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Perspective and Understanding of Libyan Physicians Regarding Cancer Pain Management

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Abstract:

Objective: To assess the mindset and level of understanding on the best way to utilize opioids and identify the obstacles to cancer pain treatment, particularly for Libya's young medical professionals.

Methods: A questionnaire-based survey was administered to five hundred physicians. Medical disciplines and individual traits were used to classify doctors. Specialties were divided into general practitioners, surgeons, anesthesiologists, pediatrics, internal medicine, and family medicine professionals. Individual traits were categorized based on their current environment and prior experiences..

Results: Even though many medical professionals believed they had a good education in pain management techniques, a sizable portion of the medical community had a bad attitude and insufficient understanding of cancer pain management. As distinct as their areas of expertise and life experiences were, so too were their attitudes and levels of knowledge. Doctors' attitudes and knowledge were influenced by the following factors: (i) medical specialty; (ii) past experience using a practical pain assessment tool; (iii) self-perception of knowledge regarding pain management; (iv) experience prescribing opioids; and (v) experience receiving education for cancer pain management. Even if many doctors were passive when it came to prescription opiate analgesics, they are eager to utilize them in the future to treat cancer-related pain. The primary perceived obstacles to the best possible management of cancer pain were the following: lack of understanding regarding opioid analgesics, fear of tolerance, drug addiction, and adverse effects..

Conclusions: We discovered that further coursework and hands-on training will be necessary for young physicians in their early careers to receive proper cancer pain management.

Key words: cancer pain, knowledge, opioids.

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Introduction:

In Libya, the number of cancer cases is increasing as well as it is worldwide **(1),** cancer also very important cause of death in our Libyan community. We found in only 2016, that more than 400 newly diagnosed patients and got files in the oncology department at Tripoli central hospital.

One of the most debilitating symptoms that cancer patients, particularly those with metastatic disease, describe experiencing is pain **(2).** About 70% of advanced cancer patients have pain, though rates vary depending on the kind of cancer and stage of the disease **(3).** More than 80% of patients with metastatic cancer have pain, primarily as a result of direct tumor infiltration **(2).** About 20% of cases of cancer-related pain (CRP) are due to surgery, radiation, and/or chemotherapy **(4).**

The cornerstone of managing cancer pain is pharmacologic therapy. These treatments include a range of anticancer medications as well as non-opioids, opioids, and other types of adjuvants. Opioids are advised as the cornerstone of treatment for cancer pain despite the absence of convincing evidence of their efficacy and possible negative effects **(5).**

The term "nonmedical opioid use" (NMOU) refers to a broad category of opioid use that combines objective and subjective measures. It includes using opioids without a prescription, using a prescription but not using it as directed, and using opioids only for the feeling or experience they provide **(6).** Many patients fall somewhere in between the two extremes when it comes to NMOU-related behaviors, which range from behaviors that appear to be "normal" for opioid adherents to behaviors that clearly indicate substance use disorder (SUD) **(7).**

The majority of people need to utilize opioid medications appropriately in order to get enough pain relief. Even though attitudes in the medical profession have changed, there are still some countries where antiquated laws and policies intended to prevent criminal activity persist, leading to abuse and addiction and perpetuating the history of opioid-related fear. Furthermore, despite amended laws supporting the use of analgesics, ignorance and cultural barriers continue to be obstacles to the responsible use of opioids. Lastly, because of similar misconceptions about opioids, nonadherence to treatment regimens, and poor communication of their concerns, patients and family frequently impede their own treatment. **(8).**

For the treatment of moderate to severe cancer pain, opioids continue to be the cornerstone. In light of this possible risk, careful administration of opioid analgesics is essential for providing effective pain management. A number of published and frequently updated guidelines have been released by many societies, including ESMO, ASCO, WHO, EAPC, and ESMO. The WHO's three-step ladder, initially published in 1986, is the basis for prescription opioids. When a patient reports mild to moderate pain, weak opioids (codeine, hydrocodone, and tramadol) are advised to start pain management; there is no difference in the medications' efficacy in this regard. Weak opioids are typically taken in combination with non-opioid analgesics such as non-steroidal anti-inflammatory medications (NSAIDs) and/or paracetamol/acetaminophen. There isn't any proof

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that starting step II opioid therapy with a weak medication will help with cancer pain management in general. A similar finding was reported with reference to step III medications, or powerful opioids **(9).**

Strong opioids, such as hydromorphone, oxycodone, and morphine, are advised when pain is moderate to severe. To achieve an ideal balance between tolerable side effects and adequate analgesia, a low dose must be started and titrated up. An summary of Cochrane Reviews (9 reviews, 152 RCTs, n = 13,524) indicates that within 10 to 14 days, oral morphine or fentanyl patch will provide meaningful pain relief for more than 90% of patients receiving opioid medication**.** According to the Cochrane Review, 10–20% of cancer patients receiving opioid medication must alter their course of treatment, and up to 77% of patients report experiencing at least one opioid side effect (mostly nausea and constipation) **(10).**

This study aims to assess Libyan physicians' ideal knowledge of prescribing opioids and their comprehension of the significance of pain management for cancer patients, as well as their attitude toward cancer pain and their use of analgesics for CPM.

Methods:

Study Population

The survey was conducted all in city of Tripoli, Libya. The study population was the physicians working in different health care facility and whom been randomly chosen, the places including hospitals (Tripoli Medical Center, Tripoli Central Hospital, Aljala Hospital, Abouslem Hospital) and some private clinics and polyclinics. The sample included all specilities, age, and experiences groups. The questionnaires handed out and collected on same day , and the period was between June 4th –Jun 21st 2018. The candidate had been given enough time to fill in their responses. The questionnaires were sent to 700 physicians. The total percentage of completed questionnaires (500/700) was 71.42%. Depending on the query, different responses were given. The age range of the group was 26–60 years.

Instruments

A questionnaire was developed by the Committee of National Cancer Control Research Institute South Korea and used for similar survey and we adapt it. The purpose of the questionnaire was to evaluate the doctors' attitudes on the CPM education experience, their attitudes toward the best way to utilize analgesics for CPM, and their understanding of the correlations and prescription of opioids **(9).**

Six questions made up the first segment, which evaluated the doctors' opinions regarding the CPM education program (Table 1). Scales of two or three degrees were applied. A review of questionnaires used in comparable surveys served as the source of some of these inquiries. (**11, 12**). Seven questions made up the second section's opinion toward the best way to utilize analgesics

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for CPM (Table 2). A Likert scale with four points—strongly disagree to strongly agree—was employed. There were sixteen entries in all in the last part (Table 3). Two items (relating to physicians' practical understanding of CPM and opioid prescription) involved multiple-choice questions, while the remaining fourteen items asked participants to search for the proper answers about the physicians' knowledge of CPM and opioid prescribing in a "yes-or-no" format.

In order to establish whether an evidence-based best practice review was necessary, the American Society of Pain and Neuroscience (ASPN) conducted a needs-based assessment of the treatment efficacy and patient safety with interventional pain methods for pain due to cancer. A group of experts in pain management from several disciplines was assembled to develop a guideline on best practices for the conservative and interventional treatment of pain associated with cancer.

The criteria for selection included diversity, practice setting, clinical experience, publications, research, and competence. Guidelines for managing pain related to cancer have been published in the past, but they mostly addressed non-interventional treatments. **(13).**

Statistical analysis:

The statistical analysis of the data was conducted through computerization and the use of the SPSS program (Statistical Package for Social Science), version 20. The range (lowest and highest), mean, standard deviation, median, and interquartile range (IQR) were used to characterize the quantitative data.

Results

Table (1): Background characteristics of public health doctors (*n* = 500)

Characteristic	N (%)
Age	34.3±4.6 26 -60
Gender	
Male	237 (47.4%)
Female	263 (52.6%)
What is the health care facility you are working in?	
Clinic	37 (7.4%)
Hospital	355 (71%)
Health center	72 (14.4%)
other	36 (7.2%)
Medical specialty	98 (19.6%)
Internal medicine	30 (6%)
Family medicine	82 (16.4%)

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Anesthesiology	105 (21%)
Pediatrics	137 (27.4%)
Cancer surgery (general surgery, Gynecology , Orthopedics)	48 (9.6%)
Other medical specialty	
Personal experience	
Experience of opioids prescription for CPM	
Yes	146 (29.2%)
No	354 (70.8%)
Educated for CPM	
Yes	231 (46.2%)
No	269 (53.8%)
Cancer patient in neighborhood (family member, friend)	
Yes	299 (59.8%)
No	201 (40.2%)
Self-rated comparative knowledge level about CPM	
Low level	272 (54.4%)
Average level	212 (42.4%)
High level	16 (3.2%)
Awareness of VAS, NRS, VRS, FPS	
Never heard about it	191 (38.2%)
Heard, but not used it	287 (57.4%)
Heard, and used it	22 (4.4%)
Awareness of WHO-guided three-step pain ladder	
Never heard about it	164 (32.8%)
Heard, but not used it	179 (35.8%)
Heard, and used it	157 (31.4%)

Table 1 lists the individual traits of the 500 physicians who completed the survey. more than 80 % of them younger than 43 years old. Most of them working in university hospitals about 53% of them females. They represented many medical specialties(internal medicine, family medicine, pediatrics, anesthesia and cancer surgery(including all the surgeon deal with cancer cases. When we asked if they knew of any cancer patients in their community, roughly 60% of them said that they did. When we asked if they thought they knew enough about CPM on their own, 55% said they did. With reference to pain assessment strategy. 38.2% never heard of them, and only 4%

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using it. When asked about the "Three Step Pain Ladder" WHO Guideline, doctors reported that only 35.8% had heard of it and used it, and 32.8% had never heard of it. (Table 1).

Table (2): Attitude about analgesics usage for CPM

Characteristic	N (%)
When patients complain pain, they usually exaggerate it	
Strongly disagree	20 (4%)
Disagree	265 (53%)
Agree	167 (33.4%)
Strongly agree	48 (9.6%)
Patients exaggerate pain for attention of medical personnel	
Strongly disagree	6 (1.2%)
Disagree	196 (39.2%)
Agree	244 (48.8%)
Strongly agree	54 (10.8%)
When patients request dosage increase of analgesics, this usually indicates malingering	
Strongly disagree	18 (3.6%)
Disagree	168 (33.6%)
Agree	283 (56.6%)
Strongly agree	31 (6.2%)
Patients will be dependent to drug if it is prescribed as their wishes	
Strongly disagree	46 (9.2%)
Disagree	301 (60.2%)
Agree	139 (27.8%)
Strongly agree	14 (2.8%)
Patients with frequently asked pain complaints need psychological consultation for drug addiction	
Strongly disagree	84 (16.8%)
Disagree	323 (64.6%)
Agree	82 (16.4%)
Strongly agree	11 (2.2%)
Endurance of pain is superior to having side effects of narcotic analgesics from dosage increment	
Strongly disagree	53 (10.6%)
Disagree	313 (62.6%)

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Agree	130 (26%)
Strongly agree	4 (0.8%)
Analgesics does not need to be saved to prepare pain aggravation	
Strongly disagree	35 (7%)
Disagree	239 (47.8%)
Agree	213 (42.6%)
Strongly agree	13 (2.6%)

The preceding tables display the physicians' responses about their opinions on the best way to utilize analgesics for CPM. Half of the doctors (43%) believed that patients usually overstated their pain when they complained, and over half (59.6%) believed that patients feigned pain to get medical attention. The majority of doctors (62.8%) also believed that patients pretended to be in pain when they asked for a dosage increase. Finally, about half of the doctors (45.2%) believed that delaying the use of analgesics would allow patients to suffer until they were in severe pain, at which point we could treat them.

Even if a patient received a prescription in accordance with their intentions, an estimated 69.4% of doctors believed that the patient would not become dependant on the medicine. Of the doctors, 81.4 percent did not believe that patients who frequently complained of pain needed to see a psychologist for drug addiction. The majority of doctors (73.2%) said that there was no need to put patients through pain in order to avoid the potential negative effects of increasing the dosage of narcotic painkillers.

From what had been mentioned above, we see that major number of doctors have negative attitude toward cancer pain management.

Table (3): Questionnaire about physicians' knowledge of CPM and opioids prescribing

Characteristic	N (%)
Q1. Pain is considered as a fifth vital sign, in addition to blood pressure, pulse rate, body temperature and respiration rate	
Yes	366 (73.2%)
No	134 (26.8%)
Q2. History of pain consists of position (P), quality (Q), relief or aggravation (R), severity (S), timing (T)	
Yes	455 (91%)
No	45 (9%)

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Q3. Pain intensity '6', according to 'pain numbering system', stands for severe pain(False question)	
Yes	378 (75.6%)
No	122 (24.4%)
Q4. Pain consists of somatic pain, visceral pain, neuropathic pain, roughly	
Yes	440 (88%)
No	60 (12%)
Q5. Oral analgesics are first options to reduce pain if patients are tolerable	
Yes	400 (80%)
No	100 (20%)
Q6. Slow-releasing agents have to be administered to breakthrough pain for patients with well-control pain (False question)	
Yes	391 (78.2%)
No	109 (21.8%)
Q7. Adjuvant pain reliever needs to be administered to increase analgesic effect according to pain character irrespective of pain severity	
Yes	339 (67.8%)
No	161 (32.2%)
Q8. Potent opioids are to be administered to severe pain from the beginning	
Yes	238 (47.6%)
No	262 (52.4%)
Q9. Long-term use of opioids can develop tolerance or physical dependence	
Yes	463 (92.6%)
No	37 (7.4%)
Q10. Opioids are high at risk of addiction (False question)	
Yes	460 (92%)
No	40 (8%)
Q11. Opioids may be increased without restriction of maximal dosage for not having ceiling effect	
Yes	188 (37.6%)
No	321 (62.4%)

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Q12. 10–15% of daily dosage of new drug can be used for breakthrough pain additionally	
Yes	299 (59.8%)
No	201 (40.2%)
Q13. If previous drugs could not relieve pain effectively, initial dosage of new drug is to be 50–75% of equianalgesic dose (False question)	
Yes	346 (69.2%)
No	154 (30.8%)
Q14. Use of stool softener is necessary when opioids are administered	
Yes	296 (59.2%)
No	204 (40.8%)
Which one is best fit for initial drug for moderate degree of cancer pain?	
Meperidine	23 (4.6%)
Codeine	162 (32.4%)
Morphine	247 (49.4%)
Fentanyl	27 (5.4%)
Oxycodone	41 (8.2%)
Which one is not used for CPM for causing CNS complication when used repeatedly?	
Meperidine	82 (16.4%)
Codeine	92 (18.4%)
Morphine	202 (40.4%)
Fentanyl	89 (17.8%)
Oxycodone	35 (7%)

Table 3 displays the doctors' answers to the knowledge questions. The majority of doctors showed severe deficiencies in their understanding of prescription opioids. A significant portion of incorrect responses (69.2%) concerned the dosage of an equianalgesic. We learned from this item that doctors did not have a proper understanding of the equivalent analgesic dosage of opioids. Regardless of the degree of the pain, 32.2% of doctors even disagreed with the use of adjuvant pain relievers to enhance the analgesic impact based on the nature of the pain. 75.6% of doctors were unable to accurately identify the pain numbering system. The majority of doctors (62.4%) were still unaware that opioids have no upper limit and can be taken indefinitely. An estimated 52.4% of doctors disagreed that strong opioids should be given to patients experiencing severe pain right away. About 40.8% of doctors did not know that using stool softeners is required while administering opioids. Regretfully, 78.2% of doctors believed that patients with well-controlled

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pain could benefit from the use of slow-releasing medications for breakthrough pain. Nevertheless, in addition to blood pressure, pulse rate, body temperature, and respiration rate, 73.2% of doctors regarded pain as a fifth vital sign. Furthermore, 59.8% of doctors were aware that breakthrough pain might be treated with an extra 10–15% of a new drug's daily dosage. 92% of doctors were concerned about the possibility of drug addiction. When patients are bearable, oral analgesics are the primary line of treatment, as identified by 80% of doctors. An further 92.6 percent of doctors were aware that prolonged use of opioids might lead to tolerance or physical dependency. Ninety-one percent of doctors were aware that the history of pain includes position (P), quality (Q), relief of aggravation (R), severity (S), and timing (T). In contrast, eighty-eight percent of doctors were aware that somatic, visceral, and neuropathic pain comprise the three main categories of pain. Meperidine was the opioid that only 16.4% of doctors correctly identified as worsening central nervous system (CNS) problems when asked to choose (Table 3).

Discussion:

One of the most prevalent and unwelcome symptoms among cancer patients is pain. Despite the broad availability of effective drugs and treatment methods, undertreatment of cancer pain remains a critical concern **(14).** Provider-related hurdles are among the obstacles to the best possible treatment for cancer pain. **(15),** system-related barriers **(16)** and patient-related barriers **(17).**

In the present study the mean age of 34.3±4.6 ranged from 26 to 60 years.

In line with our research, **Darawad et al. (18)** showed that the age range of physicians was 24 to 59 years old, with a mean of 30.5 years (SD = 7.2). With a range of 1 to 30 years, the mean score for overall work experience was 4.9 years (SD = 5.6). A mean score of 2.6 years (SD = 2.5) was reported for the range of oncology experience, which was found to be between 6 months and 12 years. Recruits from the specialist oncology center made about 50% of the participating physicians. Males made up 61% of the physician population..

According to **Alkhatib et al. (19),** the mean age of the physicians ranged from 25 to 63 years old. Years (mean difference 5.8). The majority of physicians (n = 36, 64.3%) were male, and the majority (n = 38, 67.9%) were in their residency years.

Regarding the "pain assessment strategy," in the current study. Just 4% of people use it, and 38.2% have never heard of them. The majority of doctors (73.2%) said that there was no need to put patients through pain in order to avoid the potential negative effects of increasing the dosage of narcotic painkillers.

Among the four categories (facial, numeric, visual, and lingual) of "pain assessment strategy," doctors preferred numerical rating scales (327 doctors, 29.8%) and visual analogue scales (297, 27.1%) **(20).**

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According to **Kim et al. (21),** the majority of doctors (91.4%) believed that suffering needlessly due to concern over narcotic painkiller side effects from dosage increases was unnecessary, and 87.3% did not feel that delaying the administration of analgesics would be a good idea in case pain worsened.

Zhang et al. (22) demonstrated that when evaluating cancer pain, almost all clinicians (95.4%) employed visual analog or numeric rating scales. The majority of doctors (84.0%) told their patients about the potential negative effects of opioids, and the majority of them dealt with strong opioid side effects either at the time the side effects occurred (49.8%) or when the medications were first prescribed (42.6%).

While 29.2% of respondents had experience prescribing opioids for CPM, nearly half of the respondents had taken part in at least one pain management training program.

According to **Zhang et al. (22),** 41.4% of participants had been employed by the hospital for five years. About 33% of doctors said they saw patients with cancer pain more than once a day, and about 45% of doctors said they saw patients with cancer pain several times a week. Over 80% of those surveyed had taken part in at least one pain management course. Nearly half of doctors (48.1%) thought they knew about cancer pain management only to a fair extent. While 51.6% of doctors said their residency training was sufficient, just 23.8% of doctors said their medical school training was enough (good or outstanding). The majority of doctors (62.2%) evaluated cancer patients' pain on a daily basis, while just 14.5% said they frequently treated patients' pain after consulting psychologists..

In the current study, 46.2% of physicians had education for CPM while 53.8% had never had education for CPM. Only 35.8% heard of Three Step Pain Ladder' WHO Guideline and used it, 32.8% they never heard of it.

According to **Srisawang et al. (23),** 42.5% of doctors said they had never had any kind of CPM training or education. Of the doctors, 58% were specialists and 42.0 percent were general practitioners (gPs). 53.4% of the practitioners had treated 10 or fewer patients in the previous six months, 50.2% employed the WHO three-step ladder, and over half (59.4%) worked at community hospitals. Sixty-four percent of doctors did not belong to a palliative care team.

About half of the doctors in the current study (43%) believed that patients usually overstated their pain when they complained, and more than half (59.6%) believed that patients did so to get the attention of medical professionals. The majority of doctors (62.8%) also believed that patients feigned pain when they asked for a dosage increase. Approximately half of doctors (45.2%) felt that delaying the use of analgesics would allow patients to suffer until they were in severe pain, at which point we could treat them.

According to **Kim et al. (21),** over half (47.5%) of the doctors believed that patients typically overstated their pain when they complained, while the other half (51.4%) believed that patients

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did so in order to attract the attention of medical professionals. Nonetheless, the majority of doctors (89.6%) did not believe that patients who asked for a dosage increase were pretending to be in pain. Seventy-five percent of doctors believed that even if a patient received a prescription in accordance with their wishes, they would not become reliant on it. Of all the doctors, 67.1% did not believe that drug addiction required psychiatric treatment when patients regularly complained of discomfort..

According to **Zhang et al. (22),** replies to inquiries concerning doctors' opinions regarding cancer pain treatment.The majority of respondents were aware that over 50% of cancer patients have significant chronic pain that requires analgesic medication (73.5%) and that over 50% of patients could have their pain properly controlled with this therapy (77.2). Roughly 75% of participants assessed their usage of analgesics for cancer patients as neither liberal nor conservative. The majority of polled physicians (78.2%) said that treating cancer pain was almost as important as treating cancer itself.. Physicians ranked the management of nausea in patients receiving opioids, the titration of opioid dose in patients with poor control, the assessment of pain severity and cause, and the calculation of dose when transferring between oral and parenteral routes of opioid administration as the knowledge most urgently needed to manage pain appropriately.

According to **Srisawang et al. (23),** 31.5% of doctors said that only patients with severe or unmanageable pain should be prescribed opioids, while 33.8% of doctors expressed unfavorable opinions.

A significant number of doctors in the current survey showed significant knowledge gaps regarding the prescription of opioids. A significant portion of incorrect responses (69.2%) concerned the dosage of an equianalgesic. We learned from this item that doctors did not have a proper understanding of the equivalent analgesic dosage of opioids.

According to **Kim et al. (21),** a significant number of doctors demonstrated significant knowledge gaps on the prescription of opioids. One of the higher percentages of incorrect answers (76.7%) concerned the dosage of an equianalgesic. We learned from this item that doctors did not have a proper understanding of the equivalent analgesic dosage of opioids.

In the current study, 32.2% of doctors even disagreed with the use of adjuvant pain relievers to improve analgesic efficacy based on the nature of pain, regardless of the intensity of pain. 75.6% of doctors were unable to accurately identify the pain numbering system. The majority of doctors (62.4%) were still unaware that opioids have no upper limit and can be taken indefinitely.

According to **Kim et al. (21),** the majority of doctors (75.2%) even disagreed with the idea of increasing the analgesic impact based on the type of pain, regardless of how severe the pain was. Seventy-four.9% of doctors were unable to accurately identify the pain numbering system. The majority of doctors (69%) were still unaware that opioids have no upper limit and can be taken indefinitely.

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An estimated 52.4% of doctors in the current study disagreed that strong opioids should be given to patients experiencing severe pain right away. About 40.8% of doctors did not know that using stool softeners is required while administering opioids. Regretfully, 78.1 % of doctors believed that patients with well-controlled pain could have breakthrough pain and benefit from using slow-releasing medications. Nevertheless, in addition to blood pressure, pulse rate, body temperature, and respiration rate, 73.2% of doctors regarded pain as a fifth vital sign. Furthermore, 59.8% of doctors were aware that breakthrough pain can be treated with an extra 10–15% of a new drug's daily dosage.

According to **Kim et al. (21),** an estimated 61.9% of doctors disagreed that strong opioids should be given to patients experiencing acute pain right away. When prescribing opioids, almost half of doctors (56.5%) did not know that using a stool softener was essential. 48.6% of doctors were unduly concerned about the possibility of opiate addiction. Nevertheless, in addition to blood pressure, pulse rate, body temperature, and respiration rate, 58.4% of doctors regarded pain as a fifth vital sign. Furthermore, 58.3% of doctors were aware that breakthrough pain can be treated with an extra 10–15% of a new drug's daily dosage.

In the current study, 92% of doctors expressed concern about the possibility of opiate addiction. When patients are bearable, oral analgesics are the primary line of treatment, as identified by 80% of doctors. An further 92.6 percent of doctors were aware that prolonged use of opioids might lead to tolerance or physical dependency. Ninety-one percent of doctors were aware that the history of pain includes position (P), quality (Q), relief of aggravation (R), severity (S), and timing (T). In contrast, eighty-eight percent of doctors were aware that somatic, visceral, and neuropathic pain comprise the three main categories of pain. Meperidine was the opioid that only 16.4% of doctors correctly identified as worsening central nervous system (CNS) problems when asked to choose.

According to **Kim et al. (21),** 68.2% of doctors correctly identified oral analgesics as the first line of treatment for patients who are tolerating for pain. An additional 72.8% of doctors were aware that long-term opioid use can result in tolerance or physical dependency. Of the doctors, 84.9% were aware that the history of pain includes position (P), quality (Q), relief of aggravation (R), severity (S), and timing (T); in contrast, 88.0% were aware that the three main types of pain are visceral pain, neuropathic pain, and somatic pain. We also inquired about doctors' awareness of useful medications. Mepheridine was the first medicine of choice for almost 25% of doctors when patients need strong opioids, whereas morphine, fentanyl, and oxycodone were chosen by 22.9% of doctors for patients with moderate to severe cancer pain. When asked which opioids would be best for a complicated central nervous system (CNS) issue, 26.3% of doctors correctly answered mepheridine..

Zhang et al. (22) found that patients' inability to pay for analgesics (39.0%), patients' or families' unwillingness to report pain (38.0%), patients' reluctance to use opioids (62.2%), and poor staff knowledge of pain management (61.4%) all contributed to pain and pain management (63.0%). Answers from doctors regarding their understanding of managing pain in cancer patients. The

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majority of doctors (65.0%) gave the wrong answer when asked if they would raise the dosage of a strong opioid and give it every four hours as needed (60.0% agreed and 5.0% had no opinion). The majority of respondents had accurate knowledge about the use of meperidine; 67.4% would not recommend meperidine to patients who needed strong opioids instead of morphine; 55.0% disagreed that meperidine had fewer negative effects when used over an extended period of time; and 59.4% would not recommend 50 g intramuscular meperidine q4h PRN to patients with moderate to severe pain. Furthermore, the majority of physicians (60.4%) knew exactly how oral morphine is absorbed.

Alkhatib et al. (19) demonstrated that the KASRP-R total scores were computed and transformed into a percentage for every participant, with a maximum score of 97.56% (mean 50.6%, SD 13.6) and a lowest score of 31.7%. Question 20 (87.5%) had the highest frequency and percentage of responses compared to the other questions. Question 10 (83.9%) asked about elderly patients' ability to tolerate opioids for pain relief. Question 13. (83.9%) asked whether patients' spiritual beliefs could lead them to believe that pain is necessary. Question 14. (83.9%) asked about adjusting subsequent opioid doses based on each patient's responseThe doctors' understanding of assessing pain was lacking: only four of them answered questions 39 and 41 properly (only sixteen tried to answer), and only four of them answered question 40 on prescribing opioids.

According to **Srisawang et al. (23),** the average knowledge score of doctors and regulators/policy makers was 6.4 ± 2.6 and 4.8 ± 2.9, respectively. The item that stated that physical dependency while using opioids is an indication of addiction received the lowest percentage of right answers in both groups (27.4% of physicians and 19.1% of policy makers/regulators). Of the two groups, the majority (62.1% of physicians and 74.5% of policy makers/regulators) lacked sufficient understanding. In order to determine whether background characteristics were associated with insufficient knowledge, univariate logistic regression was used for additional study. The number of cancer patients treated in the previous six months, hospital type, gender, age, last time of cPM education or training, medical specialty, use of the wHo three-step ladder, and membership in a palliative care team were among the background characteristics that significantly correlated with the physicians' level of knowledge. Policymakers' and regulators' gender and the duration of their previous cPM education or training had a substantial impact..

Conclusion:

In conclusion, majority of Libyan physicians displayed significantly various attitudes and knowledge status about pain management strategy by their specialties and personal experiences in Libya, in which mainly considered weak. Many efforts are required for an adequate CPM through further education improvement in the medical school and practical training during the residency programs.

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