Making an ethical plan for treating patients in pain

By Ann Quinlan-Colwell, PhD, RN-BC

MS. W, 36, WAS ADMITTED for I.V. antibiotic therapy to treat cellulitis and an abscess on her right thigh. She consistently reports the pain in her thigh as 10 on a pain intensity rating scale of 0 to 10, with 0 being no pain and 10 being the worst pain imaginable (10/0-10). She describes her pain as “the worst in my life.” She receives oxycodone every 4 hours p.r.n. as prescribed, and she always requests it 30 minutes before the next dose can be given.

During hourly rounds at 0900 and 1000, the nurse observes Ms. W talking on the phone. At 1100, she’s reading a magazine and requests something stronger than the oral opioid, saying, “I can’t stand the pain anymore; I need something stronger.” She then asks for another opioid by name.

Nurses caring for Ms. W think she wants an I.V. opioid because she has a history of substance abuse. She also uses hydrocodone for chronic back pain. Notified about Ms. W’s clinical status and continuing requests for analgesia, the healthcare provider (HCP) asks the nurse if the patient’s pain is “real” or if she’s exhibiting drug-seeking behavior.

Ms. W’s case raises several ethical issues involving pain management. This article explores ethical issues that are involved with making ethically sound pain management decisions and proposes a plan for overcoming barriers and providing ethical care for people experiencing pain.

**Foundations of ethical caregiving**

Ethics involves morals, tenets, rules, and practices of society. Giordano and Schatman tell us that functioning from an ethical basis involves seeking to do what’s good. When the goal is to relieve pain and suffering, many ethical challenges can arise, including those related to:

- access to care
- assessment
- treatment
- education
- pain management.

These challenges can be more intense when they involve children, older adults, minorities, noncommunicative patients, and those with comorbidities, particularly mental health or substance abuse issues. Four ethical principles or standards encompass duties to do no harm, to remove and prevent harm, and to support and encourage the patient. This often involves balancing risks with benefits and is closely aligned with the principle of nonmaleficence, which is the duty not to harm patients.

When working with patients in pain, these principles form the basis for balancing patient goals for comfort with patient safety. Because many adverse reactions to medications are dose related, achieving ideal pain control while ensuring patient safety can be a challenge. Exceeding the dose limit for acetaminophen can cause liver damage. Nonsteroidal anti-inflammatory drugs can also cause adverse reactions that may limit the dose or duration of treatment. Opioids can cause adverse reactions that may require dose limitations in some patients as well. Interventions and surgeries are never free from risk. The goal needs to be to help patients control pain as well as possible while keeping them as safe as possible.

Ms. W reports her pain isn’t controlled. Healthcare professionals must assess her clinical status and determine if what she’s requesting is reasonable, appropriate, and safe for her. The ethical principle of beneficence also requires nurses to decide how to advocate for her.

Justice. The principle of justice can be considered from various frameworks. The most appropriate in this case is this: People with similar diagnoses should be treated in a similar way and those with different diagnoses should be treated differently. For instance, when following this principle, all patients who complain of leg pain would be assessed and subsequently treated in a similar manner, regardless of race, ethnicity, gender, or ability to pay. Those diagnosed with a fractured femur would all be treated in a similar manner while considering their individual assessment and pain control needs. Those with a sprained ankle would all be treated similarly considering their individual assessment and pain control needs, but their treatment would be different from those with a fractured femur and different than each other depending on their particular situation.

This principle is also important in pain control because opioid-tolerant patients will need to receive their home medications or equivalent doses as well as additional medication to address acute pain. In that sense, opioid-tolerant patients can be...
considered to be different than opioid naïve patients who may be sensitive to opioids and require less medication.

The principle of justice can be particularly challenging when addressing pain. The definition that “pain is whatever the experiencing person says it is” conveys that pain is unique to every individual. Nurses see this when two or more patients with the same diagnosis, injury, or surgery have very different reports of pain, with differing responses to and expectations for pain control.

Because pain can’t be measured objectively, self-report is the most reliable way to assess it. This can be perplexing for healthcare professionals when a patient’s self-report is severe pain but the patient’s behavior isn’t what they expect to observe when a person is in severe pain.

Like patients, healthcare professionals have cultural backgrounds and experiences with pain that influence their concept of how a person in severe pain usually looks and behaves. This quandary develops because about 55% of communication is nonverbal, and many people trust nonverbal cues more than verbal communication. When Ms. W reports severe pain (verbal) while she’s observed reading or talking on the phone (nonverbal communication), nurses may have trouble integrating seemingly conflicting messages.

Understanding another person’s severe pain is more difficult for a nurse who’s had a similar surgery or injury and experienced little pain. Nurses raised in a culture that encourages emotional expression of pain may not understand how a patient raised in a stoic culture can stay very quiet despite being in severe pain.

Each patient experience with pain is unique requiring individualized assessment, intervention, and care. The Platinum Rule encourages people not to treat others as you would have them treat you, as with the Golden Rule, but rather to treat others as they would have you treat them. Autonomy. The principle of autonomy calls for nurses to respect, support, and advocate for patients to make decisions about their own healthcare. To exercise autonomy, patients must be able to understand pertinent information about the choices and be free from external pressures, controlling influences, or impingements.

In some instances, patient autonomy can conflict with what healthcare professionals consider optimal pain management (nonmaleficence). Ms. W specifically requests an opioid that wasn’t prescribed and asks for it to be given via a particular route. A patient may insist on receiving a particular medication or undergo a certain procedure when the healthcare professional doesn’t consider such treatments appropriate, desirable, or even safe when evaluating factors such as diagnosis, history, and comorbidities. On the other hand, the patient may know better than anyone else what’s been effective in the past. Be sure to ask the patient why he or she is requesting a particular medication or treatment. This can open a dialog and improve patient care, education, and satisfaction.

Looking for a meaning
Pain may be complicated by fears about what the pain means. Acute pain is a symptom that relays a message. Many patients, realizing this, become concerned when pain is greater than they expected. Patients may be worried about postsurgical pain if they weren’t well educated before surgery. After trauma or a cancer diagnosis, patients may interpret pain as an indication of the gravity of their condition. Understanding what pain means to the patient can provide healthcare professionals with information they need to intervene appropriately (beneficence, nonmaleficence, autonomy, justice).

Barriers to optimal pain control
By definition, pain is a subjective experience that can’t be objectively seen, felt, or measured in another person. In technologically dependent healthcare settings, this makes pain an anomaly among the signs that are assessed and measured. Because only the person experiencing pain knows how it feels, that person is the expert and the healthcare professional must accept the patient’s self-report as fact.

Pain is a multifaceted experience. Besides physical sensations, it has emotional, cognitive, and spiritual aspects. Pain is influenced by each person’s culture, experiences, and coping mechanisms. Patients may have difficulty explaining characteristics of the pain they’re feeling.

Time constraints often interfere with nurses’ ability to actively listen to patients. Many healthcare professionals lack adequate education in pain assessment and management. Personal experiences, beliefs, and emotional responses to pain can affect how a healthcare professional responds to a patient’s behavior or self-report of pain.

Societal factors, such as limited access to providers or therapies, can cause inadequate or inappropriate treatment of pain. Patients may lack adequate insurance coverage for pain management specialists, as well as pharmacologic and nonpharmacologic interventions. Insurance coverage is often limited or completely lacking for interventions such as physical therapy, cognitive behavioral therapy, or biofeedback, and few people have insurance that covers complementary modalities such as...
acupuncture or massage therapy. (See Consider nonpharmacologic and complementary modalities.)

With all these points in mind, we’ll now consider how to design an ethical pain management care plan that balances beneficence (doing good) with nonmaleficence (doing no harm) while advocating for autonomy and justice.

**Taking an ethical approach to pain**
An important first step in providing ethical care (beneficence, nonmaleficence) for patients with pain is for healthcare professionals to assess their own beliefs, experiences, and possible biases about pain, patients experiencing pain, and pain behaviors. Besides nurses’ attitudes about pain based on culture and personal experience, personal beliefs about opioids and substance misuse or abuse can affect nurses’ interactions with patients requiring or requesting opioids.

Sometimes past experiences provide lessons that can affect a nurse’s approach to subsequent patients. For example, a patient may seem like another patient, friend, or family member who had severe pain that was difficult to relieve. Or a patient may seem like someone the nurse knows who abuses opioids or other substances. Accepting undesirable or distressful behavior in people who remind us of ourselves or someone we know can be the biggest challenge; being tolerant of people with whom you don’t seem to have anything in common can be easier. When problematic connections occur, it’s important for nurses to remind themselves that this patient is unique. Every patient needs to be understood as an individual.

Impressions relayed by other healthcare professionals can influence assessments and opinions about a patient. When one healthcare professional labels a patient as “drug seeking,” this can negatively influence the perceptions of those who hear it, even before they meet the patient. Each patient deserves to have each healthcare professional become acquainted with him or her on an individual basis. Healthcare professionals can only begin to understand the pain being experienced by actively listening to what the patient self-reports without preconceptions and bias and trying to understand what the patient is saying (beneficence, nonmaleficence, autonomy, justice).

Working with patients who continue to report high levels of pain despite healthcare professionals’ best efforts can be frustrating for nurses and may stir up latent prejudices. They can’t erase their own culture or experiences, but they can and should acknowledge and understand them.

Self-awareness about pain behavior is an important starting point. Develop a habit of assessing your reactions to patients with pain, particularly if pain is difficult to control. Think of the words that describe how you feel. People with pain that’s difficult to manage may elicit feelings of sadness, sympathy, frustration, anger, disgust, annoyance, or inadequacy.

To capture the distinctive qualities and experience of pain, assess each patient with no expectations or preconceived notions. Listen to what the patient says while observing behavior, then try to understand any behavior that seems contradictory. Often it helps to ask about what seems inconsistent. “Please help me to understand how you can seem so relaxed when your pain score is so high. How do you do that?”

The character, intensity, and impact of pain are unique for each individual (beneficence, autonomy, justice). It’s impossible to understand the pain being experienced simply by knowing the etiology, even though some diagnoses have some common pain characteristics (for example, neuropathic pain with herpes zoster; aching pain with arthritis). Pain can be appreciated only by listening to the person who’s experiencing it. When patients can’t communicate what their pain is like, it’s important to consider if they’ve had chronic pain previously, what analgesic medications they were taking, if their illness or injury generally causes pain, and how they normally respond to pain. (See Assessing pain in a patient who can’t communicate meaningfully)

To prevent harm (nonmaleficence), assess for medication adverse reactions, contraindications, and interactions with other medications. When opioids are administered, for example,
Setting goals for pain control

When patients are asked what level of pain would be satisfactory, many respond with “no pain,” which is understandable—nobody wants to be in pain. But nurses must help patients understand the need to balance safety with comfort and work toward realistic goals (beneficence, nonmaleficence, autonomy, justice).

Differentiate between pain elimination and pain control. Some pain control is always possible, but eliminating pain while keeping the patient safe may not be possible. Inform patients that while you care about their comfort, you also care about their safety (beneficence, nonmaleficence).

Realistic goals may be easier for patients to understand and identify from a functional perspective. Because most facilities or agencies require pain management goals to be recorded numerically, nurses need to help patients put functional goals into numeric form. If Ms. W, the patient requesting more pain medication, has the goal of walking around the unit four times per day, help her to identify what number her pain needs to be to accomplish that goal.

Multimodal plan for analgesia

Optimal pain management is like making customized vegetable soup. Among the many options that can be included, some may not be appropriate for the individual and others may not be safe for the individual. In some situations, the patient may not want to receive a particular medication (autonomy, justice). Medication selection depends on various factors, such as the etiology of pain, previous experiences, allergies, comorbidities, and contraindications. Work to help patients control pain by finding the recipe that works best for them.

Ask patients what has worked previously to manage pain and what doesn’t work (beneficence, nonmaleficence, autonomy, justice). Knowing what has worked to control pain in the past is critical to respecting ethical principles and requires you to put aside preconceived notions. Ironically, patients with diabetes who know dietary precautions and their type and dose of insulin are considered well educated, but people with chronic pain who know medication names and doses that relieve their pain may be erroneously labeled drug seeking.

Analgesic medications are only one component in multimodal pain management. Depending on the type of pain, patient preferences and beliefs, and available resources, adding various nonpharmacologic interventions can help control pain and foster patient autonomy and justice. Healthcare providers can improve available options for patients (justice) by identifying available nonpharmacologic and complementary modalities.

Assessing pain in a patient who can’t communicate meaningfully

Regardless of what tool is used to assess pain in a patient who can’t communicate in a meaningful way, some basic concepts apply. It’s important to consider the following:

- Attempt to obtain a self-report of pain: Remember that someone with dementia may be able to accurately report pain.
- Does the patient have chronic pain? If so, what medications does the patient take regularly?
- Is the pathology underlying the acute condition known to cause pain? If so, advocate to begin a trial of analgesic medication. Then assess the patient’s response to the analgesic trial.
- Ascertain how the patient generally exhibits pain.
- Assess the patient’s behavior.
- Keep in mind that patients may experience discomfort with prolonged immobilization.
- The most accurate assessment of pain is through patient self-report.
- Remember that pain behavior scores do not reflect pain intensity.

Need for education

Knowledge is power. Educate yourself in pain assessment and multimodal pain management, remembering that pain is multidimensional. Seek assistance from other professionals, such as pain management experts, physical and occupational therapists, clergy, managers, and members of ethics committees.

Self-knowledge is imperative. Know your biases and limitations (beneficence, nonmaleficence). Educate patients and families to understand:

- the etiology and meaning of pain
- reasonable expectations and goals for pain control
- medication prescriptions and adverse reactions
- nonpharmacologic options.

Always remind patients and families that you care about helping them control their pain while ensuring their safety (beneficence, nonmaleficence, autonomy, justice).

Follow up with Ms. W

When the nurse caring for Ms. W puts aside any preconceived notions and others’ opinions and accepts her self-report of pain, a trusting therapeutic relationship develops. With the
INFOBYTES

Resources for COPD

Use these resources to help teach patients about chronic obstructive pulmonary disease (COPD).

**COPD Foundation**
http://www.copdfoundation.org

This website has information for patients, caregivers, healthcare professionals, and employers (“70% of COPD sufferers are in the workforce”). Teach patients about the Foundation’s educational materials, including the COPD Big Fat Reference Guide and the Slim Skinny Reference Guides, which are free for download. Healthcare professionals can use this website to learn more about COPD, including current treatments, and earn continuing-education credits.

**COPD Alliance**
http://www.copd.org

The COPD Alliance created the “COPD Prepared” campaign, which provides clinicians with four “STEPS”: screen patients at risk, test and diagnose using spirometry, educate patients about COPD, and provide care and support. The website also has resources for patients, including a COPD screen test and a living well format with COPD guidebook.

**National Heart, Lung, and Blood Institute**
http://www.nhlbi.nih.gov/health/health-topics/topics/copd/

Geared toward consumers, the National Heart, Lung, and Blood Institute (NHLBI) website provides easy-to-understand information about COPD, its risk factors, diagnosis, treatments, prevention, and more. NHLBI also promotes the Learn More, Breathe Better campaign for men and women over age 45 diagnosed with COPD to raise awareness about the severity of COPD and available treatments. Those at risk for COPD are encouraged to see a healthcare provider for evaluation.

**American Lung Association**
http://www.lung.org/lung-disease/copd/

Direct patients to the American Lung Association (ALA) website to learn more about living with COPD. It offers information on finding social support and making treatment decisions. A COPD management tool helps patients discuss the disease with their primary care providers. The ALA also works in COPD advocacy at the federal, state, and local levels.

DOI:10.1097/01.NURSE.0000431122.07851.e0

CONTROLLING PAIN

...patient’s respect and trust, her nurse can work with her to establish reasonable goals for pain control.11

Ms. W tells the nurse that she’ll be able to rest if her pain level is a 6/0-10. Ms. W explains that because she used large doses of opioids after an accident last year, she seems to need more medication to relieve pain. Using data from pain assessment and concepts of multimodal analgesia, the nurse advocates for the patient to obtain analgesia that includes adequate scheduled (around-the-clock) and p.r.n. opioids for breakthrough pain, acetaminophen, distraction, therapeutic touch, and animal-assisted therapy. When her pain is 6/0-10, Ms. W reports being more comfortable and better able to concentrate and sleep. By putting aside personal biases and listening to the patient, the nurse successfully developed a pain control plan that was safe, effective, and ethically sound.

**REFERENCES**


**RESOURCE**


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The author has disclosed that she has no financial relationships related to this article.

DOI:10.1097/01.NURSE.0000431122.07851.e0