25 Years of Pain Management Nursing
Facing Challenges & Celebrating Victories

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The Unrelenting Problem of Pain

- Chronic pain affects 5% of American children and adolescents\(^1\) and ~100 million American adults\(^2\)
  - More adults are affected by chronic pain than by heart disease, cancer, and diabetes combined\(^2\)
  - Cost annually is estimated to be $635 billion in medical costs and lost productivity\(^2\); 19.5 billion in adolescents\(^1\)

- As many as 75% of people with solid tumors have clinically significant chronic cancer pain\(^3\)

- As many as 86% of patients report moderate to severe pain following surgery.\(^4,5\)

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2. Institute of Medicine: [www.iom.edu/relievingpain](www.iom.edu/relievingpain)
Pain Management Remains Suboptimal in the Acute Care Setting

<table>
<thead>
<tr>
<th></th>
<th>Warfield 1995 (N=500)</th>
<th>Apfelbaum 2003 (N=250)</th>
<th>Gan 2012 (N=300)</th>
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</thead>
<tbody>
<tr>
<td>Any Pain</td>
<td>77%</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Slight</td>
<td>82%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Moderate</td>
<td>86%</td>
<td>25%</td>
<td>8%</td>
</tr>
<tr>
<td>Severe</td>
<td>49%</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>Extreme</td>
<td>49%</td>
<td>47%</td>
<td>45%</td>
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2012 National Health Interview Survey (N = 8,781 adults)

- 126.1 million (55.7%) reported pain in the 3 months before the survey.
- 25.3 million (11.2%) suffer daily pain.
- 23.4 million (10.3%) reported “a lot” of pain.
- 14.4 million (6.3%) reported the “most severe” pain.
- Women, older adults, and non-Hispanics were more likely to report any pain, while Asians were less likely.

Challenges, Victories, and Consequences

- Challenges in pain research, communication, ethics, and clinical practice are never-ending.
- Many victories have been achieved over the past 25 years since ASPMN was founded.
  - Victories have good and bad consequences.
  - Both good and bad consequences lead ultimately to new challenges.

1990

Challenges in Research and Communication
1990: Countless Hours at the “Office”

1990: Countless Hours with the Index Card Catalog
1990: Countless Hours Searching for Guidance and Evidence

1990: Requests for Journal Articles, Books, and Dissertations
THE PAIN CHART
K. D. KEELE M.D. London, M.R.C.P.
PHYSICIAN, ASHFORD COUNTY HOSPITAL, MIDDLESEX

THE assessment of pain is of prime importance and necessarily depends on the patient’s statement and the observer’s judgment. In so far as a method can be devised whereby the inaccuracies involved in a patient’s description are reduced to a minimum, an approximation to a “true” description of pain will be obtained.

Agony ➔ Severe ➔ Moderate ➔ Slight ➔ Nil ➔ Sleep

1948
*The Lancet*, 252 (6514):6-8

1990: Countless Hours Reading, Interpreting, Entering Dot Matrix Data
1990: Countless Hours “Xeroxing”

And Dealing with the Occasional Idiot
1990: Countless Hours Typing, Correcting, Cutting, and Pasting

1990: The Patient’s “Chart”
1990: Film Development, Slide and Overhead Projectors for Teaching

1990: Land-line Telephones, Answering Machines, and “Beepers”
1990: Communication via USPS

Major Changes: The Internet and World Wide Web (in 1969 and 1989, respectively)
1993 survey of ASPMN members by Jan Frandsen showed less than 5% had access to a computer and the Internet at home or work.

1991: Anesthesia Dept. Computer
1991: Anesthesia Dept Super FAX, but No One had a FAX Number!

Major Change: Evolution of the Personal Computer
Evolution of the Home Office
Evolution of Portable and Hand-held Devices

Fingertip Communication
Portable Offices

Countless Hours in Line for Coffee and a Sandwich
Consequences of Victories in Research and Communication

- Ability to share and obtain information worldwide
- More informed providers and consumers
- New Challenges
  - Time and paper saving?
  - Loss of privacy and individuality
  - Information overload
  - Ironic reduction in effective communication
    - Loss of one-on-one, face-to-face communication
    - Loss of “touch-ability”

Are we Fostering a Lack of “Touch-Ability” in the Next Generation of Nurses?
Remote Pain Management Teaching

“Seamless”???
“No Shoes or Technology Allowed”

1990

Challenges in Ethics and Clinical Practice
1990: “Experienced-Based” Practice

- Evidence-based practice was non-existent.
  - There was very little evidence on how to treat pain.
  - Pain management was not an accepted specialty.
  - 1992: Cochrane Collaboration
  - 1994: Sigma Theta Tau Integrative Reviews

- Guidelines and position papers were lacking.
  - 1991: ANA Analgesia by Catheter Techniques
  - 1992: ANA Pain Relief in Dying Patients

1986: WHO Analgesic Ladder for Cancer Pain was Rarely Applied.

1990: “Experienced-Based” Practice

- Minimal educational opportunities or resources related to pain management nursing
  - 1991: First Annual ASPMN Meeting, Coral Gables, FL
- 1993: ASPMN survey then certification task force chaired by Kathleen G. Wallace
- Pain was not routinely assessed.

1985 Memo to Director of Nursing from Medical Director of Surgery

“Please inform all bedside nursing personnel to refrain from asking patients if they have pain. The prevailing understanding is that patients are more likely to complain about pain if nurses ask if they have it. If necessary, doctors will determine if a patient has pain.”
1990: Deceptive Placebo Administration

- Was accepted practice and defended by many as:
  - Helpful in determining if pain is real.
  - Capable of identifying “drug seeking” individuals.
- 1996: “The Oncology Nursing Society's position is that placebos should not be used in the assessment and management of cancer pain.”
- 1998: ASPMN developed first version of current position statement for all types of pain.

1990: Practice was guided by the belief: “Pain Never Killed Anybody.”

Guest Editorial by John C. Liebeskind *Pain*
1991; 44: 3-4.

**PAIN CAN KILL**
1990: Multimodal Analgesia

• The term “multimodal analgesia” was relatively unknown and rarely prescribed for postop pain.

• Opioids ruled. Nonopioids were rarely added.
  ➢ Oral nonopioids for analgesia were an outpatient phenomena (headache).
  ➢ IV ketorolac was rarely prescribed until mid to late 90’s.

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1990

There were essentially two pain management methods in the inpatient setting...
Opioids via IM Injections

Opioids via IV PCA
1990: Preemptive Analgesia for Painful Procedures and Approaches to Prevent Chronic Pain were Rare.

1990’s: Nurses Began to be Recognized as Authorities on Pain

- **Margo McCaffery**: “Pain is what the experiencing person says it is, existing when he says it exists.”
- **Donna Wong**: “Until proven otherwise, babies and children can feel pain and deserve the same quality of pain treatment as adults.”
- **Ada Jacox**: Served as co-chair of first evidence-based pain guideline, 1992.
Events that Changed the Way Pain was Managed in the 90’s

- Early 90’s: Evolution of anesthesia pain services
  - Reimbursement of therapies ➔ ↑ in PCA and EA
- 1990: ONS position paper on pediatric cancer pain
- 1990: AAP Report on pain in childhood cancer and management of associated procedures
- 1992: ANA: Give full opioid doses to dying patients
Events that Changed the Way Pain was Managed in the 90’s

- 1996: James Campbell’s APS presidential address:
  - Concept of “Pain as the 5th Vital Sign”
- 1998: VA adoption of “Pain as the 5th Vital Sign”
- 2000-2001: TJC pain standards
  - Education of patients about pain and their right to pain assessment and treatment was mandated.
  - Use of numerical pain rating scales became standard operating procedure.

Consequences of Widespread Use of Pain Rating Scales

- Patients are finally being asked about pain, but assessment has been boiled down to a number.
  - The pain experience is more than its intensity.
- It is unclear if the collection of pain ratings leads to improved pain relief. More adverse events?
- Self report as a standard has led some to:
  - Suspect addiction if the patient’s report of pain does not match the caregiver’s opinion.
  - Discount or refuse to accept the patient’s report of pain.
Personal Opinion vs. Self Report

- It is important to acknowledge that we are entitled to our personal opinions about the patient’s pain.
- Expect nurses to move forward with the best possible treatment regardless of opinion.
  - If unable to do this, find someone else who is able.
- Doubting a patient’s report of pain is likely to endure until we have a scientific method that can verify the report of pain.
  - Even with scientific proof, there will be doubters and those who will suspect ulterior motives.

New Challenge: What if the Patient Can’t Use a Self-report Tool?

- Preemies, infants, toddlers
- Cognitively impaired
- Anesthetized, sedated
- Unconscious, intubated
- Semi-comatose, comatose
- Painful procedures
Victory: Hierarchy of Pain Measures (McCaffery & Pasero, 1999)

1. Self report
   - Patient is the primary source of information
2. Behaviors, e.g., cry, grimace, moaning, guarding, change in activity
   - Surrogate report of behaviors
3. Presence of a pathologic condition or procedure that usually causes pain; assume pain present (“APP”)

Victories and Consequences

Under-prescribing of opioids in the past was replaced with an increase in the use of opioids in many populations.

- Many patients are now getting better pain relief.
- Opioids are often prescribed without thought.
  - Not everyone is a good candidate for an opioid.
  - Better screening is needed.
- Not all pain is responsive to opioids.
- Increase in opioid side effects and fatal adverse events.
- New levels of opiophobia have been introduced.
Victories and Consequences

Addiction is recognized as a complex, multifactorial disease and not caused by simply consuming a substance.
- Addiction has many forms and is difficult to treat.
- The terms physical dependence, tolerance, addiction, abuse, and misuse continue to be confused.
- Pain and addiction often co-exist, but misconceptions interfere with appropriate treatment of pain in individuals who suffer both.
  - The belief that not everyone is deserving of the best possible pain relief persists.

Victories and Consequences

IM opioids were replaced by IV PCA and IV boluses.
- “PCA is safe because the sedated patient will drop the button, thereby preventing administration of more opioid.”
  - We learned that some patients continue to self-administer despite excessive sedation.
  - Not all patients are good candidates for PCA.
- Risk screening and monitoring standards and technology continue to be inferior or impractical.
- PCA by proxy is more common than originally thought to be.
Victories and Consequences

Meperidine was replaced by hydromorphone.
• We thought we had a safer opioid.
• We learned there was a general lack of understanding of equianalgesia.
• Increase in dosing errors in the form of massive hydromorphone dose administration.
• Increase in deaths and other adverse events related to hydromorphone.

Victories and Consequences

Opioid dose range orders became common practice and helped to insure safer pain management.
• Ill-informed accrediting surveyors and pharmacists led effort to abolish range orders and encourage linking opioid doses to pain intensity numbers, i.e., “Dosing to Numbers”.
  ➢ Nurses have allowed others to dictate their practice.
  ➢ Individualized pain treatment has been lost.
  ➢ Increase in adverse events from dosing to numbers.
Victories and Consequences

Individualized, multimodal analgesia is gradually replacing opioid-only treatment plans.

- More research and experience are needed to establish consensus and consistency in terms of right combinations, doses, and when to initiate.
- Many continue to prescribe by tradition.
- Opioids are “cheaper” than safer and more appropriate analgesics.
- Opioid-only treatment persists.
  ➢ Ask Dr. Henrik Kehlet to speak at next ASPMN conference!

Challenges for the Future

- Change the practice of assessing and treating pain as a number.
  ➢ Establish a practical assessment process that gathers the information needed to manage pain safely and effectively.
- Re-establish opioid dose range orders and insure competency in their implementation.
Challenges for the Future

• Eliminate opioid-only treatment plans: Red Flag
• Continue to improve pain care in the vulnerable:
  ➢ Those who are unable to report pain using traditional pain assessment tools and methods
  ➢ Co-morbidities, e.g., addiction, depression, mental illness, obese
• Demand to be “at the table” when decisions are made that affect your practice and liability.

What was True in 1990, is True Today, and Will be True 25 Years from Now

• Nurses are experts in assessment.
• Nurses are the primary pain managers by virtue of their 24-hour, 7-days-a-week bedside presence.
• Nurses are ethically bound to advocate for the best possible pain relief for their patients.
• Nurses are often the only lifeline for people with pain.
  ➢ Perhaps the most important part of your job is to expand the role of bedside nurses.
The Next 25 Years…

If you treat people with pain the way you would want your loved ones treated, you will always do the right thing, even if you aren’t sure what the right thing is.