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 initiation, titration, supervising, rotating, tapering and discontinuing medications and analgesic techniques used in the management of patients with pain, 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 (EPA 1), evidence for the relevant drug or technique and accounting for patient contextual factors, including patient wishes and preferences.

By the end of Q3, the trainee should e entrusted to undertake the pharmacological management of common 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, the prescription, monitoring, tapering or discontinuation of pharmaceutical agents or analgesic techniques for children under the age of 16.

Related Graduate Outcomes

Primary graduate outcomes addressed are the Clinician, Communicator, Scholar and Professional roles

Related roles in practice

Role in Practice	Related Learning Outcome
Clinician role	2.1.21, 2.1.22, 2.1.23, 2.1.24, 2.1.25, 2.1.26, 2.1.27, 2.1.30, 2.1.34, 2.1.36, 2.1.37
Communicator role	2.4.1, 2.4.2, 2.4.3, 2.4.5, 2.4.9, 2.4.10, 2.4.13, 2.4.15, 2.4.16
Collaborator role	2.5.8
Manager leader role	2.6.4, 2.6.7, 2.6.8
Health advocate role	2.7.8, 2.7.11

Scholar role	
Professional role	2.2.7, 2.2.8, 2.2.13, 2.2.15, 2.2.16, 2.2.20
Cultural safety role *	

Related Essential Topic Areas

Role in Practice	Related Learning Outcome
Conceptual Basis of Pain	1.9
Mechanisms in the Biomedical Dimensions of Pain	3.1.15
Acute Pain	3.2.6, 3.2.7, 3.2.8-3.2.22
Spinal pain	3.3.22
Problematic substance use	3.4.1-3.4.20
Visceral pain	3.5.11
Cancer pain	3.6.6,
Headache & Orofacial pain	3.7.13, 3.7.15, 3.7.16

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 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)

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 medication 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 or conflict with patients, their families and whanau or other prescribers
- adaptation of prescribing and monitoring strategies for populations at higher risk of harm (e.g. older adults, renal/hepatic 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 including plans for escalation, weaning, rotating and

de-prescribing medications, for 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

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.

To demonstrate knowledge of pharmacology a mandatory requirement is an overall mark of 80% in the MCQ examination in the questions covered by pharmacology and the use of analgesic techniques.

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 documented 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. Horlocker T, Vandermeuelen E, Kopp S, Gogarten W, Leffert LR, Benzon HT. American Society of Regional Anesthesia and Pain Medicine Evidence Based Guidelines (4th Ed). Reg Anesth & Pain Med, 2018; 43(3): 263-309. doi: 10.1097/AAP,0000000000000763
6. 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
7. Simpson AK, Levy N, Mariano ER. Opioid stewardship. BJA Education, 2023. 23:10; 389-397.
8. FPM, Introduction to Resources for Opioid Stewardship Implementation (ROSI), 2024

ANZCA. https://www.anzca.edu.au/getContentAsset/e13ce50a-9644-49a9-9127-3ca018810018/80feb437-d24d-46b8-a858-4a2a28b9b970/ROSI_Introduction.pdf?language=en

9. Federico JR, Warner NS, Acampora G, Coleman JR, Kohan L. Substance Use Disorders: Basic Overview for the Anesthesiologist. Anesth & Analg, 2023; 137(3): 508-520. DOI: 10.1213/ANE.0000000000006281. https://journals.lww.com/anesthesia-analgesia/pages/articleviewer.aspx?year=2023&issue=09000&article=00005&type=Fulltext

10. Cohen MJ and Jangro WC. A clinical ethics approach to opioid treatment of chronic non-cancer pain. AMA J Ethics. 2015;17(6):521-529. doi: 10.1001/journalofethics.2015.17.6.nlit1-1506.

11. Maxwell SRJ. Pharmacodynamics and pharmacokinetics for the prescriber. Medicine. 2023; 52(1): 1-10.

12. Pirmohamad M. Pharmacokinetics for the prescriber. Medicine, 2023; 52(1): 11-14.

13. Hitchings AJ, Monitoring drug therapy. Medicine, 2023; 52(1): 23-30.

14. Maxwell SRJ. Writing prescriptions: how to avoid common errors. Medicine, 2023; 52(1); 40-44.

15. MacIntyre IM, Prescribing medicines for people with renal impairment. Medicine, 2023; 52(1): 30-35.

16. Gudin J. Opioid therapies and cytochrome P450 interactions. J. Pain Symptom Manage, 2012; 44: S4-14. https://www.sciencedirect.com/science/article/pii/S0885392412004927

17. Ferraro MC, Cashin AG, Visser EJ, Abdel Shaheed C, Wewege MA, Wand BM, Gustin SM, O'Connell NE, McAuley JH. 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

18. 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

19. Lin CWC, Langford AV. Opioid deprescribing in patients with non-cancer pain. NEJM, 2025; 393(18): 1833-42. DOI: 10.1056/NEJMcp2414789

20. Langford AV, Lin CCW, Bero L, Blyth FM, Doctor J, Holliday S, Jeon YH, Moullin J, Murnion B, Nielsen S, Osman R, Penm J, Reeve E, Reid S, Wale J, Schneider CR and Gnjidic D. Clinical practice guidelines for deprescribing opioid analgesics: summary of recommendations. MJA, 2023; 219(2): 80-89. doi: 10.5694/mja2.52002

21. 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

22. Ahuja HK, Jones DS, Williams WW. Prescription without Precision — Dangers of Dosing on the Basis of Race as Biology. NEJM, 2026 Published June 6th, 2026. https://www-nejm-org.ezproxy.anzca.edu.au/doi/full/10.1056/NEJMp2516090?query=WB

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 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 in the context of the patient, 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.