PATIENT SATISFACTION AT THE CHRONIC PAIN MANAGEMENT CLINIC AT GROOTE SCHUUR HOSPITAL

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Declaration

I, Dr Munyaradzi BM Majangara, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor part of it has been, is being, or is to be submitted for another degree in University of Cape Town or any other university.

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Abstract:

Background: Chronic pain is a costly and debilitating ailment with an estimated global prevalence of 20%. The evaluation of patient satisfaction with pain management is crucial to ensure that care provided remains fit for purpose, and it helps to identify opportunities for improvement. Groote Schuur Hospital has one of the few functional interdisciplinary pain clinics in South Africa with more than 900 patients seen per year. To date we have no data informing us about patient satisfaction at the clinic. The aim of our study was to survey patients being treated at the pain clinic to determine their level of satisfaction with the service.

Methods: A descriptive cross-sectional study was conducted with a sample of 67 patients who had been attending the Chronic Pain Management Clinic for more than 3 months. Data were collected telephonically using the patient demographics form and internationally validated Pain Treatment Satisfaction Scale. Data were analysed using descriptive statistics.

Results: The mean age of the 67 participants was 56.5yrs (SD: 12.9; Age range: 18-83). Eighty-one percent of the sample identified as female, and 70% had not completed 12 years of schooling. Most patients were referred from orthopaedics (48%) followed by referrals from day clinics (13.5%). The median pain severity score was 7.5 (IQR: 7-9) a week prior to data collection. The majority (70%) of participants reported that they were able to ask the staff questions and were provided with adequate support and care. Results indicate that 6 in every 10 patients are satisfied with their pain management at the GSH chronic pain management clinic. One aspect of care which was less than satisfactory related to receiving information about their condition and treatment. In general, participants would have liked more information about their illness or injury (51%), causes and treatments for pain, as well as side effects of pain medication (60%).

Conclusions: Most participants were somewhat satisfied or very satisfied with all aspects of care they were asked about. It is clear that patient-satisfaction is not only driven by pain relief but can be enhanced by good patient-provider relationships and shared decision making. It is important to continually train health care providers to improve their communication skills.

Keywords: chronic pain, chronic pain management clinic, patient satisfaction, Cape Town

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Author Contributions

MBM Majangara: First author and MMed candidate was involved in preparing the protocol, data collection, data analysis, interpretation, write-up and editing of the manuscript under supervision.

Romy Parker: Involved with overall conception and design of the study. Supervised the writing of the protocol, data collection, data analysis and the write-up of the final manuscript.

Katleho Limakatso: Supervised the protocol development, data collection and analysis, and writing and editing of the final manuscript.

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PAPER ACCEPTED FOR PUBLICATION IN THE SOUTH AFRICAN JOURNAL OF ANAESTHESIA AND ANALGESIA:

Patient satisfaction at the Chronic Pain Management Clinic at Groote Schuur Hospital

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ABSTRACT

Background: Chronic pain is a costly and debilitating ailment with an estimated global prevalence of 20%. The evaluation of patients' satisfaction with pain management is crucial both to ensure that care provided remains fit for purpose and to identify opportunities for improvement. Groote Schuur Hospital (GSH) has one of the few functional interdisciplinary pain clinics in South Africa with more than 900 patients seen per year. To date, there had been no data informing us about patient satisfaction at the clinic. The aim of our study was to survey patients who are being treated at the Chronic Pain Management Clinic to determine their level of satisfaction with the service.

Methods: A descriptive cross-sectional study was conducted with a sample of 67 patients who had been attending the Chronic Pain Management Clinic for more than three months. Data were collected telephonically using the patient demographics form and the internationally validated pain treatment satisfaction scale (PTSS). The data were then analysed using descriptive statistics.

Results: The mean age of the 67 participants was 56.5 years (SD 12.9; Age range: 18–83). In this sample, 81% of the participants are female while 70% of the participants had not completed 12 years of schooling. Most of the participants were referrals from orthopaedics (48%) followed by referrals from day clinics (13.5%). The median pain severity score was 7.5 (IQR 7–9) a week prior to data collection. The majority of participants (70%) reported that they could ask the staff questions and were provided with adequate support and care. Results indicate that six in every ten patients are satisfied with their pain management at the GSH Chronic Pain Management Clinic. One aspect of care which was less than satisfactory

related to patients receiving information about their condition and the treatment thereof. In general, participants would have appreciated more information about their illness or injury (51%), causes and treatments of the pain, as well as side effects of the pain medication (60%).

Conclusion: Most participants were either somewhat satisfied or very satisfied with all aspects of care they were asked about. It is clear that patient satisfaction is not only driven by pain relief but can also be enhanced by good patient-provider relationships and shared decision-making. It is, therefore, important to continually train healthcare providers to improve their communication skills.

Keywords: chronic pain, Chronic Pain Management Clinic, patient satisfaction, Cape Town

1. INTRODUCTION

The global prevalence of chronic pain is estimated at 20% and it accounts for nearly one fifth of physician visits.[1,2] The figures are similar in South Africa with one in five South Africans reporting chronic pain.[3] This high prevalence translates into a large societal burden as chronic pain is a costly and debilitating ailment.[2] Chronic pain has a negative impact on multiple aspects of patient health including mental health, work, sleep, relations with other people and overall quality of life.[4] It is estimated that the societal burden of chronic pain may be larger in the developing world than in the developed world, with chronic musculoskeletal pain being the most common pain condition in developing communities.[5,6]

Current treatment guidelines for chronic pain recommend multidimensional management of pain by an interdisciplinary team of healthcare professionals.[7] Chronic pain is a complex pathology involving maladaptive changes at multiple levels of the peripheral and central nervous system. These changes can be upregulated by the interaction of various biological, psychological and social factors.[8] Targeting these factors using an interdisciplinary approach has shown a greater effect than biomedical interventions alone in improving pain, depression, anxiety and psychosocial functioning, including return to work.[9] Given the complex mechanisms and the promising evidence, it is not surprising that evidence-based guidelines recommend the use of a combination of pharmacological and non-pharmacological treatments delivered by teams of healthcare professionals to effectively manage pain.[10]

An association between patient satisfaction and the comprehensive assessment and management of pain has been shown in recent years.[11] Patient satisfaction is defined as the extent to which patients are happy with the healthcare service they are receiving. This evidence-based outcome is dependent on many variables including improvement in pain outcomes, attitude of medical staff, clear communication and patient's expectations being met or exceeded.[12] Moreover, improved patient satisfaction has been shown to positively affect clinical outcomes, patient trust levels, adherence to treatment, patient-carer relations and the quality of healthcare delivery.[13]

To date, there are no official data informing us about patient satisfaction with the Chronic Pain Management Clinic at Groote Schuur Hospital (GSH). The Commission on Patient Safety and Quality Assurance recommends that clinical audits and other quality improvement

processes, including evaluations of patient satisfaction with received care, be undertaken regularly with the aim of improving patient care and outcomes.[14] These processes are crucial to ensure that care provided remains fit for purpose and to identify opportunities for improvement.[15] In keeping with this principle, the aim of this study was to survey patients being treated in the GSH Chronic Pain Management Clinic to determine their level of satisfaction with the service.

2. METHODS

Ethical approval was obtained from the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (Ref: 715/2018). Following the approval, we conducted a descriptive cross-sectional study to determine the level of satisfaction with pain management among patients who had been receiving treatment at the GSH Chronic Pain Management Clinic for a minimum of three months.

The interdisciplinary team at the GSH Chronic Pain Management Clinic comprises anaesthetists, nurses, physiotherapists, psychiatrists, and clinical psychologists. The pain clinic sees more than 900 patients per year, of which one fifth are new presentations. Patients seen at the clinic range in age from 18 to 90 years with the most common presenting age being 40 to 65 years (Dr. Janieke van Nugteren, personal communication, June 17 2018). Since January 2018, the clinic has been receiving 15–20 referrals per week. Although a triage system is implemented to prioritise patients requiring urgent medical care, some patients may await treatment for four to nine months. Many of the patients seen at the GSH Chronic Pain Management Clinic have been using the service for several years, with numerous barriers encountered when discharging back to primary care contributing to long waiting lists.

We excluded participants from this study who, (i) had recorded cognitive impairment or dementia, (ii) were not able to verbally communicate in English, Afrikaans or isiXhosa, or (iii) had ongoing legal proceedings or complaints against GSH. To minimise selection bias, patients meeting the eligibility criteria were randomly identified from the registry of patients attending the clinic. The eligible patients were contacted telephonically by a trilingual research assistant (competent in English, Afrikaans and isiXhosa) to invite them to participate in the study and to screen the consenting participants according to the eligibility criteria.

Eligible patients who consented to participating then completed a telephonic interview using the validated pain treatment satisfaction scale (PTSS).[16] The PTSS has shown good validity and reliability in patients with various chronic pain conditions and has been widely used in research involving pain treatment satisfaction and pain management programmes.[16,17] We were particularly interested in the following subsections of the PTSS: (i) satisfaction with current medication and care, (ii) satisfaction with information about pain and its treatment, (iii) medication side effects, and (iv) general health. On completion of the telephonic interview, further information was obtained from the patients' files and collated onto a data collection sheet. This information included demographics such as age, sex, education and employment status, medical history and chronic pain history. Pain severity and pain interference scores on admission and at the most recent consultation were extracted from the Brief Pain Inventory (BPI) which is routinely used at the clinic. The BPI scores were classified as either mild (1–4), moderate (5–6) or severe (7–10).[10]

3. STATISTICAL ANALYSIS

The sample size (n) was calculated using the Yamane formula ($n = \frac{N}{1+N(e)^2}$) for calculating a sample size in cross-sectional studies[18] where n represents the patient population and e is the level of precision for a 95% confidence interval. Using a population size of 82 (based on the number of patients seen during a one-month period at the Chronic Pain Management Clinic) and a precision of 0.05 (based on a 95% confidence interval), the formula indicated that a sample of 68 participants with chronic pain were needed for the results to be generalisable to the sampling frame of all patients seen during a one-month period. This time frame was chosen because the effect of the treatment is evaluated over the following one-month period. Descriptive statistics [median (interquartile range) or mean (standard deviation)] were used according to the distribution of data to summarise demographic, health, chronic pain profile and treatment information. Categorical data are presented as frequencies (n) and percentages. Sections of the PTSS were analysed individually.

4. RESULTS

The recruitment process is illustrated in Figure 1 and indicates that participant recruitment continued until the sample size of 68 participants was achieved. On analysis of the participants, one was found not eligible, resulting in a final sample of 67 participants.

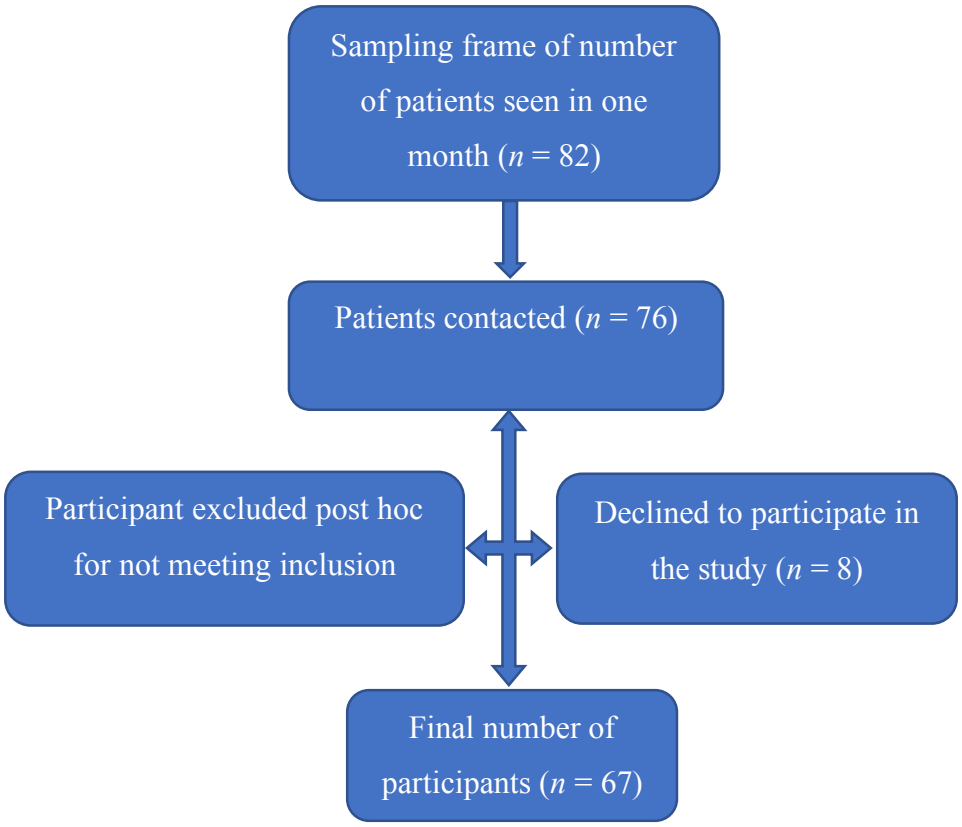

Figure 1: A flow-diagram illustrating the recruitment process.

4.1 Demographic characteristics of participants

The mean age of the 67 participants was 56.5 years (SD 12.9). Most of the participants were female (81%). Of the total number of participants, 70% had not completed 12 years schooling; and were either retired (39%) or receiving a disability grant (37%) (Table 1).

Table 1: Demographic characteristics of the participants (n = 67).

Characteristics	n (%)
Sex	
Female	54 (81)
Male	13 (19)
Level of education	
No schooling completed	3 (4.5)
Completed Grade 4	3 (4.5)
Completed Grade 7	17 (25)
Completed Grade 10	24 (36)
Completed Grade 12	12 (18)
University/Technikon/College graduate	7 (10.5)
Postgraduate qualification	1 (1.5)
Employment status	
Disability grant	25 (37)
Not employed	6 (9)
Employed, part-time	4 (6)
Employed, full-time	4 (6)
Housewife	1 (1.5)
Retired	26 (39)
Student	1 (1.5)

4.2 Health profile of participants

In addition to having chronic pain, most participants presented with multiple comorbidities, with the most common being hypertension and diabetes (Table 2). The majority of participants (72%) were self-reported cigarette smokers.

Table 2: Common comorbidities in participants who took part in the study (n = 67).

Condition	n (%)[1]
Hypertension	45 (67)
Diabetes Mellitus type 2	18 (27)
Hypercholesterolemia	12 (18)
Chronic obstructive pulmonary disease/asthma	10 (15)
Depression	9 (13)
Arthritis	9 (13)
Ischemic heart disease	5 (7)
Chronic kidney disease	4 (6)
Peripheral vascular disease	2 (3)
Retroviral disease	2 (3)

1 The numbers do not add up to the total sample size because some participants had more than one comorbidity.

4.3 Chronic pain profile of participants

Participants were referred from a variety of primary, secondary and tertiary level clinics with most referrals originating from the department of orthopaedics (Table 3). The majority of participants had first been seen in the Chronic Pain Management Clinic within the last four years. The most common conditions presenting were non-specific back pain (24%) and failed back syndrome (21%) (Table 3).

Table 3: Referring departments, year of referral and chronic pain conditions of the participants (n=67).

Referring department	n (%)
Orthopaedics	32 (48)
Day clinic	9 (13.5)
Neurosurgery	7 (10)
Rheumatology	3 (4.5)
Medical outpatients' department	3 (4.5)
General and vascular surgery	3 (4.5)
Physiotherapy/occupational therapy	2 (3)
Psychiatry	2 (3)

Cardiothoracic	2 (3)
Plastic surgery	1 (1.5)
Ophthalmology	1 (1.5)
Dermatology	1 (1.5)
Urology	1 (1.5)
Year of referral to the Chronic Pain Management Clinic	
2005–2014	14 (21)
2015	11 (16)
2016	6 (9)
2017	14 (21)
2018	17 (25)
2019	1 (2)
Not indicated	4 (6)
Condition	
Non-specific back pain	16 (24)
Failed back syndrome	14 (21)
Fibromyalgia	10 (15)
Neuropathic pain	7 (10)
Spinal stenosis	5 (7.5)
Complex regional pain syndrome	5 (7.5)
Spondylolisthesis	2 (3)
Persistent postsurgical pain	2 (3)
Postsurgical neuropathic pain	1 (1.5)
Fibromyalgia and spinal stenosis	1 (1.5)
Fibromyalgia and bilateral carpal tunnel syndrome	1 (1.5)
Cauda equina syndrome	1 (1.5)
Chronic eye pain	1 (1.5)
Phantom limb pain	1 (1.5)

4.4 Pain treatment

Participants were prescribed a range of pharmacological and non-pharmacological treatments for their pain conditions. Multimodal analgesia was common with more than 50% of participants on a combination of paracetamol, tramadol, pregabalin and antidepressants. Six participants had received regional nerve blockade in the form of caudal blocks. Seventy-two percent of the participants were referred to the chronic pain management programme (Pain Education Empowerment Programme – PEEP) incorporating pain education, exercise and mindfulness training. Participants were also referred for one-on-one physiotherapy, psychiatry, psychology and acupuncture sessions.

4.5 Brief Pain Inventory

The scores for the BPI on admission to the Chronic Pain Management Clinic were available for 61 participants. All the participants had severe pain severity scores (median: 8.1; IQR: 7.5–9) and pain interference scores (median: 8.5; IQR: 6.7–9.2) on admission. Pain scores on their most recent visit to the clinic were 6.5 (IQR: 4.5–8.5) for pain severity and 4.84 (IQR: 2.4–7.28) for pain interference with function. During the survey, participants reported that their median pain scores in the last week were 7 (IQR: 7–9) with similar scores reported for their pain in the last 24 hours and their current pain. Using a 0-10 Visual Analogue Scale (VAS), participants reported that they waited until they had a severity score of six before asking for medication and nine before taking the medication.

4.6 Pain treatment satisfaction scale

The results for each of the subsections of the PTSS are presented in Figure 2, Figure 3 and Table 4.

4.6.1 Satisfaction with current pain medication and care

Overall, most participants (61%) were either satisfied or very satisfied with their current pain management. In addition, 54% of the participants reported that the level of pain relief met or exceeded their expectations (Figure 2).

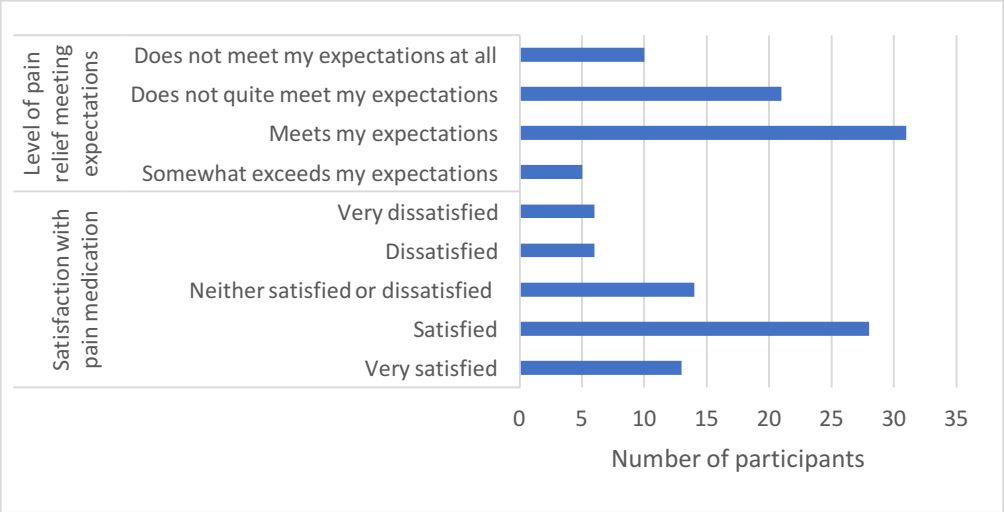

Figure 2: Overall satisfaction of participants with medication and level of pain relief.

The participants were either somewhat satisfied or very satisfied with all aspects of care that they were asked about (Figure 3). Most participants agreed with all the statements about pain medication improving their health, function, participation, mood and cognition (S2). However, fewer participants were somewhat satisfied with the duration of pain relief suggesting they would have been more satisfied with longer durations of pain relief. Despite the appearance of satisfaction with the pain management as indicated above, 51% of the participants indicated that their current pain medication could probably be more effective in relieving their pain. Also 30% were not sure whether the medication could be more effective, and 19% believed it probably could not be more effective. Of the 67 participants, 36 (54%) had previously used other pain medication and 21 (31%) of these participants indicated that their current pain medication was better than the previous medication, while eight (12%) indicated that it was the same as their previous medication. Seven (10%) indicated that their current medication was somewhat worse, or much worse than their previous medication.

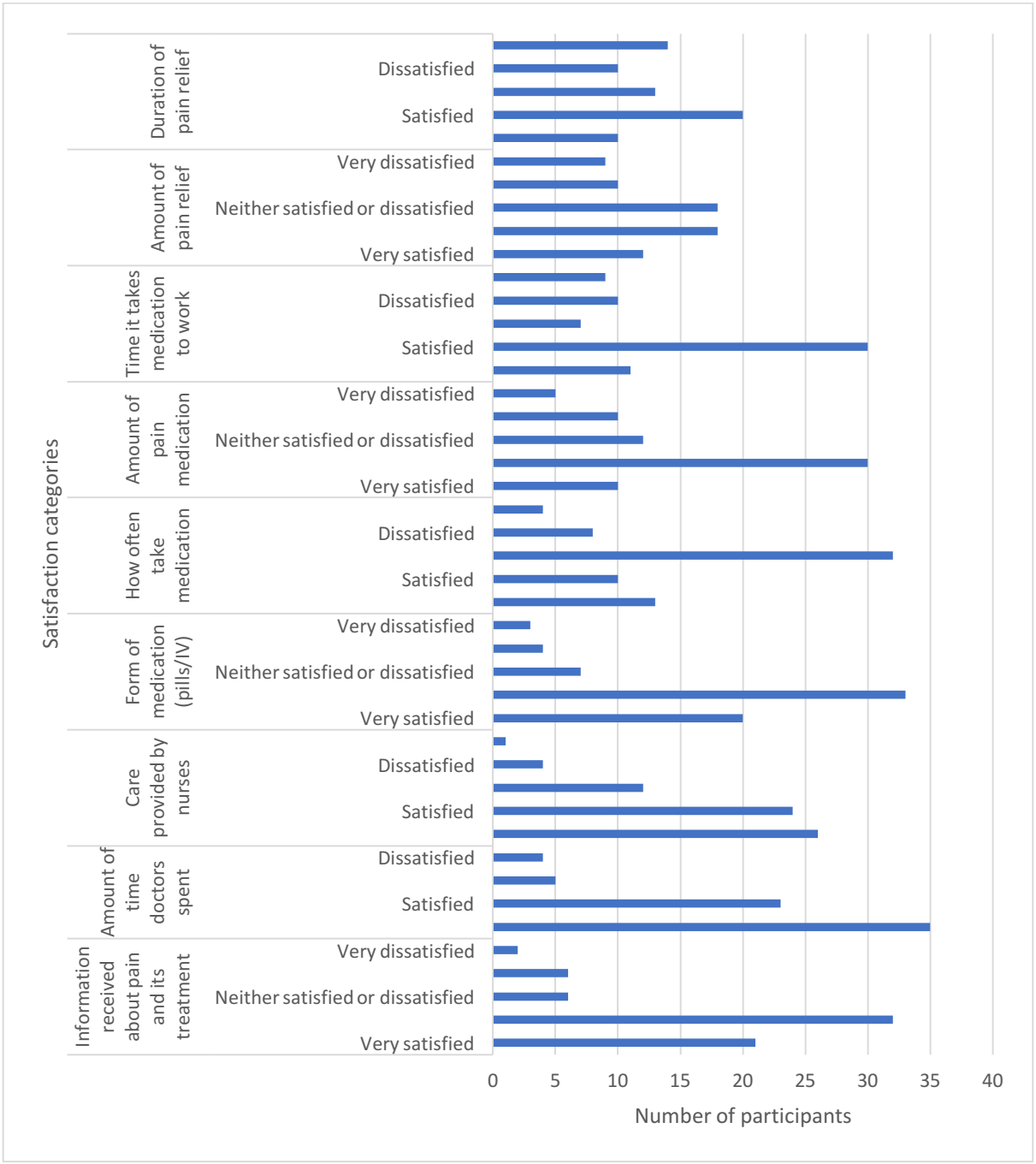

Figure 3: Participants' satisfaction with current pain medication and care.

4.6.2 Medical care

The summary of participants' responses to questions about current medical care is presented in Table 4. The main factor contributing to patient satisfaction was good patient-provider relationships. The majority of participants agreed that they were able to ask the staff questions and were provided with adequate support and care.

Table 4: Summary of participant responses to questions about current medical care.

Statement	Strongly agree n (%)	Somewhat agree n (%)	Neither agree or disagree n (%)	Somewhat disagree n (%)	Strongly disagree n (%)
It is easy to ask the medical staff questions.	47 (70)	14 (21)	2 (3)	2 (3)	2 (3)
The medical staff always do their best to keep me from worrying.	44 (66)	12 (18)	8 (12)	1 (1.5)	2 (3)
The medical staff is willing to provide me with the pain medication that I feel I need.	41 (61)	17 (25)	3 (5)	3 (5)	3 (5)
The medical staff provide adequate follow-up care.	36 (54)	19 (28)	4 (6)	6 (9)	2 (3)
The medical staff does not ask me about the pain I experience.	4 (6)	4 (6)	5 (7)	12 (18)	42 (63)

4.6.3 General health

Despite the satisfaction as indicated above, most of the participants still reported that they were currently either only in fair (46%) or poor (27%) health. Only (3%) reported excellent health. The remainder reported that they were in good (19%) or very good (5%) health.

4.6.3 Information about pain and its treatment

In general, participants wanted more information about their illness or injury, causes and treatments for pain as well as pain medications (S1). Sixty percent of the participants would have liked much more information about the possible side effects of the pain medication.

4.6.4 Side effects of medication

Most participants (94%) reported that their oral medications were easy to swallow. Regarding oral medication leaving an aftertaste, 54% of the participants strongly disagreed or disagreed with this statement, while 22% agreed that there was an aftertaste. Participants were asked whether they experienced the following side effects from their medication: unintentional weight gain; excessive fatigue; drowsiness; inability to concentrate; nausea; diarrhoea; dizziness; constipation; skin rashes; stomach aches; heartburn; vomiting (S3). The participants were generally not bothered by most of these side effects. However, the most experienced and bothersome side effects were drowsiness (51%), excessive fatigue (49%), constipation (39%) and the inability to concentrate (37%).

5. DISCUSSION

According to our knowledge, this is the first study to report on satisfaction with pain management among chronic pain patients attending an interdisciplinary pain clinic in South Africa. Our results indicate that 61% of the participants were generally satisfied with their pain management. Furthermore, the treatment expectations of 54% of the participants were either met or exceeded. Overall, the participants experienced moderate to severe pain at the time of the survey and had been receiving a combination of pharmacological and non-pharmacological treatment at the GSH Chronic Pain Management Clinic for an average of four years.

Overall, a high proportion of the participants in this study were either satisfied or very satisfied with their pain management. The positive findings from this study are consistent with another study involving people with chronic pain conducted in the USA.[19] However, the findings were lower than those in mixed samples of acute and chronic pain patients in Vietnam[20] and lower than those of a study showing that 85% of acute pain patients were either satisfied or extremely satisfied with the management of their pain.[21] The consistently high levels of satisfaction in this study are encouraging and are indicative of the successful delivery of pain management.[22] In addition, the results may be a reflection that patients' expectations of ideal care were matched by their perception of the care they received.[22]

Met or exceeded expectations regarding pain relief was one of the key determinants of satisfaction with overall treatment in this study. Patients who have their treatment

expectations either met or exceeded, have higher satisfaction and improved outcomes.[23-25] We found it interesting that the participants' expectations were exceeded because the levels of pain reduction from their most recent clinical visit and the 24 hours preceding data collection were not clinically significant (median difference: 1.6 out of 10 on VAS). This suggests that the participants' expectations went beyond merely reducing pain severity. The primary goal of managing patients with complex pain conditions at the GSH Chronic Management Pain Clinic is moving away from a single focus to reducing pain severity towards a holistic management of the patient to improve function and participation in meaningful life roles. Communication about this holistic strategy with an emphasis on improving function and participation in meaningful life roles by the healthcare professionals may have resulted in shifted expectations about pain relief, to the extent where minimal improvements in pain met or even exceeded the participant's expectations.

It is of interest that the participants reported high overall satisfaction scores despite reporting severe pain[7] (IQR: 4–9) in the preceding 24 hours. It may be logical to assume that high pain scores will have a negative correlation with patient satisfaction scores. This notion is however not supported by the results of this and earlier studies.[19,26] The paradoxical relationship between satisfaction and pain scores has previously been well described.[26-28] The role of the patient-provider relationship appears to be pivotal in understanding this paradox. In our study, most participants reported being satisfied with their relationships with staff members, finding it easy to interact with them and to ask questions. Where relationships are good, patient satisfaction is likely to be high, despite continued pain.[19,27] This is an encouraging result and reflects positively on the interdisciplinary team approach and ability of the team members to develop therapeutic relationships with patients.

Another important consideration is that overall satisfaction may have been positively influenced by the achievement of the primary treatment goal – improved function and participation in meaningful life roles despite pain.[29] This is supported by the clinically significant improvement in the scores for pain interference with function (median difference: 3.6 out of 10 on VAS) between the most recent clinical visit and for the 24 hours preceding data collection. According to the Patient-Reported Outcomes Measurement Information System (PROMIS)® guidelines, an improvement of three points or more (on a 0–10 VAS) is clinically meaningful.[30] The global measure of pain interference with function incorporates general activity, mood, walking ability, work, relations with other people, sleep and

enjoyment of life.[30,31] Improvement in these affective and functional domains has been associated with greater levels of satisfaction with treatment.[32] This evidence further highlights the importance of pain management which focuses beyond merely the reduction of pain severity to equipping chronic pain patients with the tools to help them participate in meaningful life roles and to reduce pain interfering with function.

The one area which participants were less satisfied with in their pain management related to the amount of information received. Most participants indicated that they wanted more information on pain and its treatment. This is despite many patients having been referred for either Pain Neuroscience Education or to participate in the chronic pain management programme (PEEP) which includes a large educational component including a workbook.[33] This finding illustrates that even in a group of patients who are generally satisfied with their treatment, there is a need to continually engage in strategies to improve patient-provider communication in order to facilitate information giving. Many studies have shown the importance of information giving and patient education using effective communication and shared decision-making in chronic pain management.[27,28] Shared decision-making results in improved patient compliance and participation with their treatment.[28] In chronic disease management, information giving is often a focus at the initiation of treatment. As many of the participants in this survey had been receiving treatment at the clinic for several years, it is possible that the emphasis on information giving had decreased over time.

There are several limitations to this study. Firstly, a cross-sectional survey provides limited insight into mechanisms as exploration of causation not possible. There may also be a strong selection bias in the study with many patients not being contactable. There is also a bias towards chronic pain associated with orthopaedic conditions, as most of the participants had been referred from the orthopaedics department with non-specific back pain and failed back syndrome being the most common conditions. While this predominance of back pain is similar to that reported elsewhere it may be of value for future studies to subgroup patients according to condition.[34]

6. CONCLUSION

The results of this study indicate that 6 out of 10 patients with chronic pain are satisfied with their pain management at the GSH Chronic Pain Management Clinic. This is encouraging and

reveals the positive impact on chronic pain management made by the interdisciplinary Chronic Pain Management Clinic in Cape Town, South Africa. The findings of this study also show that patient satisfaction is not only driven by pain relief, but can be augmented by good patient-provider relationships and shared decision-making. This highlights the importance of continuous training of healthcare providers to improve their clinical communication skills. While this study provides valuable insight into patients' satisfaction with pain management, we recommend that further studies explore healthcare providers' views on managing and improving patient satisfaction with chronic pain management.

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6.2 Conflict of interest

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

6.3 Funding source

No funding was required.

6.4 Ethical approval

Ethical approval was obtained from the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC Ref: 715/2018).

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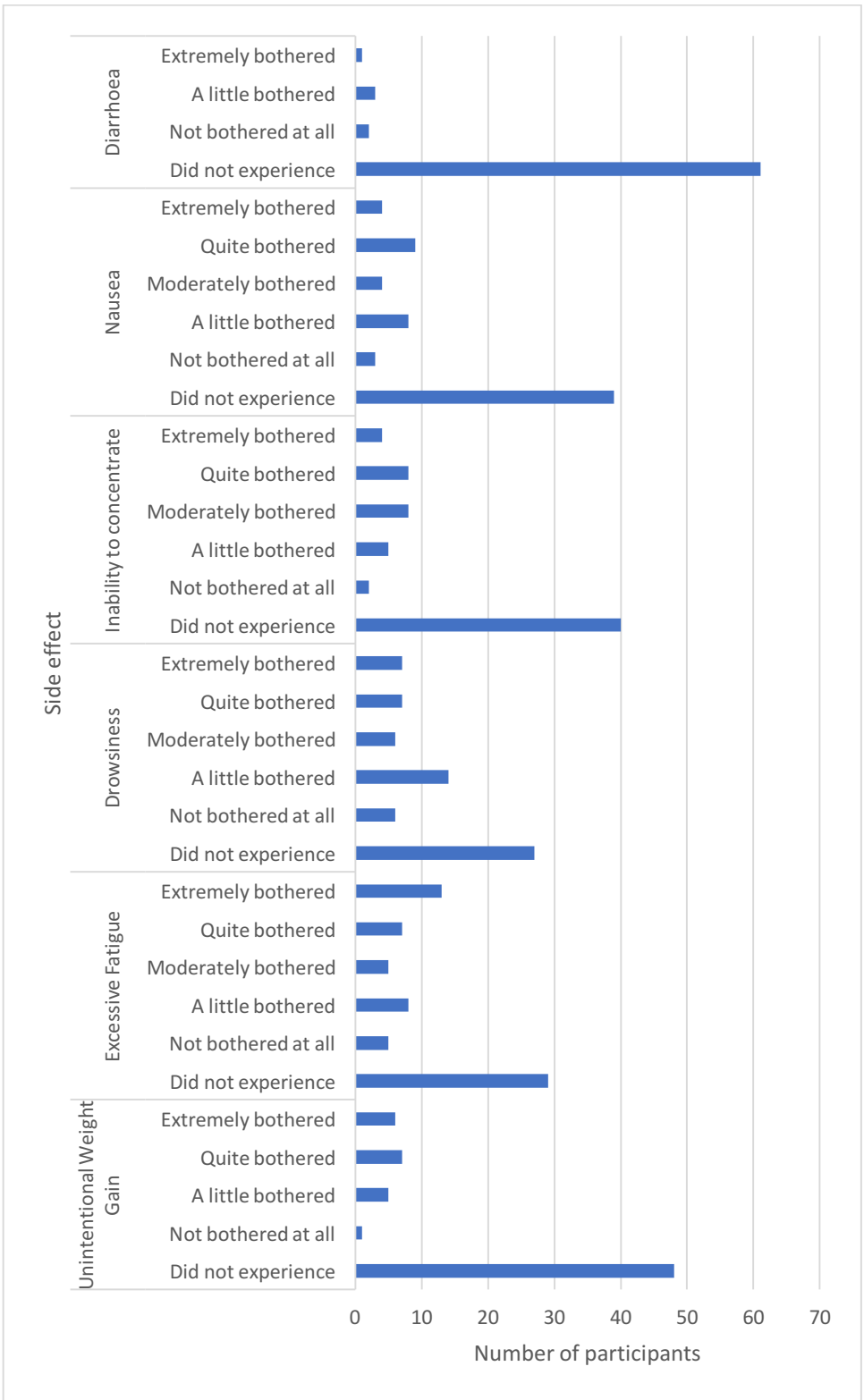
8. SUPPLEMENTARY FILES

S1: Summary of participant responses regarding receiving information about their pain and its treatment.

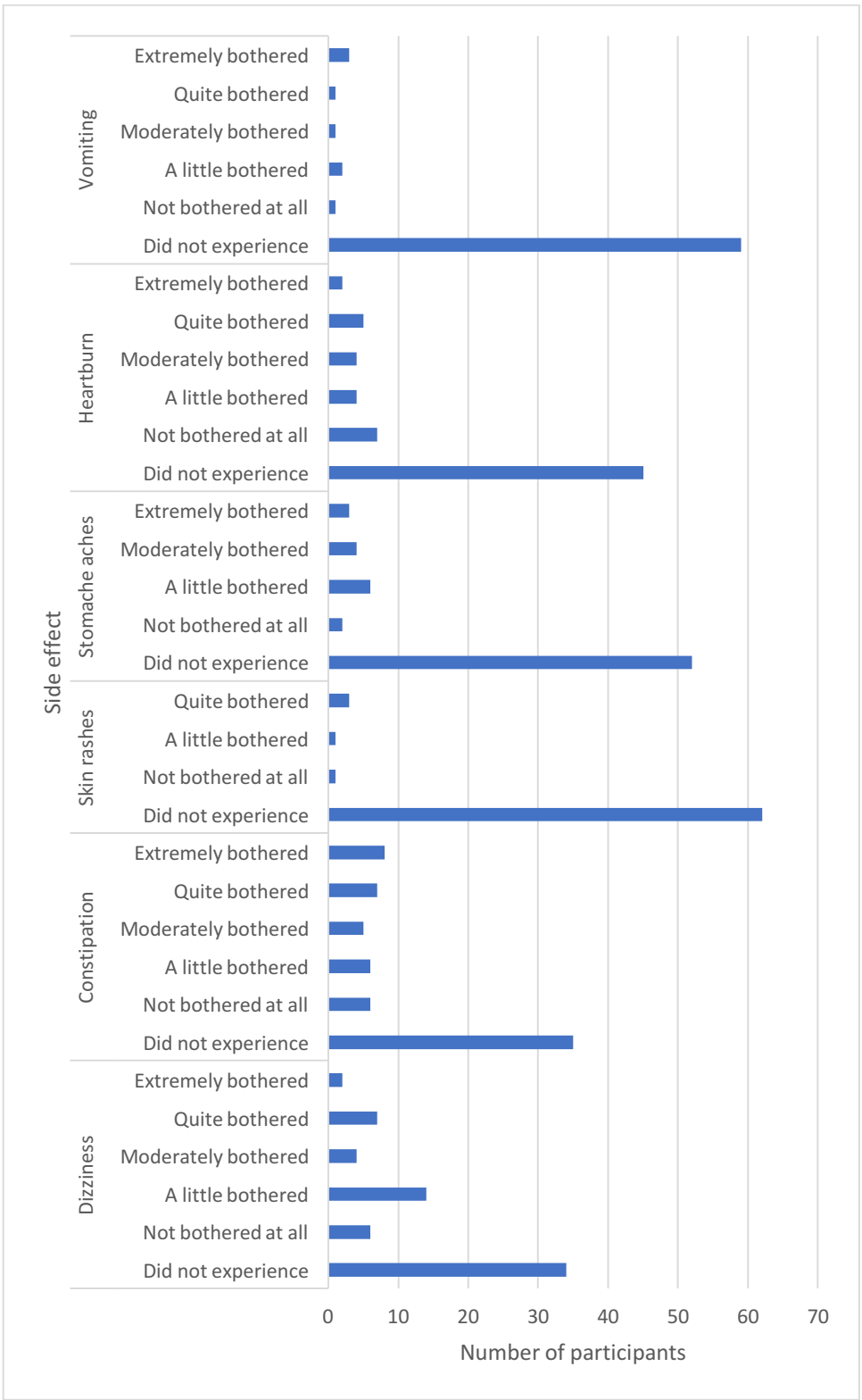
How much information you would have liked to have received about…	I would have liked much more information n (%)	I would have liked a little more information n (%)	The amount of information was right for me n (%)	I would have liked less information n (%)	I would have liked no information n (%)
My illness or injury	34 (51)	15 (22)	17 (25)	0 (0)	1 (1.5)
The cause(s) of my pain	31 (46)	17 (25)	19 (28)	0 (0)	0 (0)
Treatment options for my pain	28 (42)	19 (28)	19 (28)	1 (1.5)	0 (0)
Pain medication in general	25 (37)	26 (39)	16 (24)	0 (0)	0 (0)
Possible side effects of pain medication	40 (60)	15 (22)	10 (15)	0 (0)	2 (3)

S2: Summary of participants' responses to statements about their current pain medication.

	Strongly agree n (%)	Somewhat agree n (%)	Neither agree nor disagree n (%)	Somewhat disagree n (%)	Strongly disagree n (%)
Has a positive effect on my physical health	17 (25)	25 (37)	7 (10)	11 (16)	7 (10)
Helps me have a better outlook on life	21 (31)	20 (30)	10 (15)	8 (12)	8 (12)
Allows me to perform my daily activities more easily	15 (22)	23 (34)	12 (18)	7 (10)	10 (15)
Allows me to participate in my leisure activities more often	11 (16)	18 (27)	16 (24)	12 (18)	10 (15)
Helps me do things independently	23 (34)	20 (30)	8 (12)	9 (13)	7 (10)
Allows me to have better relationships with others	19 (28)	22 (33)	10 (15)	8 (12)	8 (12)
Improves my mood	26 (39)	10 (15)	13 (19)	8 (12)	10 (15)
Allows me to concentrate better	15 (22)	21 (31)	15 (22)	6 (9)	10 (15)



S3a: Participants' responses to side effects from pain medication



S3b: Participants' responses to side effects from pain medication

9. APPENDICES

9.1 Letter of Ethical Approval

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

14 December 2018

HREC REF: 715/2018

A/Prof R Parker
Division of Anaesthesia & Perioperative Medicine
D-23
NGSH

Dear A/Prof Parker

PROJECT TITLE: PATIENT SATISFACTION AT THE CHRONIC PAIN CLINIC AT GROOTE SCHUUR HOSPITAL (MMED Candidate - Dr M B Majangara)

Thank you for your response letter dated 06 December 2018, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 December 2019.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: Dr Munyaradzi Majangara will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

9.2 Data Collection Sheet

Patient Information (Folder Number:)

Information obtained from Pain Clinic Folder

Age: ____ DOB: _____

Gender: Female ☐ Male ☐

Occupation:

- ☐ Yes, full- time
- ☐ Yes, part-time
- ☐ No, I am unemployed
- ☐ No, I am a seasonal worker/temporary
- ☐ Unable to find work
- ☐ Disability grant
- ☐ Retired
- ☐ Student

Highest Educational Level:

- ☐ No schooling completed
  Completed grade:
  4☐; 7☐; 10☐; 12☐
- ☐ University/Technicon/College Graduate
- ☐ Masters
- ☐ PhD

Co-morbidities:

_____

_____

Current Smoker: Yes ☐ No ☐ Number of years as a smoker: _____

Number of cigarettes smoked per day: _____

Chronic pain diagnosis: _____

Date of first consultation at pain clinic: _____

Route of referral to pain clinic: _____

Brief Pain Inventory

On admission: PSS PIS:

Most recent: PSS PIS:

Pain Treatment:

Pharmacological:

Intervention:

Nonpharmacological:

Psychology

Chronic Pain Management Program/Pain Education Empowerment Program

Physiotherapy

Psychiatry

9.3 Pain Treatment Satisfaction Scale (PTSS)

General

1. In general do you feel that your health is: (circle one)

Excellent	Very Good	Good	Fair	Poor

The following statements ask you about the level of pain that you suffer from. On a scale of 0 to 10, with 0 representing "no pain" and 10 representing the "worst pain possible", please circle the number that represents:

2.	How much pain you had in the last week.										
	0	1	2	3	4	5	6	7	8	9	10
3.	How much pain you had in the last 24 hours.										
	0	1	2	3	4	5	6	7	8	9	10
4.	How much pain you have right now.										
	0	1	2	3	4	5	6	7	8	9	10
5.	The level of pain you reach before asking your doctor for medication.										
	0	1	2	3	4	5	6	7	8	9	10
6.	The level of pain you reach before taking your medication.										
	0	1	2	3	4	5	6	7	8	9	10

Information about Pain and its Treatment

The following questions ask about your pain and its treatment. Please answer each question below but ticking the box that best represents your opinion (tick only one box per question).

How much information would you have like to have received about each of the following:		I would have like much more information	I would have liked a little more information	The amount of information was right for me	I would have liked less information	I would have liked no information
7.	My illness or injury	1	2	3	4	5
8.	The cause(s) of my pain	1	2	3	4	5

9.	Treatment options for my pain	1	2	3	4	5
10.	Pain medication, in general	1	2	3	4	5
11.	Possible side effects of pain medication	1	2	3	4	5

Medical Care

The following statements ask about your medical care. Please answer each question below by ticking the box that best represents your opinion (tick only one box per question).

How much do you agree or disagree with each of the statements:		Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree
12.	It is easy to ask the medical staff questions	1	2	3	4	5
13.	The medical staff always do their best to keep me from worrying	1	2	3	4	5
14.	The medical staff is willing to provide me with the pain medication that I feel I need	1	2	3	4	5
15.	The medical staff provide adequate follow-up care	1	2	3	4	5
16.	The medical staff does not ask me about the pain I experience	1	2	3	4	5

Current Pain Medication

The following statements are about your current pain medication. Please answer each question below by ticking the box that best represents your opinion (tick only one box per question).

How much do you agree or disagree with each of the statements:		Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree
17.	My pain medication has a positive effect on my physical health	1	2	3	4	5
18.	My pain medication helps me have a better outlook on life	1	2	3	4	5
19.	My pain medication allows me to perform my daily activities more easily	1	2	3	4	5
20.	My pain medication allows me to participate in my leisure activities more often	1	2	3	4	5
21.	My pain medication helps me do things independently	1	2	3	4	5
22.	My pain medication allows me to have better relationships with others	1	2	3	4	5
23.	My pain medication improves my mood	1	2	3	4	5
24.	My pain medication allows me to concentrate better	1	2	3	4	5

Pain Medication Route of Administration

How is your current pain medication administered? Please tick all that apply and complete those sections.

☐ Orally (pills, capsules, liquid etc) ⟶ Go to Section A

☐ By intravenous injections ⟶ Go to Section B

☐ By patches ⟶ Go to Section C

SECTION A

TO BE ANSWERED BY PATIENTS TAKING ORAL MEDICATION

How much do you agree or disagree with each of the statements:		Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree
25.	My oral pain medication is easy to swallow	1	2	3	4	5
26.	My oral pain medication leaves an after-taste	1	2	3	4	5

SECTION B

TO BE ANSWERED BY PATIENTS TAKING INTRAVENOUS (IV) PAIN MEDICATION

How much do you agree or disagree with each of the statements:		Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree
27.	My IV medication works quickly	1	2	3	4	5
28.	My IV medication hurts when it is injected	1	2	3	4	5
29.	My IV injections leave too many bruises	1	2	3	4	5

SECTION C

TO BE ANSWERED BY PATIENTS TAKING PATCH PAIN MEDICATION

How much do you agree or disagree with each of the statements:		Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree
30.	My patch pain medication irritates my skin	1	2	3	4	5
31.	My patch pain medication is easy to apply to my skin	1	2	3	4	5
32.	My patch pain medication is easy to take off	1	2	3	4	5
33.	My patch pain medication falls off easily	1	2	3	4	5

Side Effects of Medication

The following statements ask about side effects of your current pain medication. Please answer each question below by ticking the box that best represents your opinion (tick only one box per question).

Because of your pain medication, how much were you bothered by the following:		Did not experience	Not bothered at all	A little bothered	Moderately bothered	Quite bothered	Extremely bothered
34.	Unintentional weight gain	0	1	2	3	4	5
35.	Excessive fatigue	0	1	2	3	4	5
36.	Drowsiness	0	1	2	3	4	5

37.	Inability to concentrate	0	1	2	3	4	5
38.	Nausea	0	1	2	3	4	5
39.	Diarrhoea	0	1	2	3	4	5
40.	Dizziness	0	1	2	3	4	5
41.	Constipation	0	1	2	3	4	5
42.	Skin rashes	0	1	2	3	4	5
43.	Stomach aches	0	1	2	3	4	5
44.	Heartburn	0	1	2	3	4	5
45.	Vomiting	0	1	2	3	4	5

Satisfaction with Current Pain Medication and Care

The following statements are about your satisfaction with your current pain medication and the care you receive. Please answer each question below by ticking the box that best describes your level of satisfaction (tick only one box per question).

How satisfied are you with each of the following:		Very satisfied	Satisfied	Neither satisfied or dissatisfied	Dissatisfied	Very dissatisfied
46.	The information that you received about your pain and its treatment	1	2	3	4	5
47.	The amount of time that doctors devoted to you during their visits	1	2	3	4	5
48.	The care provided by the nurses for your pain and its treatment	1	2	3	4	5
49.	The form of your medication (eg pills, IV)	1	2	3	4	5
50.	How often you take your medication	1	2	3	4	5
51.	The amount of pain medication you take	1	2	3	4	5
52.	The time it takes your pain medication to work	1	2	3	4	5
53.	The level or amount of pain relief provided by your pain medication	1	2	3	4	5

54.	The duration of pain relief provided by your pain medication	1	2	3	4	5

55. Overall, how satisfied are you with your current pain medication?

Very satisfied	Satisfied	Neither satisfied or dissatisfied	Dissatisfied	Very dissatisfied

56. Overall, how does your level of pain relief meet your expectations of pain relief?

Greatly exceeds my expectations	Somewhat exceeds my expectations	Meets my expectations	Does not quite meet my expectations	Does not meet me expectations at all

57. Do you think that your current pain medication could be more effective in relieving your pain?

Yes, definitely	Probably yes	I don't know	Probably not	Definitely not

58. Would you like to continue taking your current pain medication?

Yes, definitely	Probably yes	I don't know	Probably not	Definitely not

59. Some people say that they get nervous at the thought of taking pain medication for a short time period. How nervous do you feel about taking your current pain medication for a short time period?

Not at all nervous	A little nervous	Moderately nervous	Very nervous	Extremely nervous

60. Some people say that they get nervous at the thought of taking pain medication for a long time period. How nervous do you feel about taking your current pain medication for a long time period?

Not at all nervous	A little nervous	Moderately nervous	Very nervous	Extremely nervous

61. Have you ever used another pain medication?

☐ Yes ☐ No

If yes, overall, how would you compare your current pain medication with the other one?

☐ This medication is much better than my other one

☐ This medication is somewhat better than my other one

☐ This medication is about the same as the other one

☐ This medication is somewhat worse than my other one

☐ This medication is much worse than my other one

9.4 Introductory script for the telephonic interview.

May I speak to_____

Hello, my name is_____ and I am calling you from Groote Schuur Hospital. I am calling you because you are a patient receiving care at the Chronic Pain Management Clinic. We are conducting a very important survey to find out how satisfied our patients are with the care that you are receiving at the chronic pain management clinic at GSH. This survey will help us to improve the quality of care that we offer to you as our patient.

The survey consists of several questions about your pain, treatment and your level of satisfaction.

The survey is voluntary and you may stop at any time. None of the staff at the pain clinic will know what you have said, your answers are completely confidential. Whether you choose to take part in the survey or not is totally up to you and will not affect the care you get at the clinic or at Groote Schuur in any way. The survey will take between 10 and 15 minutes on the phone.

Would you be willing to take part in this survey?

Is this a convenient time to start the survey or would you like me to call you back at another time?

9.5 SAJAA Instructions to authors

Author Guidelines

Submitted manuscripts that are not in the correct format and without the required supporting documentation specified in these guidelines will be returned to the author(s) for correction and will delay publication.

AUTHORSHIP

Named authors must consent to publication by signing a covering letter which should be submitted as a supplementary file. Authorship should be based on substantial contribution to:
(i) conception, design, analysis and interpretation of data;
(ii) drafting or critical revision for important intellectual content; and
(iii) approval of the version to be published. These conditions must all be met (uniform requirements for manuscripts submitted to biomedical journals; refer to www.icmje.org); and
(iv) exact contribution of each author must be stated.

DECLARATION OF CONFLICT OF INTEREST

Authors must declare all sources of support for the research and any association with a product or subject that may constitute a conflict of interest. If there is no conflict of interest to declare please include the following statement: The authors declare no conflict of interest.

FUNDING SOURCE

All sources of funding should be declared. Also define the involvement of study sponsors in the study design, collection, analysis and interpretation of data; the writing of the manuscript; the decision to submit the manuscript for publication. If the study sponsors had no such involvement, this should be stated as follows: No funding source to be declared.

RESEARCH ETHICS COMMITTEE APPROVAL

The submitting author must provide written confirmation of Research Ethics Committee approval for all studies including case reports. The ethics committee as well as the approval number should be included.

STATISTICAL ANALYSIS

Authors are advised to involve medical statisticians at the protocol stage of their research project: to plan sample size, and the selection of appropriate statistical tests for analysis and presentation.

PROTECTION OF PATIENT'S RIGHTS TO PRIVACY

Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives informed written consent for publication. The patient should be shown the manuscript to be published. Refer to www.icmje.org.

ETHNIC CLASSIFICATION

The rationale for analysis based on racio-ethnic-cultural categorisation should be indicated.

CATEGORIES OF SUBMISSIONS

Shorter items are more likely to be accepted for publication, owing to space constraints and reader preferences.

Original articles

Original articles on research relevant to anaesthesia and analgesia should not exceed 3 200 words, no more than 30 references, with up to 6 tables or figures. A structured abstract under the following headings, Background, Methods, Results, and Conclusions is a requirement and should not exceed 300 words.

Clinical Review articles

Review articles relevant to anaesthesia and analgesia should not exceed 2 400 words, with a maximum of 20 references and no more than 6 tables or figures. A summary of 300 words or less is required.

Case reports

Case reports should not exceed 1 800 words with no more than 10 references. Figures are limited to 2 figures and may include images or photographs. The case report should have three headings: Summary (not exceeding 100 words), Case report (with no introduction) and Discussion. Case reports will be published online only. The summary and the URL will appear in the printed version.

Scientific Letters

Scientific Letters should not exceed 2 400 words with a maximum of 10 references. Only one table or illustration is permissible. A structured abstract under the following headings, Background, Methods, Results, and Conclusions, is a requirement and should not exceed 250 words.

Letters to the editor

Letters to the editor should be 800 words or less with only one image or table.

MANUSCRIPT PREPARATION

Refer to articles in recent issues for the presentation of headings and subheadings. If in doubt, refer to 'uniform requirements' - www.icmje.org. Manuscripts must be provided in UK English.

Qualification, affiliation and contact details

This information must be provided for ALL authors and must be submitted as a supplementary file.

Email addresses of all author must be provided.

ORCID number of ALL authors must be provided - if authors do not have ORCID, please register at https://orcid.org/

Abbreviations

All abbreviations should be spelt out when first used and thereafter used consistently, e.g. 'intravenous (IV)' or 'Department of Health (DoH)'.

Scientific measurements

Scientific measurements must be expressed in SI units except blood pressure (mmHg) and haemoglobin (g/dl). Litres is denoted with a lowercase 'l' e.g. 'ml' for millilitres). Units should be preceded by a space (except for %), e.g. '40 kg' and '20 cm' but '50%'. Greater/smaller than signs (> and 40 years of age) should also be preceded by a space e.g. > 20 years. No spaces should precede ± and °, i.e. '35±6' and '19°C'.

Numbers should be written as grouped per thousand-units, i.e. 4 000, 22 160...

Quotes should be placed in single quotation marks: i.e. The respondent stated: '...'

Round brackets (parentheses) should be used, as opposed to square brackets, which are reserved for denoting concentrations or insertions in direct quotes.

General formatting

The manuscript must be in Microsoft Word or RTF document format. Text must be 1,5-spaced, in 12-point Times New Roman font, and contain no unnecessary formatting (such as text in boxes, except for Tables). The manuscript must be free of track changes.

Disclaimers should follow the Conclusion and it should be in the following order: Acknowledgements, Declaration conflict of interest, Funding source, Ethics declaration and ORCID.

ILLUSTRATIONS AND TABLES

If tables or illustrations submitted have been published elsewhere, the author(s) should provide consent to republication obtained from the copyright holder.

Tables may be embedded in the manuscript file and provided as 'supplementary files'. They must be numbered in Arabic numerals (1,2,3...) and referred to consecutively in the text (e.g. 'Table 1'). Tables should be constructed carefully and simply for intelligible data representation. Unnecessarily complicated tables are strongly discouraged. Tables must be cell-based (i.e. not constructed with text boxes, tabs or enters) and accompanied by a concise title and column headings. Footnotes must be indicated with consecutive use of the following symbols: * † ‡ § ¶ || then ** †† ‡‡ etc.

Figures must be numbered in Arabic numerals and referred to in the text e.g. '(Figure 1)'. Figure legends: Figure 1: 'Title...'. All illustrations/figures/graphs must be of high resolution/quality: 300 dpi or more is preferable, but images must not be resized to increase resolution. Unformatted and uncompressed images must be attached as 'supplementary files' upon submission (not embedded in the accompanying manuscript). TIFF and PNG formats are preferable; JPEG and PDF formats are accepted, but authors must be wary of image compression. Illustrations and graphs prepared in Microsoft PowerPoint or Excel must be accompanied by the original workbook.

REFERENCES

Authors must verify references from the original sources. Only complete, correctly formatted reference lists will be accepted. Reference lists may be generated with the use of reference manager software, but the final document must be delinked from the reference database or otherwise generated manually. Citations should be inserted in the text as superscript, e.g. These regulations are endorsed by the World Health Organization,[2] and others.[3,4-6] The superscript reference number should come after the punctuation mark and should not be in brackets.

All references should be listed at the end of the article in numerical order of appearance in the Vancouver style (not alphabetical order). Approved abbreviations of journal titles must be used; see the List of Journals in Index Medicus. Names and initials of all authors should be given; if there are more than six authors, the first four names should be given followed by et al. First and last page, volume and issue numbers should be given. Wherever possible, references must be accompanied by a digital object identifier (DOI) link and PubMed ID (PMID)/PubMed Central ID (PMCID). Authors are encouraged to use the DOI lookup service offered by CrossRef. Crossref DOIs should always be displayed as a full URL link in the form https://doi.org/10.xxxx/xxxxx

Journal references:

Jun BC, Song SW, Park CS, Lee DH. The analysis of maxillary sinus aeration according to aging process: volume assessment by 3-dimensional reconstruction by high-resolutional CT scanning. Otolaryngol Head Neck Surg. 2005 Mar;132(3):429-34.

Polgreen PM, Diekema DJ, Vandeberg J, Wiblin RT, et al. Risk factors for groin wound infection after femoral artery catheterization: a case-control study. Infect Control Hosp Epidemiol [Internet]. 2006 Jan [cited 2007 Jan 5];27(1):34-7. Available from: http://www.journals.uchicago.edu/ICHE/journal/issues/v27n1/2004069/2004069.web.pdf.

Book references: Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworth, 1975:96-101. Chapter/section in a book: Weinstein L, Swartz MN. Pathogenic Properties of Invading Microorganisms. In: Sodeman WA jun, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974:457-472.

Internet references: World Health Organization. The World Health Report 2002 - Reducing Risks, Promoting Healthy Life. Geneva: World Health Organization, 2002. http://www.who.int/whr/2002 (accessed 16 January 2010).

Other references (e.g. reports) should follow the same format: Author(s). Title. Publisher place: publisher name, year; pages. Cited manuscripts that have been accepted but not yet published can be included as references followed by '(in press)'. Unpublished observations and personal communications in the text must not appear in the reference list. The full name of the source person must be provided for personal communications e.g. '...(Prof. Michael Jones, personal communication)'.

COVERING LETTER

A covering letter to the editor is mandatory and must include statements that the manuscript has not been published previously and is not under review elsewhere. It should state details of any prior publication of the research in abstract form or in Congress proceedings. The letter must declare if any of the authors have a conflict of interest and that the requirements for submission, including ethics approval and patient permission for case reports have been fulfilled. All authors must sign the covering letter.

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9.6 Reviewer comments and author responses round one.

Comments made by Reviewer 1	**Responses**
Abstract: The aim and the rationale for this study is not clear. The aim should relate directly to the conclusion	Thank you for identifying our oversight in not aligning the rationale for this study to the conclusion. We have revised the abstract to clearly show the aim and justification for the study. Lines 8 – 15. **Background** "Chronic pain is a costly and debilitating ailment with an estimated global prevalence of 20%. The evaluation of patient satisfaction with pain management is crucial to ensure that care provided remains fit for purpose, and it helps to identify opportunities for improvement. Groote Schuur Hospital has one of the few functional interdisciplinary pain clinics in South Africa with more than 900 patients seen per year. To date we have no data informing us about patient satisfaction at the clinic. The aim of our study was to survey patients being treated at the pain clinic to determine their level of satisfaction with the service." Lines 34 – 37 **Conclusions** "Results suggests that 6 out of 10 patients are satisfied with their pain management at the GSH chronic pain clinic. It is clear that patient satisfaction is not only driven by

	pain relief but can be enhanced by good patient-provider relationships and shared decision making. It is important to continually train health care providers to improve their communication skills.”
Introduction: The aim of the study was to describe patient satisfaction with their management of chronic pain. Patient satisfaction in this population must be addressed specifically rather than general aspects of chronic pain and the pain clinic at GSH. Aspects that affect satisfaction (both positively and negatively) in this population group must be addressed. This is important as it will direct what is key to highlight in the results and the discussion. Literature in other contexts or other countries on this topic must be highlighted here	Thank you for your helpful suggestion. The purpose of describing the chronic pain clinic here is to provide contextual information that is necessary to help the reader understand the framework of our clinic and translate the information into their own setting. We agree that including aspects that positively and negatively affect patient satisfaction with treatment would be valuable. However, despite a comprehensive search of the literature, we could not find relevant studies reporting on this subject.
Methods: What was the rationale for "randomly" identifying eligible patients? Why was a time frame of one month deemed appropriate? Some information should be given on the validity of the scale used for assessment. Was the sample size calculated with the assistance of a biostatistician.	We randomly selected patients to avoid recruitment bias. This study is one of several that forms the basis for future quality improvement cycles. We chose to use a one-month sampling frame of 82 patients to provide baseline data for future comparisons. Furthermore, the staff rotates through the clinic at 4- to 6-week intervals. Therefore, interventions are implemented within a relatively short period of time with rapid evaluation of effect over the following one-month period. The rationale for using this timeframe is now mentioned in Lines 110-111.

	"Using a population of 82 (based on the number of patients seen over a one month period in the pain clinic) and a precision of 0.05 (based on a 95% confidence interval), the formula showed that a sample of 68 patients with chronic pain were needed for the results to be generalizable to the sampling frame of all patients seen during one month. This time-frame was chosen because the effect of treatment is evaluated over the following one-month period." Thanks for this suggestion. The details on the validity and reliability of the instrument are now presented in in Lines 92 – 96. "Eligible patients who consented to participate then completed a telephonic interview using the validated Pain Treatment Satisfaction Scale (PTSS). [13] The PTSS has shown good validity and reliability in patients with various chronic pain conditions and has been widely used in research involving pain treatment satisfaction and pain management programs. [13, 14],, The sample size calculation was conducted by a researcher who is experienced in research methodology and biostatistics. The calculations were conducted based on biostatistical guidelines for determining sample size in cross-sectional descriptive

	studies: Yamane, Taro. (1967). Statistics: An Introductory Analysis, 2nd Ed., New York: Harper and Row.
Results: Figure one should start with the eligible patients (82), not the entire population. Please revise the use of multiple tables. This should be limited to those where information cannot be given succinctly in the text. The numbering of figures and tables must be corrected. In Table 6, for the question: "Is it easy to ask the medical staff questions?" the numbers given do not add up to 67. Figure 5 forms the crux of what the study aims to discuss. More information should be given on this. The supplementary table seems more suitable to be in text.	Thank you for the helpful suggestion. Figure 1 has been revised accordingly. The results presented in what was Table 4 are now presented in Lines 152 – 160. "The scores for the BPI on admission to the Chronic Pain Clinic were available for 61 participants. All the participants had severe pain severity scores (median: 8.1; IQR: 7.5 - 9) and pain interference scores (median: 8.5; IQR: 6.7 – 9.2) on admission. Pain scores on their most recent visit to the clinic were 6.5 (IQR: 4.5 – 8.5) for pain severity and 4.84 (IQR: 2.4 – 7.28) for pain interference with function. In the survey, participants reported that their median pain scores in the last week were 7 (IQR: 7 – 9) with similar scores reported for their pain in the last 24 hours and their current pain. Participants reported that they waited until they had a pain severity of six (out of 10 on 0-10 VAS) before asking for medication and nine before taking medication." We have removed what was figure 2 (participants' nervousness at the thought of taking pain medication for different time periods) because it adds no extra value to our study.

	The results presented in what was Figure 3 (Summary of participants' self-evaluation of general health) are now summarised in Lines 200 – 203. "Despite the satisfaction as indicated above, most of the participants still reported that they were currently only in fair (46%) and poor (27%) health. Only (3%) reported excellent health. The remainder reported that they were in good (19%) and very good (5%) health." The result of what was Table 5 (Summary of participant responses regarding receiving information about their pain and its treatment) are now summarised in Lines 204 – 208. The table is now presented as supplementary file 1. Thanks for identifying the errors in our calculation. The errors have been corrected as follows: "Strongly agree=47; somewhat agree=14; neither agree nor disagree=2; somewhat disagree=2; strongly disagree=2." The results presented in what was figures 4a and 4b are now presented in Lines 210 – 217. "Most participants (94%) reported that their oral medications were easy to swallow.

	With regard to oral medication leaving an after-taste, 54% of the participants strongly disagreed or disagreed with this statement, while 22% agreed that there was an aftertaste. Patients were asked whether they experienced the following side effects from their medication: unintentional weight gain; excessive fatigue; drowsiness; inability to concentrate; nausea; diarrhoea; dizziness; constipation; skin rashes; stomach aches; heartburn; vomiting (S Files 2 & 3). The most experienced side effects were excessive fatigue, drowsiness, inability to concentrate, and constipation." Figures 4a and 4b are also presented as supplementary files 2 & 3.
Discussion: The discussion section is well written. However, it should incorporate findings from the literature on this topic. All key aspects linked to patient satisfaction that has been identified from the literature should be discussed rather than all the results.	Thank you for your suggestion. We had initially planned to discuss each component of the patient satisfaction scale. However, the literature on this topic is in its infancy. Therefore, we could not find the literature that would allow us to frame the discussion of the results in this manner. In consideration of this, we discussed the overall results and aspects of the patient satisfaction scale that we believe to contribute significantly to the literature and inform clinical practice.
Conclusion: It is appropriate to what was found in the study.	Thank you!

References: Almost half of the references are more than 10 years old. Is this because there is scant literature on the topic? If so, this must be highlighted in the text. Alternatively, more recent literature must be found as available.	Thank for noting the use of some old references in our manuscript. We used this literature because of a lack of new studies on the topic. We have highlighted this in Lines 221 – 223. "According to our knowledge, this is the first study to report on satisfaction with pain management among chronic pain patients attending an interdisciplinary pain clinic in South Africa. In fact, there is a paucity of the literature on this topic."

Comments made by Reviewer 2	Responses
A very relevant research question considering the increasing prevalence – more likely increasing diagnosis rates – of chronic pain syndromes. Clinical audits are a vital aspect of clinical governance; completing the "circle" would provide superb data. Despite the available international literature, the study is original in the study setting. A relatively well written article with a good introduction on the effects of chronic pain.	We thank you for your positive comments and feedback regarding our study.
There is some inconsistency in the use of upper case letters for e.g. Brief Pain Inventory, Pain Treatment Satisfaction Scale.	Thanks for identifying our oversight regarding the inappropriate use of upper-case letters. These mistakes have been corrected in Lines 20, 93, 100, 151 and 160.
Please avoid the use of "amongst" and rather use "among"	Thank you for your suggestion. We have applied the changes accordingly.
An additional aspect which I feel should have been explored further is the reason(s) for the inability to discharge these patients back to a primary level of care	Thank you for raising such an important point. The reasons for the inability to discharge patient back to a primary level of care are complex and involve system issues and how the patient interacts with system. We did not explore this aspect as it was not the focus of the study. We believe this point could be explored carefully in future studies.
A good explanation for sample size estimation, but there is no mention of what the expected satisfaction rates were	Thank you for your compliment on our explanation of how we calculated our sample size. Considering a paucity of the literature from the developing countries on this topic, we found it challenging to provide a valid hypothesis for the results. A few available studies on this topic were conducted in developed countries. Therefore, we could not extrapolate the findings of these studies due to the known significant differences in patient demographics and social

	and economic determinants of pain between developing and developed countries.
Recommendations on changes to implement and a follow-up study to complete the clinical audit circle are required.	Thank you for this important point. The need for the implementation of the results and further research have been noted in Lines 314 – 320. "The findings of this study also suggest that patient satisfaction is not only driven by pain relief, but can be augmented by good patient-provider relationships and shared decision making. This highlights the importance of continuous training of health care providers to improve their clinical communication skills. While this study provides valuable insight into patients' satisfaction with pain management, we recommend that further studies explore health care providers' views on managing and improving patient satisfaction with chronic pain management"
There is a concern regarding the recruitment flow diagram (Figure 1). The first box states the annual patient load at the clinic, the second box states the inability to contact (a very large number of) patients. The second box should rather have stated the number who were eligible (as per the eligibility criteria) and then continued to those excluded because they could not be contacted	We agree that figure 1 was a bit confusing. We have revised the figure for easy interpretation.
However, there are a large number of tables and figures that add no extra value and some could rather be written as text	Thank you for the helpful suggestion. Figure 1 has been revised accordingly. The results presented in what was Table 4 are now presented in Lines 152 – 160. "The scores for the BPI on admission to the Chronic Pain Clinic were available for 61 participants. All the participants had severe pain

	severity scores (median: 8.1; IQR: 7.5 - 9) and pain interference scores (median: 8.5; IQR: 6.7 – 9.2) on admission. Pain scores on their most recent visit to the clinic were 6.5 (IQR: 4.5 – 8.5) for pain severity and 4.84 (IQR: 2.4 – 7.28) for pain interference with function. In the survey, participants reported that their median pain scores in the last week were 7 (IQR: 7 – 9) with similar scores reported for their pain in the last 24 hours and their current pain. Participants reported that they waited until they had a pain severity of six (out of 10 on 0-10 VAS) before asking for medication and nine before taking medication." We have removed what was figure 2 (participants' nervousness at the thought of taking pain medication for different time periods) because it adds no extra value to our study. The results presented in what was Figure 3 (Summary of participants' self-evaluation of general health) are now summarised in Lines 200 – 203. "Despite the satisfaction as indicated above, most of the participants still reported that they were currently only in fair (46%) and poor (27%) health. Only (3%) reported excellent health. The remainder reported that they were in good (19%) and very good (5%) health." The result of what was Table 5 (Summary of participant responses regarding receiving

	information about their pain and its treatment) are now summarised in Lines 204 – 208. The table is now presented as supplementary file 1. The results presented in what was figures 4a and 4b are now presented in Lines 210 – 217. "Most participants (94%) reported that their oral medications were easy to swallow. With regard to oral medication leaving an after-taste, 54% of the participants strongly disagreed or disagreed with this statement, while 22% agreed that there was an aftertaste. Patients were asked whether they experienced the following side effects from their medication: unintentional weight gain; excessive fatigue; drowsiness; inability to concentrate; nausea; diarrhoea; dizziness; constipation; skin rashes; stomach aches; heartburn; vomiting (S Files 2 & 3). The most experienced side effects were excessive fatigue, drowsiness, inability to concentrate, and constipation. " Figures 4a and 4b are also presented as supplementary files 2 & 3.
There is extensive use of the phrase "it appears that"; be more decisive with the reporting of the statistics.	Thank you for this suggestion. We have omitted the phrase in the reporting of the statistics.
Table 2, please clarify type of diabetes	The relevant revisions are now shown in Table 2. "Diabetes Mellitus Type 2".
In the paragraph describing the Brief Pain Inventory, the second sentence is unclear, "The participants had severe pain severity (median…." –the sentence would read better if started as "All the participants had severe pain….". This	Thank you for this suggestion. The results presented in what was Table 4 are now presented in Lines 152 – 160. In addition, the necessary revisions have been made to improve the clarity of the sentences.

paragraph also denotes the majority of the information in Table 4, therefore Table 4 should be removed and the additional data provided in the text.	"The scores for the BPI on admission to the Chronic Pain Clinic were available for 61 participants. All the participants had severe pain severity scores (median: 8.1; IQR: 7.5 - 9) and pain interference scores (median: 8.5; IQR: 6.7 – 9.2) on admission. Pain scores on their most recent visit to the clinic were 6.5 (IQR: 4.5 – 8.5) for pain severity and 4.84 (IQR: 2.4 – 7.28) for pain interference with function. In the survey, participants reported that their median pain scores in the last week were 7 (IQR: 7 – 9) with similar scores reported for their pain in the last 24 hours and their current pain. Participants reported that they waited until they had a pain severity of six (out of 10 on 0-10 VAS) before asking for medication and nine before taking medication."
Please check the grammar in line 153 "…medication could be probably more effective…" requires "could" and "be" to be swapped	Thanks for identifying this grammatical error. The revisions are now shown in Lines 176 -178 "Despite the appearance of satisfaction with pain management as indicated above, 51% of the participants indicated that their current pain medication could probably be more effective in relieving their pain."
There is concern about what is depicted in Figure 2 and what is explained in the text. The text reports that participants appeared more nervous about taking pain medication for longer periods of time, however, the graph does not appear to depict this. Exact numbers and frequencies would be suitable to justify this statement. Consider removing Figure 2 to avoid confusion	Thank you for this helpful suggestion. After a careful look at the results. We have agreed that figure 2 does not have a meaningful contribution towards the aim of this study. Therefore, we have removed figure 2 to avoid confusion

There is a mathematical error in line 163: the 21% should be 31% (21 of 67 participants).	Thank you for identifying our mistake in making these calculations. The revision is now presented in Lines 180 – 182. "Twenty-one (31%) of these participants indicated that their current pain medication was better than their previous medication, and eight (12%) indicated that it was the same as their previous medication. Seven (10%), indicated that their current medication was somewhat worse, or much worse than their previous medication."
Of all the tables depicted in the article, the table in the supplementary file is the most important. This should be depicted in the text and earlier within the results section, possibly after line 155. This table speaks to the ENTIRE questionnaire, the effects of chronic pain and the research question "are your patients satisfied?". This should be at the forefront of the results.	Thank you for the suggestion. Indeed, the supplementary file has important information that contributes towards the aim and objectives of the study. To avoid having too many tables, we resolved to the descriptive reporting of the results in Lines 160 -206. Our reporting is supported with the illustration of the results in table 4, S file 1 and figures 2 and 3.
In lines 191 and 192 describing the most common side effects, the frequencies of these side effects should be mentioned to provide a holistic picture and for the reader to grasp important aspects of chronic pain management It will also add valuable information for the discussion e.g. potential reasons that the patients are not adhering to the "on the clock" treatment approach (if there is a high frequency of very unpleasant side effects). However, Figures 4a and 4b are misleading showing that most patients are experiencing side effects that are bothering	Thank you for this thoughtful comment. Indeed, adding the frequencies to the most experienced side effects provides a holistic picture. The revisions are now presented in in Lines 210 – 216. "Patients were asked whether they experienced the following side effects from their medication: unintentional weight gain; excessive fatigue; drowsiness; inability to concentrate; nausea; diarrhoea; dizziness; constipation; skin rashes; stomach aches; heartburn; vomiting (S Files 2 & 3). The participants were generally not bothered

them which adds concern as to reasons why the medication routine is erratic. It would be more appropriate to rather describe these two figures in text or provide a simplified table with numbers and frequencies, perhaps with only the more common side effects.	by most of these side effects. However, the most experienced and bothersome side effects were drowsiness (51%) excessive fatigue (49%), constipation (39%), and the inability to concentrate (37%) ." We also opted to submit what were figures 4a and 4b as supplementary files 2 and 3.
Figure 5 is also part of the "heart" of the research question and should be displayed and discussed earlier	As per the restructuring of the results outlined above, these results and this figure now have a more prominent position as Figure 2.
Please check the label of the second last box "Amount of time doctors spent". Is this the amount of time that doctors spent with the patient? Please clarify.	Thank you for pointing out the lack of clarity in this label. The label has been revised as follows: "Duration of time doctors spent with you"
Remove the sentence in lines 201 and 202 "These findings suggest that participants….", this is said in the preceding sentence; or clarify the two sentences about the general satisfaction of pain relief and the satisfaction of the duration of pain relief	Thank you for this suggestion. Lines 173 – 174 have been revised to clearly reflect the intended message. "However, fewer participants were satisfied with the duration of pain relief suggesting they would have been more satisfied with longer durations of pain relief"
The discussion is adequate, however, some further information and perhaps some comparisons to the international literature would serve well in the opening paragraph.	Thank you. It would have been appropriate to compare our findings with those of similar studies. However, a few available studies were conducted in developing countries using a sample of people with varying demographics, who are also exposed to substantially different socioeconomic determinant of pain. In consideration of these reasons, we opted to discuss our results in light of the general literature on pain in developing countries.
Refrain from repeating the results in the Discussion section; rather provide commentary of similarities and differences between other	Thank you for this thoughtful comment. We have revised the discussion to improve the clarity and flow of main discussion points.

studies and possible influences of the differences and consider exploring the aspect of the developed vs the developing world as mentioned in the introduction.	
The references are a bit slack, please refer to index medicus for journal title abbreviations (8, 11, 15, 16, 21, 23, 25, 26, 28). Please keep article titles in lower case unless a proper noun as recommended by the Vancouver reference style guidelines. What is reference 14? A book or a website? Please provide correct reference style.	The references have been checked and corrected as needed.

9.7 Reviewer comments and author responses round two

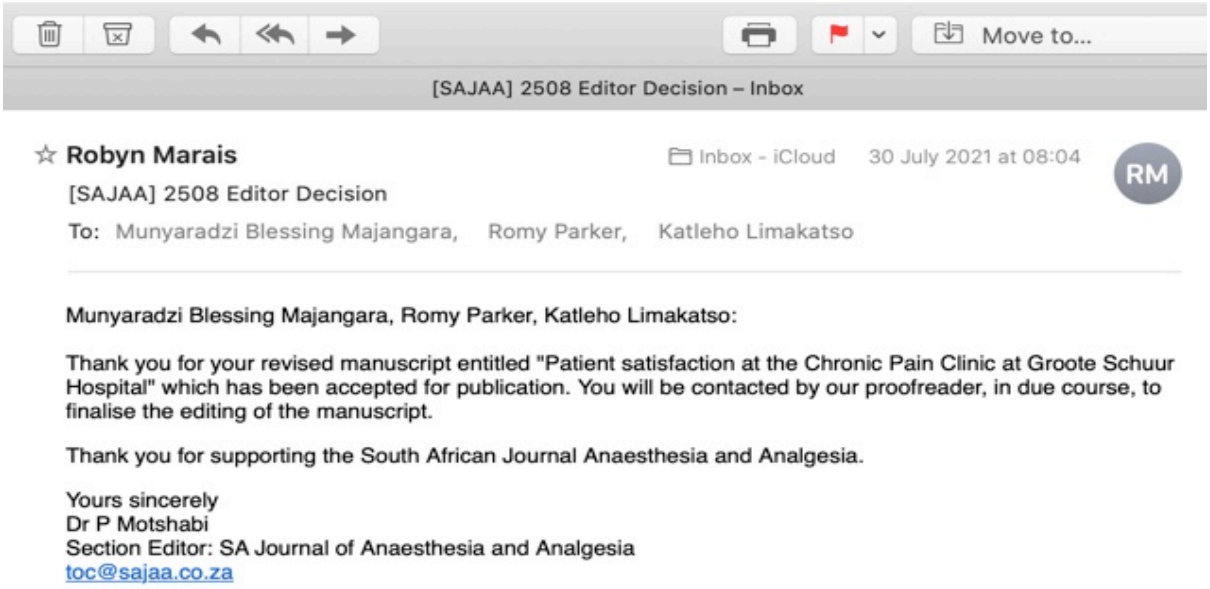
Reviewer's comments	Responses	Changes
Abstract		
Line 19-20: Numbers here *and* Line 25: Rather have in results	Specific results have been moved from the conclusion section to the results section with summary now presented in the conclusion.	Line 19-21: Results indicate that 6 in every 10 patients are satisfied with their pain management at the GSH chronic pain clinic. Line 25-26: Most participants were somewhat satisfied or very satisfied with all aspects of care they were asked about.
Introduction		
Lines 50-53: This point is made at ref 7 above and may not need to be repeated	We have rephrased this sentence to emphasise that it is the range of skills the interdisciplinary teams bring that are essential to expand	Given the complex mechanisms and the promising evidence, it is not surprising that evidence-based guidelines

	on the opening sentence of the paragraph.	recommend the use of a combination of pharmacological and non-pharmacological treatments delivered by teams of healthcare professionals to effectively manage pain. [10]
Lines 62-75: This should be moved to methods please Please avoid use of non-scientific sentences such as “the clinic is busy” – please condense this paragraph whilst moving it to methods. And Line 100 Include information about the clinic here. And Lines 63-86: Please condense the paragraph into one sentence	We have moved the descriptive information about the clinic to the methods (Line 100) and adjusted the language. This information has been condensed and moved to the methods linking with the above information.	The interdisciplinary team in the Chronic Pain Clinic at GSH comprises anesthetists, nurses, physiotherapists, psychiatrists, and clinical psychologists. The pain clinic sees more than 900 patients per year, of which one fifth are new presentations. Patients seen at the clinic range in age from 18 to 90 years with the most common presenting ages from 40 to 65 years [Dr. Janieke van Nugteren, personal communication, June 17, 2018]. Since January 2018, the clinic has been receiving 15-20 referrals per week. Although, a triage system is implemented to prioritize patients requiring urgent medical care, some patients may await treatment for four to nine months. Many

		of the patients seen at the GSH pain clinic have been using the service for several years, with numerous barriers encountered when discharging back to primary care contributing to long waiting lists.
Methods		
Lines 144-145 How was categorical data represented.	This information has been included.	Categorical data are presented as frequencies (n) and percentages.
Results		
Line 186 (Table 2) Categories	We believe this has been addressed by including the statement of how categorical data are presented in the methods.	
Line 218: Figures XYZ and Tables ABC	Reference to the figures and tables has now been included.	The results are presented for each of the sub-sections of the scale (Figure 2; Figure 3; Table 4).
Discussion		
Lines 292-295: Are these statements about your population or the referenced article?	Thank you for highlighting the lack of clarity here. We have restructured for clarity.	The consistently high levels of satisfaction in this study are encouraging as they are indicative of the successful delivery of pain management. [22] In addition, they may be a reflection that patients' expectations of ideal care were matched by their perception of the care they received. [22]
Line 343:	Inserted as reference [33]	

Move to references as an internet source		

9.8 Southern African Journal of Anaesthesia and Analgesia letter of acceptance for publication.



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[SAJAA] 2508 Editor Decision – Inbox

☆ **Robyn Marais** Inbox - iCloud 30 July 2021 at 08:04

RM

[SAJAA] 2508 Editor Decision

To: Munyaradzi Blessing Majangara, Romy Parker, Katleho Limakatso

Munyaradzi Blessing Majangara, Romy Parker, Katleho Limakatso:

Thank you for your revised manuscript entitled "Patient satisfaction at the Chronic Pain Clinic at Groote Schuur Hospital" which has been accepted for publication. You will be contacted by our proofreader, in due course, to finalise the editing of the manuscript.

Thank you for supporting the South African Journal Anaesthesia and Analgesia.

Yours sincerely
Dr P Motshabi
Section Editor: SA Journal of Anaesthesia and Analgesia
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