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The Role of Education Policy in Physicians' Reluctance to Prescribe Opioids to Terminally Ill Patients in the Republic of Georgia

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ABSTRACT

Introduction: Pain management in terminally ill patients often requires opioid prescription. While national regulations in Georgia permit opioid use for incurable patients, opioids are not consistently prescribed to relieve pain and suffering. This study reviews the influence of physicians' knowledge, attitudes, and misconceptions on opioid prescribing practices, beyond the impact of restrictive regulations and systemic barriers.

Methods: Data were drawn from the author's study "Evaluating Barriers to Chronic Pain Management and Their Impact on the Quality of Health Service", which assessed the knowledge and attitudes of physicians responsible for prescribing opioids in Georgia. Findings were analyzed within the historical and socio-cultural context of a post-Soviet country.

Results: Up to 40% of primary health care physicians responsible for prescribing opioids to outpatients were hesitant to do so, and only 43% initiated treatment independently. Although 93% claimed to assess pain regularly, just 55% used standardized pain scales, and fewer than half (48%) consistently applied the WHO Analgesic Ladder. Only one-third prescribed morphine on an around-the-clock basis, and just 7% prescribed morphine for breakthrough pain. Overall, only 9–10% of physicians demonstrated "good knowledge and prescribing practice." Misconceptions were widespread: 44% believed morphine frequently causes dependence syndrome, and 46% equated physical dependence with addiction.

Conclusion: Significant gaps in medical knowledge, misconceptions, and inconsistent prescribing practices hinder effective pain management for terminally ill patients in Georgia. These findings underscore the urgent need for targeted educational interventions, reforms in medical curricula, continuous training for practicing physicians, and implementation of evidence-based guidelines to ensure safe and adequate opioid prescribing.

Keywords: Opioid prescribing, Pain management, Physicians' knowledge and attitudes, Education policy.

Background

"Opiophobia"[1] has deep roots in the global misuse of narcotic substances and their negative consequences for health and society. Among healthcare professionals, however, opiophobia often stems from insufficient knowledge, leading to unnecessary suffering in untreated terminally ill patients[2]. To prevent the illegal use or diversion of narcotic substances from legal sources, the United Nations introduced the Single Convention on Narcotic Drugs, 1961 (as amended by the 1972 Protocol)[3]. This convention imposes a dual obligation: preventing diversion while ensuring availability of narcotics for medical and scientific purposes. As opioids are essential medicines for managing moderate to severe pain, the Single Convention, in its preamble, declares that 'the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering' and further states that 'adequate provision must be made to ensure the availability of narcotic drugs for such purposes." Yet, in many countries, this balance is skewed, with restrictive regulations prioritizing prevention over medical access[4].

In Georgia, opioids may only be prescribed to terminally ill patients when no curative treatment options remain[5]. This strict regulation has resulted in very low opioid consumption rates(60-66 S - DDD)[6], a key indicator of pain treatment capacity[7]. More ever, When comparing the estimated need for opioids just in terminally ill patients—based on The World Health Organization (WHO) and International Narcotics Control Board (INCB) methodologies[8] — with actual consumption rates, it becomes evident that opioids are not adequately prescribed even to terminally ill patients in Georgia to relieve pain and suffering. The pain is most frequent symptom among palliative care patients and generally when evaluating palliative care services one of the main indicator is availability and accesibility of opioid medications, particullary morphine[9] which belongs to the group of the esentiall medicines[10] to treart the pain in palliative care patients[11–13]. Data suggest that only 17% of terminal patients' needs are met in Georgia[14]. This low rate has persisted for decades, as documented in INCB reports[6,15–17].

World Health Organization emphasizes a "triangle" model for establishing effective palliative care services: Education, Drug availability and policy[18]. The aim of the framework is to support the establishment of comprehensive and accessible palliative care systems throughout the world, particularly in resource-limited countries. All three components are essential and interdependent and must be sustained by the political will of governments. The absence of any element undermines the establishment of comprehensive palliative care and effective pain management.

The recent report of the European Association for Palliative Care, EAPC Atlas of Palliative Care in the European Region 2025, aimed to illustrate the current state of palliative care health policies and services, emphasizing the integration of palliative care into health systems[19]. According to the EAPC Atlas Georgia has 38 medical schools, but only six offer palliative care as a mandatory course and eleven as an elective. Pain management is not taught as a separate subject but is integrated into the palliative care curriculum with limited duration.

In the previous decade, attempts were made to improve opioid access by adopting relevant pain management guidelines based on modern knowledge, along with some liberalization of opioid prescribing practices. Despite these efforts, indicators of pain management adequacy remain critically low in Georgia. Thus, it can be suggested that a lack of medical knowledge, negative attitudes, and misconceptions regarding opioid use for pain treatment adversely affect physicians' clinical practice and the adequate prescription of morphine, which remains the only opioid available for ambulatory patients in Georgia.

The current article highlight barriers related to physicians' knowledge and attitudes toward opioid use in terminally ill patients. Economic barriers were

excluded, as opioid costs for terminally ill outpatients are covered by the state program[20]. Legislative, policy, and administrative barriers have been discussed in detail in other articles[21–25].

Methods

To identify why physicians hesitate to prescribe opioid analgesics even when legally permitted, data from the study Evaluating Barriers to Chronic Pain Management and their Impact on the Quality of the Health Service (2016–2018, Georgia) were analyzed [26]. The study targeted primary health care physicians (family doctors, rural doctors, general practitioners) responsible for prescribing opioids to outpatients. Of 550 questionnaires distributed, 302 physicians responded (55%), and 289 met inclusion criteria.

The inclusion of the physicians into the survey occurred within the framework of the educational course for primary health care physicians in Tbilisi and three other regions of Georgia. Statistical analyses were performed with SPSS version 20. Armonk, NY: IBM Corp. Pearson's chi squared test ($\chi 2$) was used to test association between categorical variables. Fisher's exact test was used when appropriate. Probabilities less than 0.05 was considered as statistically significant.

To obtain a more comprehensive picture, two additional studies conducted in Georgia were subsequently reviewed, and corresponding data from the EAPC Atlas of Palliative Care in the European Region 2025 were incorporated.

The findings were further analyzed within the historical and socio-cultural context of a post-Soviet country. This analysis examined how legislation and educational policies influence the adequacy of pain management for patients with terminal illness.

Results

The review of a study conducted in Georgia among 289 primary health care physicians (general practitioners and family and rural doctors), who are the only professionals legally authorized to prescribe opioids to outpatients, revealed serious gaps in knowledge and awareness regarding opioid use in pain management.

Overall, 62% (179/289) of the physicians responsible for prescribing reported that they prescribe opioids (issuing prescriptions after a local commission decision or based on medical records from another facility where an oncologist initiates opioid treatment). However, only 43% of them stated that they independently decide to initiate pain treatment with opioids. Although 93% reported that they assess pain regularly and 88% believed they assess pain comprehensively, only 67% were aware of standardized pain assessment scales, and just 55% reported using them in practice.

Eighty percent (230/289) of physicians considered morphine the most effective treatment option for patients with severe cancer-related pain. While 69% indicated awareness of the World Health Organization's 3-Step Analgesic Ladder, only 48% (139/289) reported using it always or frequently. Notably, just 51% (148/289) disagreed with the statement: "Morphine is not necessary to treat a patient with severe chronic cancer pain because other equally effective medicines (Step 1 medicines) are available."

Responses to more practical questions were very low. For example, when asked about prescribing morphine to patients with severe chronic pain, 45% reported prescribing it on an around-the-clock basis, while 35% prescribed it on an as-needed basis. Crosstabulation revealed that 30 of the physicians (129 total) who claimed to prescribe morphine around the clock also reported prescribing it as needed—two mutually exclusive practices in the case of constant pain. Thus, in reality, only about one-third of physicians prescribe morphine on an around-the-clock basis.

Despite the availability of sustained-release oral morphine in Georgia since the early 2000s (reintroduced in 2009), only one-third of physicians legally obliged to prescribe opioids were aware of

oral formulations. Among the 73 physicians who reported prescribing morphine around the clock, 60 were aware of sustained-release oral morphine formulations.

Eighteen percent (52/289) of physicians stated that they always or frequently prescribe morphine for breakthrough pain. However, only 37% of these (19/52) knew that legislation permits prescribing two opioids on a single prescription form. Therefore, in practice, only about 7% (19/289) of all physicians prescribe morphine for breakthrough pain.

To summarize the knowledge results, we created a "good practice" variable, defined as physicians who use pain assessment scales, apply the WHO Analgesic Ladder, prescribe opioids on an around-the-clock basis, and issue prescriptions according to patient needs. Only 10% of physicians demonstrated "good practice" knowledge. When prescribing behavior was added to this variable, only 9% (26/289) qualified as having "good prescribing practice."

Physicians' attitudes and misconceptions regarding opioid-based pain treatment were evident. Forty-four percent (128/289) of physicians believed that prescribing morphine to patients with severe chronic cancer pain always or frequently causes "dependence syndrome." Furthermore, 46% (133/289) equated "physical dependence" on morphine with "dependence syndrome" (addiction), while 26% (74/289) were uncertain about the distinction. Only 17% (49/289) correctly recognized that "physical dependence" is not the same as "dependence syndrome."

As expected, these attitudes and misconceptions significantly influence opioid prescribing practices and contribute to inadequate pain management (table1).

Table N1 Impact of knowledge, attitudes and misconceptions

From those who don't consider morphine to be the most effective treatment option for patients with severe pain from cancer	
less of them prescribe morphine, if non-opioid treatments have failed	χ^2(df2)=269, p< 0.001
More of them think, that morphine is not necessary to treat severe chronic pain from cancer because other equally effective medicines are available	χ^2 (df 1) = 257, p < 0.001
Those physicians who think that morphine is not necessary to treat severe chronic pain from cancer because other equally effective medicines are available	
less prescribe morphine.	χ^2 (df1)=232, p=0.001
Less have "good practice"	χ^2 (df1)=262, p=0.026
Those physicians who think that "physical dependence" on morphine is the same thing as "dependence síndrome" to morphine	
Are (40% versus 14%) more concerned that they can be investigated because of morphine prescribing practices	χ^2 (df1)=138, p=0.023
More of them (58% versus 12%) consider that prescribing morphine to treat severe chronic pain always/frequently causes "dependence síndrome"	χ^2(df2)=253, p<0.001

Discussion

The focus of the current paper is to examine the relationship and influence of national education policies on pain management, particularly their role in shaping physicians' knowledge and attitudes that affect the ability to provide effective pain management for terminally ill patients in Georgia. Despite being legally responsible for prescribing opioids to incurable outpatients, only 62% of surveyed physicians reported that they prescribe opioids, and less than half (43%) stated that they independently initiate opioid treatment. Consequently, a substantial proportion of terminally ill patients either do not receive opioid therapy or experience delays due to reliance on commission decisions or referrals to oncologists[23].

Knowledge and Practice Gaps

Overall, physicians' responses to the theoretical questions were not entirely sincere and appeared to reflect socially acceptable answers rather than actual practice. Although 93% declared that they assess pain regularly and 88% believed they assess pain comprehensively, only 55% reported using pain assessment scales. This finding suggests that physicians often do not recognize the need to assess pain systematically or to document its severity and progression in medical records. Instead, their primary focus tends to be whether the patient has a documented terminal illness and a limited life prognosis. According to legislation, drug regulators verify the diagnosis (which must be incurable) and prognosis (which must be terminal), rather than the severity of pain or the patient's physical condition requiring opioid treatment.

Most physicians were not sincere when reporting adherence to pain guidelines (75%). If they truly followed these guidelines, they would also be aware of the WHO 3-Step Analgesic Ladder and morphine formulations. Similarly, one-third (76/230) of physicians were inconsistent when stating that they consider morphine the most effective treatment option, while simultaneously acknowledging that non-opioid medicines are equally effective.

Despite the availability of palliative care instructions (since 2008) and chronic pain management guidelines (since 2012), which emphasize prescribing oral morphine on an around-the-clock basis, the data reveal significant gaps in knowledge and practice. Summing thematic responses, we can conclude that only 26% (75/289) of physicians are aware of the chronic pain management guideline, a maximum of 34% (99/289) prescribe morphine on an around-the-clock basis, up to 21% (60/289) prescribe oral morphine to patients, and just 7% (19/289) prescribe morphine for breakthrough pain. Further ever, just 9% of physicians demonstrated "good opioid prescribing practice," defined as adherence to pain assessment scales, the WHO ladder, appropriate scheduling, and patient-centered prescribing.

Attitudes and Misconceptions

Negative attitudes and misconceptions further undermine effective pain management. Nearly half of physicians believed that prescribing morphine frequently causes "dependence syndrome," and only one-sixth correctly distinguished physical dependence from addiction. These misconceptions foster fear of investigation and reluctance to prescribe opioids, even when medically indicated. Importantly, misconceptions were widespread across all groups, with no significant difference between physicians demonstrating good practice and those without it.

In summary, the combination of insufficient medical knowledge, negative attitudes, and misconceptions about opioid use has a detrimental impact on physicians' prescribing practices and results in inadequate provision of morphine for incurable terminal patients in Georgia—the only strong opioid available for ambulatory care.

Similar problems were identified in the study "Availability and Accessibility of an Essential Medicine: Key Issues Around Opioid Pain Relief for Palliative Care in Georgia" conducted by Sandra Elisabeth Roelofs[27]. The results, based on focus group interviews, highlighted the negative impact of

healthcare and legislative barriers, as well as the lack of knowledge linked to myths and misconceptions, fear of side effects, and concerns about dependence and tolerance. The author emphasized that insufficient knowledge fosters misconceptions, such as the belief that morphine is administered only at the final stage of life, thereby creating an apparent causal relationship between the initiation of morphine and death. Concerns about side effects lead to cautious prescribing and underdosage, while fear of dependence and tolerance generates "opiophobia," which delays the initiation of opioid treatment.

Another study, "Cancer Pain and Its Management with Opioids in Georgia," conducted several years later among cancer patients undergoing treatment, revealed that 66.4% of patients (235/354) experienced pain, with 75.3% (177) reporting moderate to severe pain ($p < 0.001$). Despite this, only 9.6% (17) of patients received opioid therapy[22].

Thus, morphine consumption rates in Georgia have remained almost unchanged for decades, placing the country in the "very low consumption" category according to the International Narcotic Control Board[1428].

Educational gaps compound these barriers. The Atlas of Palliative Care in the European Region 2025, published by the European Association of Palliative Care (EAPC), applied the World Health Organization's novel framework of indicators to evaluate palliative care services and their development across Europe[19]. The report revealed that only 16% of Georgian medical schools offer mandatory palliative care courses, while 29% provide them as electives. Since pain management is integrated into palliative care curricula rather than taught as a separate subject, 55% of medical schools provide no education in pain management at all. This lack of structured training perpetuates misconceptions and poor prescribing practices among physicians.

Georgia, as a post-Soviet country, continues to carry the heavy influence of its Soviet inheritance. Like many other post-Soviet states, overly restrictive regulations impede effective pain management. Beyond legislative barriers, however, opioid accessibility is also shaped by educational policies and the overall level of medical education. The persistently low rates of opioid consumption for pain management can be traced back to the former Soviet medical education system, where pain management with opioids was almost entirely neglected, and physicians received no training on how to manage pain or prescribe opioids. Even today, Russian sources states that the maximal single dose of immediate-release morphine is 20 mg and the maximum daily dose is 50 mg[29]. It further indicates that morphine may only be prescribed twice daily, disregarding the formulation of the medicine or the type of constant pain, and warns physicians to exercise caution because morphine and other "narcotic analgesics" may cause "narcomania" (addiction/dependence syndrome).

Many physicians in post-Soviet countries—particularly middle-aged and older doctors—continue to rely primarily on Russian medical literature due to language barriers. This reliance, combined with insufficient academic training in chronic pain management and opioid prescribing, has fostered vague attitudes and persistent fears about opioid use for medical indications. Over decades, these factors have contributed to widespread misconceptions and reluctance to prescribe opioids. While Georgia's challenges are rooted in its historical, cultural, and legislative context, insufficient knowledge and misconceptions about opioids are recognized globally as barriers to accessibility. International literature confirms that fear of dependence, stigma, and inadequate training negatively influence opioid prescribing practices worldwide[30–36].

Another factor that reinforced "opiophobia"[1,37,38] within the medical community was the terminology and definitions related to opioid use and dependence syndrome in Georgian legislation. Until 2012, the Georgian law on "Narcotics, Psychoactive substances, Precursors and Narcological Aid" conflated the medical use of opioids with drug dependence[39].

The definition of dependence syndrome itself was based on the 1957 WHO definition, which described it as psychic and/or physical dependence[40]. As a result, physical dependence alone was sufficient to establish a diagnosis of "drug dependence." In 1969, the WHO redefined "drug dependence" to include behavioral criteria such as compulsive use and harm, making physical dependence alone no longer sufficient to define the syndrome[41]. However, this updated definition was never reflected in the drug laws of Soviet countries. Consequently, the terminology and definitions in national drug control legislation remained confusing and archaic.

Moreover, the terms used to describe individuals with dependence syndrome were stigmatizing. Persons with dependence syndrome were legally categorized as "drug addicts" (narco-mans, derived from "narcotics"). The same concept was applied to patients using opioids for legitimate medical purposes: if they developed physical dependence, they were labeled as "somato drug addicts" (somato-narco-mans). Naturally, this influenced physicians' practices, as nearly all patients receiving opioids for longer than two weeks were considered "somato-narco-mans." Physicians therefore sought to avoid prescribing opioids whenever possible. These attitudes inevitably permeated the general population, reinforcing stigma and fear surrounding opioid use.

The Soviet legacy continues to shape medical practice and attitudes. Soviet culture stigmatized suffering and discouraged expressions of pain, framing endurance as a sign of strength. Soviet culture generally denied spirituality and psychological aspects of illness, including the concept of "total suffering"[42]. Soviet citizens were expected to be strong, and suffering or complaining about pain was stigmatized. Physicians often dismissed patients' complaints, reinforcing cultural norms that minimized pain. Expressions such as "You have gone through such a serious operation, how can you now complain of pain" or "You are a strong person and can overcome it" were common in everyday healthcare practice. Although many years have passed since the collapse of the Soviet Union, the impact of its political, socio-cultural, and educational system remains strong.

Ethical and Human Rights Dimensions

Terminology and definitions in national drug laws, used for decades alongside poor medical knowledge, created misconceptions about opioids. These misconceptions were reinforced and deepened over time by strict and unjust regulations. Physicians' lack of knowledge about how to treat pain with opioids, reliance on prescribing schedules not based on pharmacological principles, and the unjust practice of prescribing morphine only late in the course of illness—or avoiding it altogether—have caused significant and unnecessary suffering among patients with terminal conditions.

This not only undermines medical practice but also raises serious ethical and human rights concerns. Patients denied access to essential medications or subjected to delayed treatment endure unnecessary suffering, which can be described as "cruel, inhuman, and degrading treatment"[43] and challenges their fundamental rights[44]. Ensuring the right to be free from pain requires urgent reforms in medical education, implementation of evidence-based guidelines, and training programs for practicing physicians.

Conclusion

Lack of knowledge and misconceptions about opioids and their medical use significantly affect the quality of pain management in terminally ill patients. This situation highlights the urgent need to review education policies and adopt effective, evidence-based curricula in medical schools, to implement relevant clinical guidelines in everyday practice and to provide training programs targeting practicing physicians. Together, these would ensure safe and high-quality pain management for terminally ill patients, strengthen Georgia's healthcare system and safeguard patients' rights.

Conflict of Interests:

The author has no conflict of interest to declare.

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