of structured opioid rotation and deprescribing plans using opioid equivalence tables safely, including management of withdrawal, pain flare and patient anxiety.
- comprehensive documentation of the patient discussions including the rationale for, and details of, prescriptions used in the management of pain, plans for escalation, weaning, rotating and de-prescribing medications, to assist other practitioners and prescribers involved in follow-up care
- identification of clinical situations requiring referral to other specialists, where aberrant use of pharmacotherapy is suspect or proven
- adoption of overdose mitigation strategies to ensure patient safety
- advocacy for patients to have access to harm minimisation therapies (in association with analgesic therapies) that are tailored to, and consistent with, patients' needs and wishes
- conduct and document shared decision-making discussions about pharmacological options, including off-label use, in a way that supports informed consent and realistic expectations.
- liaison with, and education of, other prescribers to ensure a consistent approach to prescribing, weaning and discontinuation of analgesic medications which promote safety in patients with acute, chronic, non-cancer and cancer pain
- reporting of adverse events to the manufacturers and drug and device regulatory authorities for post-marketing evaluation of pharmaceuticals and devices used in pain management
- identification of substance misuse in colleagues including risk mitigation strategies and notification of employing bodies and regulatory authorities
- monitoring of regional analgesic techniques, seeking evidence of adverse effects and determining appropriate timing for removal of catheter systems and rotation of, or substitution with, alternative analgesics as required

- audit of their own practice with regards to the efficacy and adverse events associated with analgesic pharmacotherapy / techniques in patients with pain

3. Behaviours expected to be demonstrated

Trainees must exhibit respect for patients and their carers, and adhere to medicolegal requirements when initiating, monitoring, tapering and discontinuing drugs or analgesic techniques used for pain management. They must:

- engage patients in a shared-care model to foster trust and compliance with analgesic prescriptions including weaning and ceasing medications that are not contributing to functional improvement
- manage disagreement and conflict respectfully when communicating the rationale for tapering and ceasing medications or analgesic techniques especially when this is at odds with the patient's wishes
- recognise their own and societal stigmatisation and biases against patients using prescription opioids, those patients with substance use disorders and those patients employing therapies to minimise and prevent relapse, and actively adopt strategies to minimise the effects of such stigmatisation on patients
- demonstrate empathy for patients who have established co-morbid substance use disorders, assisting them to adopt risk minimisation strategies and referring them for therapies to address their substance use
- transparently acknowledge potential conflicts of interest (e.g. industry influence, system pressures) and prioritise patient safety and evidence over external incentives in prescribing decisions.
- consistently demonstrate use and documentation of real-time prescription monitoring (where this exists) and use of surrogates (family, pharmacist, other prescribers) to identify patients at risk of non-compliance with, and harm from, medications prescribed for pain management
- routinely reflect on their own prescribing patterns (e.g. through audit, feedback, registry data) and adjust practice to align with contemporary guidelines and stewardship principles.
- demonstrate cultural safety when discussing medications with Aboriginal, Torres Strait Islander and Māori patients and other culturally diverse groups, including respect for traditional practices and collaborative planning

Assessment method

To be entrusted with this EPA, the trainee must demonstrate safe pharmacological management of patients across multiple settings, across the age spectrum and in patients with increasing clinical and psychosocial complexity. It is anticipated that these assessments could be undertaken on acute or chronic pain ward rounds, in palliative care ward rounds, in outpatient clinics, as observed explanations to patients undertaking group programs, during professional presentations to colleagues or students or in other clinical settings e.g. addiction medicine clinics.

Multiple assessors must be used to assess different activities for entrustment.

Structured case base discussions focussed on indication, choice, monitoring, opioid rotation, tapering, deprescribing, off-label use, risk mitigation and shared care arrangements

Review of prescribing records and clinical documentation including rationale, consent, safety-netting, monitoring plan, tapering/deprescribing plan and use of real-time prescription monitoring (where available) or surrogate sources to verify compliance

Observed patient facing consultation especially where initiation, continuation, opioid tapering, boundary setting or deprescribing is being discussed.

Review of prescribing patterns over time.

Feedback from pharmacists, other prescribers or multidisciplinary team members especially for shared care or longitudinal stewardship.

Participation and presentation to morbidity and mortality / peer review meetings or other quality assurance activities specifically related to pharmacological management of pain.

References / resources

These are not meant to be a comprehensive list of the literature and trainees are expected to identify areas in which they have gaps and seek out relevant literature.

Other references may be found in the FPM resources guide relevant to the various ETAs in the ANZCA library

1. PS01(PM) Opioid analgesics in chronic non-cancer pain
2. PS10(PM) "Medicinal Cannabis" and chronic non-cancer pain
3. PS12(PM) Ketamine and chronic non-cancer pain
4. PG03(A) Major regional analgesia
5. FPM. Off-label prescribing in pain medicine, 2024. https://www.anzca.edu.au/getContentAsset/3fb65082-60fd-4147-bc32-129682beda73/80feb437-d24d-46b8-a858-4a2a28b9b970/Off-label-prescribing-in-pain-medicine-practice-overview2024(1).pdf?language=en#:~:text=No%20matter%20how%20well%2Dintentioned,of%20negligent%20or%20unprofessional%20prescribing.
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7. Australian Commission on Safety and Quality in Health Care, Opioid Analgesic Stewardship in Acute Pain. Clinical Care Standard https://www.safetyandquality.gov.au/standards/clinical-care-standards/opioid-analgesic-stewardship-acute-pain-clinical-care-standard
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14. Hitchings AJ, Monitoring drug therapy. Medicine, 2023; 52(1): 23-30.
15. Maxwell SRJ. Writing prescriptions: how to avoid common errors. Medicine, 2023; 52(1); 40-44.
16. MacIntyre IM, Prescribing medicines for people with renal impairment. Medicine, 2023; 52(1): 30-35.
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Ketamine and other NMDA receptor antagonists for chronic pain. Cochrane Database of Systematic Reviews 2025, Issue 8. Art. No.: CD015373. DOI: 10.1002/14651858.CD015373.pub2 https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD015373.pub2/full

19. Koponen ME, Senaratne DNS, Hebert HL, Smith BH. Colvin LA. Identifying predictors of neuropathic pain medication prescribing, adherence, and discontinuation: a systematic review and meta-analysis. BJA, 2026; 136(2): 600-617. doi: 10.1016/j.bja.2025.10.047

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22. National Institute of Clinical Excellence (NICE) Guideline. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults NICE Guideline (NG215), April 2022. https://www.nice.org.uk/guidance/ng215/resources/medicines-associated-with-dependence-or-withdrawal-symptoms-safe-prescribing-and-withdrawal-management-for-adults-pdf-66143776880581

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Expiration

It is not anticipated that the knowledge, skills and behaviours articulated above, will expire if specialist pain medicine physicians are using them regularly. For unfamiliar clinical situations (e.g. the complicated obstetric patient or the paediatric patient, depending upon the practitioner's usual patient cohort), it is recommended that specialist pain medicine physicians review their knowledge and skills and seek guidance prior to prescribing to ensure safe patient care. When new analgesic drugs are marketed, it is imperative that the evidence of efficacy, the pharmacology, indications, contradictions, interactions and adverse effects be understood prior to prescribing. "Off-label" prescribing has its own ethical issues – see *FPM, "Off-label prescribing in pain medicine", 2024. https://www.anzca.edu.au/getContentAsset/3fb65082-60fd-4147-bc32-129682beda73/80feb437-d24d-46b8-a858-4a2a28b9b970/Off-label-prescribing-in-pain-medicine-practice-overview-2024-(1).pdf?language=en#:~:text=No%20matter%20how%20well%2Dintentioned,of%20negligent%20or%20unprofessional%20prescribing.*

Practitioners must reflect upon the role of inducements that may be offered by manufacturers prior to prescribing, and for novel analgesics, participate in post-marketing drug evaluation. Practitioners returning to practice after a period of absence should refer to PG13 PM and the relevant regulatory guidelines for advice regarding upskilling in the safe prescribing of medicines for pain.