

# Pain medications: older adults' views and experiences

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# Context

- Perspective: Social Sciences / Health Services Research
- Population: Community-dwelling older adults
- Experiences of older adults with chronic pain

# Treatment of pain in older adults

- Lack of studies that include older adults (especially trials)
- Pharmacological treatments combined with other approaches are best
- Medication use is common, correlation with adverse effects
- Older adults are more adherent than younger adults

# The 'TOPUP' study

- Treatment Options People Use for Pain
- Collaboration between Peninsula Medical School & Bristol (MRC funded)
- Treatment Options People Use for Pain:
  - Medical pluralism
- Methods:
  - Community-based survey (2006-7)
  - Qualitative interviews (2008)

# TOPUP recruitment

- 12 GP practices, Bristol, Devon & Cornwall
- Adults, aged 18-100
- Random sample: 2/3 'likely' to have CP, 1/3 from remaining patient list
- Screening question for chronic pain

# Response to the survey

- Of those respondents with chronic pain (62%), 588 (47%) completed the questionnaire
  - 16.7% classed as 'non consulters'
  - 270 (45%) aged 65 and over, of which, 13% non-consulters

# Older adults in the survey

Variable	Mean (SD)
Activity restriction (ADL 0-36)	17.13 (8.76)*
Pain duration (years)	12.87 (12.73)
Pain severity (past week, 0-10)	5.7 (2.3)
Pain related distress (past week, 0-10)	5.37 (2.67)
	N (%)
'Pain elsewhere' (in two or more sites)	206 (77.7)
Diagnosis has been given	233 (86.9)
<b><u>Pain is not under control</u></b>	<b><u>117 (45.2)</u></b>
Pain is intermittent	148 (55.6)
Has co-morbidities	175 (68.6)*

\*Compared with younger respondents, difference is significant (to the 0.05 level)

# Older adults: Response to pain

In comparison with younger respondents, older adults

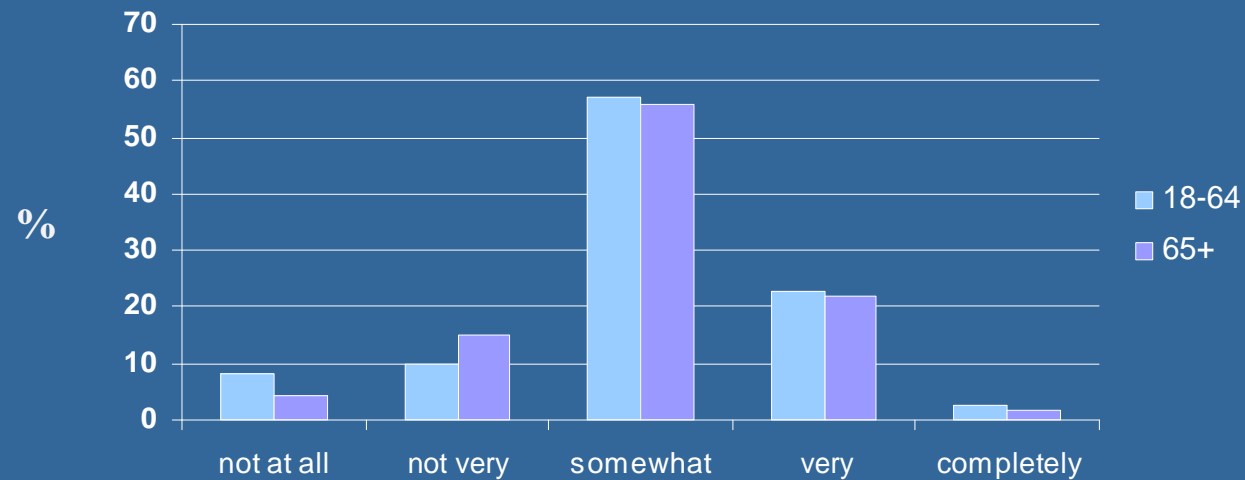
- Were less likely to have consulted their GP recently, or have ever been referred to secondary care
- Adopted fewer self-care responses, but reported similar frequency of use
- Were less likely to have used Complementary and Alternative Medicines or Over The Counter medicines
- Had a more restricted response overall (self-care, CAM, meds and orthodox care)
- Were more likely to use medication (alone or in combination with primary care)

# Use of prescribed medications

- Widespread use overall (71.2%)
- Older adults were more likely to report use (76.9% v 66.3% of 18-64 year olds,  $p < 0.05$ )
- Older adults used different medications:
  - More likely to non-opioid analgesics (paracetamol/aspirin) and oral steroids
  - Less likely to use NSAIDs and opioid analgesics
- 14.2% of the variance in number of medications used by older adults is explained by pain severity and functional limitation

# Use of prescribed medications

- 55.5% of older adults reported taking their medications only when needed
- 42.6% listed medications as their 'best' treatment
  - Relieves pain (for a while); enables functioning / sleep
- Effectiveness of prescribed medications:



# In-depth interviews

- Inductive approach, to look at processes and sense making
- 31 interviews: 3 'iterations'
- 1-2 hours, use of 'life grid' method (Blane, 1996)
- Topics included:
  - experience of pain and the illness trajectory
  - use of different forms of health care
  - acceptance (of pain and in the context of ageing)

# Respondents

Variable	Sample Mean (SD)
Age	75.2 (7.1) Range: 67-92
Activity restriction (ADL, 0-36)	18 (8.1)
Pain duration (years)	13.4 (10.6) Range: 1–45 yrs
Pain severity (past week)	6 (1.7)
	N (%)
Sex: male	15 (48.4)
Diagnosis received	26 (84)
Pain in 2 or more sites	26 (84)
Pain not under control	17 (54.8)
Pain is intermittent	17 (54.8)
Lives alone	16 (51.6)

# Key concepts

1. Beliefs about medications
  - Masking pain
  - Dependence
  - Tolerance
2. Managing medications
  - Rationing medications
  - Prioritising
  - Side effects
3. Practitioner-patient relationship
  - Medications the only choice
  - Good and bad relationships

Medications use is widespread and not seen as a matter of choice for most

I'd rather not be on it. But it's er... the lesser of two evils isn't it? You know, you've got to weigh up the fact that if you didn't take it you'd be in a lot of pain...

Frank, 78

# Beliefs about medications

- Rational beliefs, based on lay experience
- Reflect a desire to maintain control
- Some issues more prominent given pain is *chronic*

# Masking pain

- Risk of more damage
- Control of your body

I've got painkillers. Because I - I don't take them very often because I feel that if the pain's disguised you do things that will make what's making the pain, causing the pain, make it worse. So I don't take them Carol, 71

I came to an arrangement with the doctors, he's not going to give me anything which is going to knock me out too much. Because I want to be aware ... Robert, 76

# Dependence

- Dependence rather than addiction
- Control

I don't want to become beholden to a whole lot of painkillers really. So long as I can... I can deal with what I - know what I've got at the moment and I deal with it, full stop

Judith, 69

if you're dependent on something, I don't think you're really, really yourself

Joyce, 68

# Tolerance

I just don't take them any more than I've got to. I think, rightly or wrongly, that they will be effective when I do take them then. I know the doctor said, "Oh you've got to go and take them," but I still hold back, you know... I still think that um they'll be more effective if you haven't been taking them regularly

Terry, 77

The more you take, the more you've got to take, because it's going to have less effect. So if you can take as few as possible, and keep the others in reserve, and grit your teeth, you can generally - generally get away with it

Judith, 69

# Managing medication regimens

With few exceptions, respondents developed their own system for taking medications, based on taking the minimum dose / day needed

My arthrotec tablets I'm supposed to take three a day, but I only take two a day. I just I just suddenly thought, I'm taking three, why, if I'm all right. So, as I say, I cut the midday out-one out, and I was still all right

Barbara, 80

# Rationing medications

- Because of a general dislike
- To enable a good nights' sleep
- To enable activity

I try not to take them during the day, for the simple reason if I take them during the day I get my quota and I can't take them at night when... I lose a lot of sleep if I don't. So what I tend to do um, I just suffer the pain and take them at night...

William,

78

# Prioritising

- Co-morbidities
- Hierarchy of need

On prioritising Warfarin over pain medications:

I thought that was um - it - it was most probably more dangerous than the hip pain  
Gerald, 68

I guess I'm still happier having a muscular pain or a er - an orthopaedic pain than I am... what I call illness pains

Edward, 80

# Side effects

- Can be embarrassing and worrying
- Relate the experiences of others
- Escalation

he said, “Well it is, but I can give you something help that.”  
Well to me then there was a decision about whether I’m  
going to take something that helps something that helps  
something else. And I’m very loath to go down that road  
so I have now decided that I don’t take the diclofenac  
unless I really have to

Frances, 69

# The role of the practitioner

- Practitioner guides management
- Reinforces norms
- Patients' may have unexpressed information needs

I trust that they would know what to do and would always do what they could  
Jyce, 68

What's the point in going to him? Because he just says, "Oh just take the tablets" ... You know, and I mean you end up like a baby's rattle  
Janet, 77

# What have other people found?

- Unintentional non-adherence less of an issue—older adults have cognitive resources to manage medications (Park et al 1999)
- Desire to minimise medication intake; a general resistance to medicines themselves (Pound et al, 2005)

# Key points

- Prescribed medication use is widespread, but disliked
- Non-adherence is often a rational decision
- Patients know little about the mechanism or purpose of their medications
- Patients' look to their doctor for guidance, and may have unanswered questions

# Implications and conclusions

- Advocacy of non-pharmaceutical interventions is needed
- Perceptions of the desire for participation and communication needs may be underestimated
- Mutualistic relationships may improve outcome

# Further reading

Pound, P et al. Resisting medicines: a synthesis of qualitative studies of medicine taking. *Soc Sci Med* (2005) 61(1): 133-155

Elliott, R. Non-Adherence to medicines: not solves but solvable. *J. Health Serv Res Policy* (2009) 14(1): 58-61

Sale, JEM et al. How "Bad" does the pain have to be? A qualitative study examining adherence to pain medication in older adults with osteoarthritis. *Arthritis Rheum* (2006) 55(2): 272-278

Dowell, J., Hudson, A qualitative study of medication-taking behaviour in primary care. *Fam Prac* (1997) 14:369-375