

The Paradox of Pain Management



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Pain was introduced as the “fifth vital sign” in the 1990s, ranking it as important a measure as blood pressure, heart and respiratory rate, and temperature.¹ The American Pain Society promoted this notion to increase awareness of pain treatment among health care professionals. Emphasizing its importance, the Veterans Health Administration in 1999 launched the “Pain as the 5th Vital Sign” initiative, which mandated a pain intensity rating at all clinical encounters.²

Interestingly, the Joint Commission standards never stated that pain needed to be treated as a vital sign. But many organizations started to require documentation of routine pain screening for all patients. Health care providers were instructed to inquire about pain and to treat it as an essential element of health history.

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These changes were quite controversial. The additional measure, while important, competed with other priority screening needs, including diabetes, cancer, and hypertension. There was—and continues to be—quite the debate on whether pain actually can be measured and what impact that infor-

mation has on the quality of care.

I do not intend to enter that debate here. Instead, I want to discuss what continues to be a conundrum for me: the paradox of pain management.

For many patients, especially those in acute or emergency care settings, the presenting complaint is pain. I would submit that for many the *expectation* is for pain to be immediately and permanently relieved. But is this a realistic goal?

I recall a lecture on pain management I attended years ago; at that time, the approach involved early identification and prompt, aggressive treatment. When asked “How much medication and for how long?” the lecturer used diabetes as a treatment model, stating, “You would increase insulin until the blood glucose was controlled—don’t be afraid to increase pain medication until the pain is controlled.” In the early days of pain management, that was the accepted norm. The possibility that a “zero” on the pain scale was unattainable for some patients was not considered.

Yet seemingly overnight, once pain was decreed a vital sign, health care providers were mandated to measure it and faced with the responsibility to treat it. This resulted in a vague 0-10 pain scale and providers who were inadequately educated on how to begin pain management. Unlike with diabetes or hypertension, there was no protocol, algorithm, or standard upon which to base a plan of care. Moreover, there was a lack of

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differentiation between pain that was a short-lived nuisance and pain that interfered with quality of life.

Faced with growing concern for undertreated pain in the US, however, many of us strove to achieve a balance of sufficient yet appropriate treatment. We struggled to determine how to relieve the pain our patients experienced without creating other problems,

of patients whose pain is more than just an inconvenience and for whom daily use of a narcotic allows them to function—while also avoiding the pitfalls that we are now regularly warned about?

I have no doubt that each of us knows at least one person—a patient, a family member, a neighbor—for whom pain is a daily occurrence. But we must put that in perspective; not all pain is a

that identifying and assessing pain is not equated with writing an opioid or narcotic prescription. Nor will removing those medications from our formulary mitigate the crisis. We need to communicate a clear, consistent message that pain is real, that some pain is a fact of life, and that we will help our patients.

However, it is incumbent upon us to adopt a systematic yet personalized plan of care that is effective, cost conscious, culturally and developmentally appropriate, and safe—and that plan may or may not include prescribing narcotics. We have much work ahead of us in order to minimize the potential for misuse of these medications without impeding patients' access to necessary health care.

Please share your thoughts on this conundrum by writing to NPeditor@frontlinemed.com. **CR**

“Banning all opioid use is not the answer, but neither is considering narcotics the default treatment for pain.”

such as undesirable side effects, misuse, or addiction. That predicament, paired with the ever-increasing direct-to-consumer advertisements about pain relief and the insistence by (some, not all) patients that nonnarcotic pain medication is ineffective, bred the crisis of opioid overuse and addiction we now face.

But just as I chose not to debate the impact of pain measurement on quality of care, I also choose not to debate the existence of the opioid crisis. What I want to emphasize is that all policy changes have consequences. I reach out to you, my colleagues, for innovative ideas to strike the delicate balance of appropriate use of narcotics. How do we address the needs

barrier to physical and emotional functioning. Data suggest that a “33% to 50% decrease in pain intensity is meaningful from a patient’s perspective and represents a reasonable standard of intervention efficacy.”³ For those who deal with chronic pain, even a slight improvement is progress.

So, while the American Medical Association and the American Pain Society bicker about whether pain is the “fifth vital sign,” we must find a better means to resolve the discord in our society.⁴ Banning all opioid use is not the answer, but neither is considering narcotics the default treatment for pain.

We must remind our patients, our policymakers, and ourselves

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