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Pain Management: Nurses in Jeopardy

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Knowledge of pain physiology, assessment, treatment, and management has grown exponentially since the advent of aspirin in the United States in 1899. A quick Internet search on Google™ in February 2008 revealed some staggering numbers.

- *Pain* in the search engine pulls 200,000,000 hits.
- *Pain treatment* produces 8,490,000 hits.
- *Pain symptoms* reveals 3,090,000 hits.
- *Pain causes/risk factors* produces 10,500,000 hits.
- *Pain for healthcare providers* reveals 253,253,000 hits.
- *Pain organizations* produces 765,000 hits.

In addition, the number of organizations dedicated to the study, treatment, and management of acute and chronic pain abound (see Figure 1). A number of organizations exist solely to focus attention, study, and research on specific syndromes such as back pain, migraines, trigeminal neuralgia, reflex sympathetic dystrophy, chest pain, post-herpetic pain, arthritis, joint pain, pain from a cancer diagnosis, neuropathic pain, fibromyalgia, age-related pain, and sickle cell pain. This does not represent a complete list. Knowledge has been gained, published, and often presented at national meetings and the amount of pain knowledge available to learn is almost beyond comprehension.

State of Pain and Pain Management

With all of this knowledge and available expertise, what is the state of pain and pain management in the United States and the world today? Examine this sample of sobering facts.

- Twenty percent of Americans aged 65 and older reported pain that has persisted for more than 24 hours (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics Press Office, 2006).
- About 66% of adults aged 65 and older who experienced pain said it lasted one year or more (CDC National Center for Health Statistics Press Office).
- One in five adult Americans (about 30 million people) experienced chronic pain (Chou, Clark, & Helfand, 2003).
- In patients with chronic pain, 60% reported that multiple regions of the body experience pain (Trescot et al., 2006).

In a study of 753 veterans and members of the military forces who responded to a written survey, 96% reported they were in pain, with more than 54% reporting pain for more than 10 years (American Pain Foundation, 2007). Although 75% stated that emotional support was “moderately” or “very” important, 15% responded that they received no emotional support for pain (American Pain Foundation).

An estimated 4 out of 10 Americans say pain interferes with their mood, activities, sleep, ability to work, or enjoyment of life (CDC National Center for Health Statistics Press Office, 2006).

Patients with cancer experience unrelieved pain. Thirty percent of newly diagnosed patients and 30%–50% of patients undergoing active treatment for their disease report unrelieved pain. In patients with advanced malignancy, 70%–90% report pain that is not relieved (American Cancer Society, 2007).

Sixty-six percent of older adult patients with end-stage cancer report unrelieved pain and about 83% of older adult patients with dementia and end-stage cancer report unrelieved pain (Matulonis, 2004).

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) found that 73% of patients with advanced cancer admitted for palliative care receive inadequate pain relief (SUPPORT Principal Investigators, 1995). Von Gunten (2005) suggested “that, of the 1 million dying Americans who have pain, 300,000 of them want more pain relief” (p. S89). Godfrey, Harrison, Freidberg,



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American Academy of Pain Management: www.aapainmanage.org
American Academy of Pain Medicine: www.painmed.org
American Chronic Pain Association: www.theacpa.org
American Pain Foundation: www.painfoundation.org
American Pain Society: www.ampainsoc.org
American Society of Addiction Medicine: www.asam.org
American Society of Anesthesiologists: www.asahq.org
American Society for Pain Management Nursing: www.aspmn.org
National Foundation for the Treatment of Pain: www.paincare.org

Figure 1. Web Sites for Pain Management Organizations

Medves, and Tranmer (2007) reviewed nine heart failure studies where pain was a focus and found that 25%–75% of participants reported pain. Whelan, Jin, and Meltzer (2004) assessed pain and pain control in a telephone survey of 5,584 hospitalized patients and found that 59% had pain with 28% reporting severe pain, 19% moderate pain, and 12% mild pain. Among patients with common diagnoses, those with sickle cell crises were the most likely to report significant pain. Lastly, in a heterogeneous sample of 90 hospitalized veterans with cancer, about 25% reported average daily pain above the visual analog scale midpoint of 50 (based on 100 mm line printed on a sheet of paper). Some patients reported average daily pain as high as 98 out of 100 (McMillan, Tittle, Hagan, & Laughlin, 2000), meaning that the patients never experienced relief during the entire 24-hour period of data collection.

This issue is not limited to the United States alone. An estimated 80% of the world population receives inadequate treatment and pain relief (Taylor, Gostin, & Pagonis, 2008). In interviews conducted after a patient has died, surrogates reported that their loved one had moderate to severe pain more than 50% of the time during the final three days of life (SUPPORT Principal Investigators, 1995). This not only is a negative experience for the patient but also the caregiver in their grieving.

The statistics reveal that, although pain is the most common reason that individuals seek health care, promotion of health for people in pain is sadly lacking.

We know so much, yet we relieve so little. How is this possible? In examining the barriers to effective pain management and positive pain relief outcomes, obstacles spring up at the level of the patient, the healthcare professional, and the healthcare system itself. This article focuses on the barriers for the healthcare professional, specifically the oncology nursing professional. A nurse may have a preconceived notion about a topic and that belief will direct behavior, often in a way that is detrimental to patient care. The following is a case study that further highlights this point.

Case Study

Reggie, a 28-year-old African American male, was admitted to an inpatient acute care hospital with complaints of “excruciating right hip pain” with a pain score of 10 on a 0 (no pain) to 10 (extreme pain) scale. Other complaints included abdominal cramping with nausea and vomiting. Upon admission to the nursing unit, Reggie requested IV pain medication although he had received 1 mg hydromorphone IV three hours earlier in the emergency department.

Reggie’s past medical history included paraplegia for 11 years after a motor vehicle accident in which he was hit by

a drunken driver. His medical history includes left upper-quadrant pain of unknown etiology that he managed successfully for the previous five months with 40 mg of oxycodone extended-release orally every 12 hours. Reggie had taken oxycodone and acetaminophen for breakthrough pain and had less than four breakthrough pain episodes per day. He had a 4 x 5 cm decubitus ulcer on his left hip that almost was healed. Reggie had been treated intermittently for multiple episodes of urinary tract infections as a result of chronic placement of a Foley catheter. In addition, Reggie had a colostomy secondary to the accident and paraplegia.

An assessment of his right hip pain revealed the following.

- **Pain location:** Right hip; Reggie was unable to localize the pain to either the anterior or posterior region.
- **Pain duration:** Constant with no variation.
- **Intensity:** Worst pain intensity was 10 out of 10 and best was 8 out of 10, for an average of 9 out of 10.
- **Onset:** The pain started three weeks prior to admission and continued to grow in intensity.
- **Alleviating factors:** Reggie identified no behaviors, movements, or activities that provided pain relief. He reported taking extra doses of the long-acting oxycodone and short-acting oxycodone with acetaminophen. In addition, Reggie reported that he came to the emergency department after he ran out of medications and before he could get a prescription refilled.
- **Aggravating factors:** Reggie reported that any bodily movement dramatically escalated his pain above the pain score of 10 out of 10.
- **Side effects from present pain regimen:** Reggie denied nausea, vomiting, sedation, itching, constipation, or any other opioid-related symptom.
- **Quality-of-life impact:** Although Reggie was fully capable of his own self-care activities with minimal assistance, he stated that the pain had severely limited his ability to perform activities of daily living. As an active member of his local church, Reggie had become more isolated and stated that he would rather “just stay in bed.” He reported sleeping three to four hours per night since the onset of pain three weeks prior, a significant decrease from his usual eight hours. Reggie and his wife reported that his appetite was moderately decreased and that his ability to concentrate was severely diminished. Reggie said that he could not “concentrate on a 30-minute television show.”

The RN who admitted Reggie to the inpatient unit documented the following narrative note.

Patient is lying in bed watching television and immediately requests IV pain medication upon the nurse entering the room. He has a black fanny pack that he is clutching to his side. His vital signs are within normal limits, his skin is warm and dry and normal in color and no facial grimacing is noted. He does wince when he moves.

Before the nurse left the room, Reggie again asked for pain medication, this time specifying “the Dilaudid® (hydromorphone, Abbott Laboratories), not the Percocet® (acetaminophen and oxycodone, Endo Pharmaceuticals).”

The initial pain medication orders were for hydromorphone 2 mg IV every two hours as needed for severe pain and oxycodone 5 mg and acetaminophen 325 mg one to two tablets every three to four hours orally as needed for mild to moderate

pain. A notation of the physician's impression was found in the progress notes and stated

- Right hip pain of unknown etiology
- Gastroenteritis
- Drug-seeking behavior.

Patient Behaviors

Frequent Requests for Pain Medication

Drug-seeking behavior or addiction are frequently assumed by the healthcare team when a patient continues to hurt despite receiving strong medication. The frequency with which Reggie was requesting pain medication is a behavior associated with patients seeking pain relief or patients who are abusing opioids and who are addicted. Mislabeling a patient can lead to impaired and often adversarial relationships with the healthcare team and inappropriate treatment may be a consequence.

Opioids have become an essential component in the management of malignant and nonmalignant pain. By affecting specific receptors in the brain, opioids alter the unpleasant emotional experience and provide pain relief. Agonists (e.g., morphine) bind to opioid receptors and produce analgesia, whereas antagonists block the action of the agonist. An example of an agonist is naloxone hydrochloride. A partial agonist opioid binds to receptors and produces analgesia, but unlike agonists, they exhibit a ceiling effect. Opioids vary in the onset of action and the duration of pain relief. Substantial variability of at least a three- to five-fold difference exists in a single dose of opioid; therefore, a dose that may be toxic to one patient may be subtherapeutic to another. Variability in the pharmacologic response to an opioid is affected by patient compliance, age, race, gender, activity of hepatic enzymes, presence of comorbidities, the degree of body fat, and the degree of drug protein binding. In addition, metabolic and genetic variations exist in each individual that affect the drug's work in the body. There simply is no "one size fits all" or even "one size fits most" approach when it comes to opioid therapy. The frequency with which a patient requests pain medication must be examined in light of a thorough pain assessment, the patient's pain history, and belief in the patient's self-report. In the hierarchy of pain assessment, the patient's self-report is the most reliable indicator of pain.

Requests for IV Rather Than Oral Medication

I have frequently heard statements from nurses that exhibit their belief that opioids can cause addiction. Such statements include "The patient just wants the rush," "The patient likes the euphoria caused by the IV push," or "That patient just wants to escape from the real world." An IV opioid has a quicker onset than an oral dose, thereby aiding the patient in obtaining quick relief. McCaffery and Pasero (1999) report that the same doses of IV medications when given orally are likely to result in less pain relief because of a decrease in dosage from what was calculated for the equianalgesic dose. Why would a patient who is experiencing pain at a severe level not wish to receive relief in a matter of a few minutes compared to 30–60 minutes?

Patient Has Been Taking Opioids for a Long Time

In teaching nurses about pain and pain management for many years, the most common answer I have received to the question "Why is Reggie on pain medications for so long?" is "tolerance." Nurses report their belief that tolerance occurs

from long-term opioid use or that the patient has become more tolerant to pain itself because of issues with chronic pain. Rarely have I heard the answer "the patient has had pain for a long time so he is on opioid therapy for a long time." According to Passik, Kirsh, and Portenoy (2002), tolerance to opioids is "a pharmacologic property defined by the need for increasing doses to maintain effect" (p. 594). Tolerance can build to analgesia and to opioid side effects as well. In the population of patients with a malignancy, the investigation for other causes begins when the opioid is no longer working. In benign pain, tolerance again is viewed as a condition of either more pain or more disease. In the absence of increased disease, the condition is believed to be physical tolerance. The intervention in either case—tolerance or more disease—is that the opioid is increased to control the patient's pain.

The presence of tolerance does not imply the presence of physical dependence or addiction. In fact, physical dependence, tolerance, and addiction are separate phenomena but may exist together in the same patient (American Society for Pain Management Nursing, 2002). Once more, the onus for a complete assessment, specific interventions, and consistent evaluation of care is on the healthcare providers.

Patient Is Taking Extra Doses of Pain Medications

Some nurses see extra doses of pain medication as a sign of addiction and opioid use. Most patients taking prescribed opioids do not engage in drug diversion or drug abuse (Curtiss & McKee, 2004). Addiction has been defined jointly by the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine as "a primary, chronic, neurobiologic disease with genetic, psychological, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving" (Jackson & Lipman, 2004, p. 66). Examples of addictive behaviors that are illegal include

- Selling prescription drugs
- Prescription forgery
- Stealing drugs from others
- Injecting oral or topical formulations
- Multiple episodes of prescription loss.

Nurses also must take into account the iatrogenic syndrome of drug-seeking behavior that results from inadequate pain management. According to Payne (2004), "The inexperienced clinician may misinterpret the behavior of the patient with severe unrelieved pain for drug seeking behavior because poorly managed pain may produce many of the behaviors that physicians have come to fear in 'addicted individuals.' This phenomenon is recognized by the term pseudoaddiction" (pp. 76–77). In pseudoaddiction, suspicious behaviors will diminish and often disappear when pain relief becomes the priority and the patient's pain is sufficiently managed.

Patient Knows the Names of His Opioids

I have often heard nurses report that the patient knows the name of his opioids, therefore, the patient must be an addict. One would expect that the patient would know the names, doses, frequency, and potential side effects of antihypertensive medications, diabetic drugs, or congestive heart failure medications. Why then do we react when the patient is knowledgeable about opioid medications?

Education of patients and caregivers is a vital intervention that can increase the patient's sense of control. Thorough knowledge regarding pain management will include the methods of pain management, names and types of analgesics, potential side effects of medications, the participation expected by the patient, and the participation expected by the healthcare professional. Additionally, it is critical to allay fears related to addiction and the use of opioids. Emphasizing the patient's responsibility for managing treatments related to pain management is critical in completing the education needed.

Patient Is Clutching His Fanny Pack

I was called to the unit by Reggie because his nurse would not administer pain medications that were not only due but past due. In inquiring about the reason why pain medications were not being given, the nurse replied, "The fanny pack has drugs in it, and the patient is guarding and protecting it." When asked what drugs were present, the nurse reported that this had not been checked. I explained to Reggie that we needed to check the contents of the bag to protect his safety by ensuring that he was not being double-medicated. He had no pain medications in the fanny pack; however, the nurse's belief that he did had a powerful impact on the interventions that were performed or withheld. Healthcare professionals must be wary of the visual cues that prompt our biases and therefore, our actions.

Increased Irritability and Social Isolation

A myth exists that irritability and social isolation are signs of withdrawal from addiction. Irritability and social isolation also could be signs of depression. Psychological states such as depression, anxiety, anger, agitation, irritability, and confusion all can contribute to the perception and experience of pain and to the expression of pain.

Inadequate pain control can result in the following adverse consequences.

- Decreased quality of life
- Impaired ability to carry out daily activities
- Impaired recovery from injury or procedures
- Work absenteeism
- Underemployment or unemployment
- Progression to chronic pain
- Significant suffering with poorly controlled pain linked to anxiety, fear, anger, or depression
- Serious medical complications (e.g., pneumonia, deep vein thrombosis)

In examining the consequences of unrelieved pain, it is easy to see that behaviors such as irritability and isolation actually could be viewed as a normal response. In addition, suffering is a way to assess a patient's pain management. Benoliel (1996) makes this poignant statement.

Pain as a response to disease or injury is not the same as that sense of disruption and fractured identity experienced in suffering. Although pain can contribute to suffering, suffering as lived experience occurs when the meaning of a person's life situation has been ruptured by one or more salient changes that bring a diminished sense of what it means to be human (p. vii).

Questions posed to the patient regarding the nature of suffering and what it means can provide insight to the full impact of pain on the patient's quality of life.

Report of Left Upper Quadrant Pain With No Etiology

Many believe that pain is caused by detectable tissue injury and pain without a cause, therefore, must be psychogenic. Psychogenic is a label used to describe real physical pain that has a psychologic origin and is presumed to exist when no nociceptors or neuropathic mechanisms can be identified (McCaffery & Pasero, 1999). Some types of mental or emotional issues can cause pain and increase or prolong pain. In fact, no predictable relationship exists between identifiable injury to tissue and the sensation of pain (McCaffery & Pasero).

Nurse Reactions

Use of a Placebo

A placebo is defined as "any medication or procedure that produces an effect in patients resulting from its implicit or explicit intent and not from its specific physical or chemical properties" (American Society for Pain Management Nursing, 2004, p. 1). An example would be a sugar pill or an injection of saline. McCaffery & Pasero (1999) stated that "no medical conditions exist for which placebos are recommended as a method of assessment or treatment. Placebos cannot be used to diagnose malingering, psychogenic pain, or any other psychological problem. Use of placebos for pain relief does not prevent addiction to opioids" (p. 57).

It is unethical to use a placebo even with a written or verbal prescription from a physician. The American Nurse's Association's (2001) *Code of Ethics for Nurses* discusses the ethical and moral obligation to relieve patient pain. The *Code of Ethics for Nurses* has been produced to make clear the goals, values, and obligations of the nurse and is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession. These obligations and duties are non-negotiable. The code establishes the ethical standard for the profession and has nine provisions (see Figure 2). Examining the code in light of pain and pain management clearly illuminates the professional nursing role.

The Oncology Nursing Society's (2004) position statement on cancer pain management states "placebos should not be used to assess or manage cancer pain, determine if the pain is 'real,' or diagnose psychological symptoms, such as anxiety, associated with pain" (p. 1). The position statement of the American Society for Pain Management Nursing (2004) holds that "placebos should not be used by any route of administration in the assessment and/or management of pain in any individual regardless of age or diagnosis" (p. 8).

Preventing Licensure Jeopardy

A nurse accepts the assignment of a patient in pain and that acceptance is the start of a relationship with that patient. To inadequately manage a patient's pain breaches the nurse's duty to that patient and puts the nurse's licensure in jeopardy.

In the nursing profession, a RN is viewed as one who is reasonably prudent in actions and nursing care. Negligence is the unintentional failure to act as a reasonable person in the same or similar circumstances. Four elements of negligence to be considered in a lawsuit are

- **Duty:** A nurse's legal duty or responsibility to the patient to act reasonably and prudently. Duty is guided by standards of care, nurse practice acts, and the employer's policies and procedures.

- The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual unrestricted by considerations of social or economic status, personal attributes, or the nature of health issues.
- The nurse's primary commitment is to the patient, whether an individual family, group, or community.
- The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
- The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
- The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
- The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
- The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
- The profession of nursing as represented by associations and their members is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Figure 2. American Nurses Association Code of Ethics for Nurses

Note. From *Code of Ethics for Nurses Bookmark*, by American Nurses Association, 2001, Silver Spring, MD: American Nurses Association. Copyright 2001 by the American Nurses Association. Reprinted with permission.

- **Breach of duty:** A failure to act in a reasonable manner.
- **Causation:** What the nurse did or did not do resulted in injury to the patient.
- **Damages:** The patient reports harm resulting from a nurse's breach of duty. Damages can be economic, punitive, or pain and suffering.

All four elements of nursing negligence must be proven in a criminal court of law for a jury to find nursing malpractice. However, a difference exists between a criminal lawsuit and discipline by a state nursing board. A lawsuit is usually brought against a nurse for money damages and, again, all four elements must be proven. The nursing board need only demonstrate duty and breach of duty to discipline the license holder. Causation or damages are not required in a nursing board investigation.

How does one reduce the risk of licensure jeopardy? Austin (2008) cited the following strategies to reduce legal risks.

- Follow the nursing process.
- Properly administer medications.
- Monitor and report deterioration.
- Communicate effectively.
- Delegate responsibly.
- Document in an accurate and timely manner.
- Know and follow the institution's policies and procedures.
- Use equipment properly.

The Four Cs of Pain Management

Competence is defined as "the determination of an individual's skills, knowledge, and capability to meet defined expectations" (Joint Commission, 2008, p. GL-3). As a

nurse gains the skills, attitudes, and knowledge that lead to competent nursing care, confidence that optimal patient outcomes can be achieved grows as well. Nurses must own the responsibility to gain the competence and develop confidence to deliver expert pain assessment and pain management. The skills must be gained to compute equianalgesic dosing, deliver accurate reports, pass work on to colleagues, and complete detailed pain and side effect evaluations. Competence linked to a judgmental and biased attitude can only lead to an increase in the patient's pain and subsequent suffering. Xue, Schulman-Green, Czaplinski, Harris, and McCorkle (2007) reported that 60% of the medical oncology nurses rated their education and training in cancer pain as fair, 20% rated it as poor, 16% rated it as good, and 4% rated it as excellent. This highlights the need to continue to upgrade knowledge and to regularly assess competence.

Continuity is the cornerstone of effective pain management and treatment. Effective continuity of care increases the likelihood that the patient's needs will be addressed. At the center of continuity is an understanding and communication of the patient's goals for pain relief. To ensure this continuity, the same assessment tool must be used by all members of the healthcare team involved in the patient's care. This provides consistent pain assessment and consistent evaluation of the effectiveness of pain relief measures.

Another area that demands continuity is the correlation of mild, moderate, and severe pain descriptors with the pain scale. Mild pain correlates with a score of 1–4, moderate pain correlates with a score of 5–6, and severe pain correlates with a score of 7–10. Pain management interventions must be based foremost on the intensity of the patient's self-report.

Commitment to the patient in pain requires a decision on the part of the healthcare professional to partner with the patient and to remain engaged in the patient's care. To listen to the mislabeling (e.g., drug-seeker, addict) of patients by other professionals can challenge one's commitment. A patient remaining in pain despite frequent interventions is not an uncommon occurrence. This can lead to feelings of frustration that can cause the healthcare professional to doubt both their commitment and their competence. Assuring the patient of one's continued involvement and commitment to attain pain control will strengthen the patient-nurse relationship and result in increased patient satisfaction.

Compassion encompasses the art of nursing. Compassion comes from the Latin *com* meaning "to sympathize" and *pati* meaning "to bear or suffer," and is defined as a sympathetic consciousness of others' distress together with a desire to alleviate it (Merriam-Webster Dictionary, 2008).

Compassion entails giving of oneself in small ways, never underestimating the power of touch, a warm smile, a generous listening ear, or any one of a large variety of caring acts. These purposeful acts of kindness can lessen the impact of suffering for the patient experiencing uncontrolled pain and, when linked with competence, confidence, commitment, and compassion, will comfort and sustain the patient in pain.

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