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Editorial

Revisiting Pain Assessments amid the Opioid Crisis



Margo McCaffery, MS, RN-BC, FAAN was a beloved nurse pioneer whose 1968 definition of pain was ground-breaking in its day: “Pain is whatever the experiencing person says it is, existing whenever he says it does” (McCaffery, 1968, p. 95). Her compassionate, sensible approach resonated with nurses who are often required to bear witness to pain. McCaffery was a tireless advocate dedicated to improving quality of life for persons with pain and believed nurses held a critical role in successful pain management (Pirschel, 2018). She, along with many nurses, fought to ensure patients would have access to pain relief, including use of opioids. She could not have predicted today’s complicated and tumultuous times for pain care within the present public health crisis coined as an “opioid epidemic” (United States Department of Health and Human Services [HHS], 2017). Colleagues mourned her death in 2018 and paid tribute by recognizing her influence on the pain management field through her numerous articles, books, pain guidelines, and passion. With more than 50 years passed now since the publication of her oft-cited pain definition, the time seems right to reexamine her words and see if they still resonate.

Throughout her career, McCaffery championed reliable pain assessments as a means of communicating patients’ pain. While self-reported 0–10 numeric pain scales became the gold-standard for measurement of pain intensity, her plea was for greater understanding about each persons’ pain experience. A single pain intensity score fails to consider the multidimensional nature of pain (Pasero, Quinlan-Colwell, Rae, Broglio, & Drew, 2016). Nonetheless, numeric pain rating scales remain the most commonly accepted means of addressing pain. Multidimensional assessments that capture emotional and functional qualities of pain align with McCaffery’s philosophy and are now preferred; they can target symptoms and identify deficits more specifically, thus avoiding under-treatment of pain (Arnstein, Gentile, & Wilson, 2019; Wilson, 2014). Thorough assessments are key to determining exactly what the person experiencing pain is facing and initiating an appropriate plan. However, societal changes and expectations about opioid prescribing have complicated the patient-clinician relationship in recent years. Relying on a patient’s self-report of pain may not be a sufficient assessment and should be considered within the context of other information (Schiavenato & Craig, 2010).

Take the case of a patient, for example, who has been told he or she must reduce use of opioids for persistent pain. This is a likely scenario in the United States today because of concern that liberal prescribing of opioids fueled the rise in opioid misuse and overdose deaths (HHS, 2017). Indeed, the rise in overdose occurred alongside increased opioid prescribing that began in the late 1990s. Pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers (HHS, 2017).

Nurses taught patients that addiction would not occur as long as a patient used opioids for the intended reason—to relieve pain. Nurses were also coached that pain of any degree was harmful and should be avoided. Patients were encouraged to use opioids liberally and before their pain got out of hand. Subsequently, if patients have been using opioids as the primary solution for their persistent pain and are told that their supply will now cease or be reduced, it is likely they will experience fear and high anxiety. It is also probable that they will suffer from the physical symptoms of opioid withdrawal if they have developed a physical dependence and their opioid dose is discontinued abruptly. Hyperalgesia may also occur if long-term opioid use has caused a reduction in efficacy of opioids, resulting in more sensitivity to painful stimuli (Lee, Silverman, Hansen, Patel, & Manchikanti, 2011). In any one of these scenarios, it is possible that reported pain will not be quite precisely “whatever the experiencing person says it is” because (1) a person may not recognize their symptoms as withdrawal or hyperalgesia or feel safe to acknowledge those signs, or (2) he or she may do anything they need to at this point of panic to receive more opioids, including exaggerating their pain (Schiavenato & Craig, 2010).

Opioid withdrawal has been described as “the flu on steroids” with fever, vomiting, diarrhea and anxiety (Bebinger, 2017). Stigmatizing labels such as “drug seekers,” and “frequent flyers” have been assigned to patients with pain complaints who visit clinics and emergency departments repetitively for pain relief (Geiderman, 2003). Such labels do nothing to root out the true nature of a person’s pain complaint and instead fracture the trusting relationship between patient and healthcare provider. Nurses are in a prime position to rebuke such terminology and insist on respect and dignity for all patients, whether they have developed a substance use disorder, are experiencing withdrawal, or are suffering persistent, opioid-resistant pain. Nurses can demand processes in their work settings that assist in deciphering exactly what the problem may be for the presenting patient. The remedy should only be decided after a thorough pain assessment is completed.

The decision to prescribe an opioid to a person with pain is no longer a private act between patient and clinician. It often requires pain “contracts” or “agreements” set up by clinics in response to state and federal mandates to reduce opioid use. Urinalysis tests are required to assure unprescribed drugs are not being used, as is pill counting, increased frequency of office visits, and other policies that aim to avoid unintended consequences such as opioid addiction and overdose. Guidelines set by the U.S. Centers for Disease Control and Prevention [CDC] to reduce opioid use were well-intended (CDC, 2016), but have created a backlash whereby patient experiences can feel more like a law enforcement encounter than a friendly healthcare exchange. Finding the true source of a pain complaint is not simple. It never has been. Yet, in the current

opioid climate, it is more important than ever for nurses to adopt a skill set that goes well beyond a 0-10 pain intensity rating, as Margo McCaffery suggested in her definition more than 50 years ago. Here are some things to consider to meet the pain care needs of patients today:

- 1) Include multidimensional pain assessments that measure not only pain severity/intensity (“how much it hurts”), but also how much pain interferes with activity and emotional states. Scales measuring concepts of pain interference (Wilson, 2014) and pain functional scales (Arnstein, Gentile, & Wilson, 2019) are needed along with pain histories that can explain pain in a patient’s own words. The McCaffery Initial Pain Assessment Tool ©1999 remains on the National Institute of Drug Abuse (NIDA) list of recommended screening and assessment tools (2018). It includes open-ended items such as “Quality (Use patient’s own words, e.g., prick, ache, burn, throb, pull sharp)” and “What relieves the pain” or “increases the pain”?
- 2) Emotional pain exacerbates physical pain and the two can be difficult to separate. Patients may not reveal the full extent of their emotional pain, in part, because they fear providers’ judging their pain as being “all in my head.” Risk factors for suicidal ideation are so high in populations with persistent pain that it must be assumed that some proportion of those who die of drug overdoses intended to end their lives (Cheatle, 2011). Therefore, use “universal precautions” in assessing mental health. Decipher clues such as body language, eye contact, and statements of hopelessness, while recognizing that stoicism may mask external cues of pain. Note red flags that may indicate a suicide plan such as giving away personal property, lack of future goals, making a will, and experiencing a recent loss (Cheatle, 2011). Provide holistic comprehensive assessments that will root out under-treated depression, anxiety, post-traumatic stress disorder, or disturbed sleep. Use screening tools to help identify the source of emotional pain. There are many to choose from, such as The Beck Depression Inventory, The Patient Health Questionnaire-9 (PHQ-9), and The Beck Anxiety Inventory (Cheatle, 2011). Advocate for policies in the workplace that will provide efficient assessments and referral to needed resources.
- 3) Assessments to determine risk of opioid use disorder can be taken at any point in a patient’s trajectory, but may be most influential if used at the start of opioid therapy. Measurement of risk should **not** be used as rationale to withhold needed pain medicine. Use the information to start a conversation with at-risk individuals about opioid misuse, dependence and addiction concerns. A carefully crafted pain care plan should include an emotional support plan to anyone who may be more vulnerable to developing a substance use disorder, such as those with histories of childhood sexual abuse and family substance use. Two commonly used tools are the Opioid Risk Tool (NIDA, 2018) and the Drug Abuse Screen Test (DAST-10) (NIDA, 2018). Suspected substance use disorder requires a skilled evaluation and should be done as soon as aberrant behaviors surrounding opioid use are observed. Do not take it personally if opioid misuse develops or addiction occurs. It was not meant as a personal affront. Reflect and note your own biases. Become more educated about addiction and treatments so patients can be better served.
- 4) Individuals with persistent pain and/or substance use disorder often experience stigmatization, humiliation, and unsupportive relationships with family, friends and healthcare professionals. If they appear angry or defensive, they may have some justification based on past encounters (Wilson, Shaw, & Roberts, 2018b). Use “universal precautions” again and assume each person with pain has suffered from stigmatization. Compassion has always been an essential tool in the nursing toolkit. Build trust and let patients know you care. Active listening, being non-judgmental, and accepting the pain experience as credible shows patients the relationship is based on caring and empathy (Clarke & Iphofen, 2008). Caring touch is an undervalued, underutilized tool in today’s technology-obsessed world (Hendrich, Chow, Skierczynski, & Lu, 2008), so use it when appropriate after asking permission: e.g., “I’m sorry about what happened to you. Would it be all right to give you a hug?”
- 5) People who have a substance use disorder experience pain the same as anyone else. Undertreated pain is common among persons with opioid use disorder (Eyler, 2013). This occurs, in part, because of confusion about how to treat pain without risking over-sedation if medications for addiction treatment are prescribed, such as methadone or buprenorphine (Chou et al., 2014). Nurses can advocate for non-opioid options and refer to professionals who are skilled in treating comorbid pain and substance use disorders. Telehealth can be used for long-distance consultation when necessary. Online pain self-management programs can be used to deliver evidence-based pain support in any setting (Wilson et al., 2018a).
- 6) Stay abreast of current literature, while remembering that research evidence generally reports on group mean values. Nurses do not treat a group mean; nurses treat individuals. Pain policies have proceeded evidence in some cases. For example, the evidence that pain intensity does not increase on average after opioids are tapered (McPherson et al., 2018) does not mean opioids are not effective in some cases for persistent pain. Opioids may be necessary for quality of life or improve markers other than pain intensity. Therefore, policies must recognize that each person deserves an individualized assessment and plan of care. Joining an organization like American Society for Pain Management Nursing (ASPMN) can help keep nurses up to date on current research and emerging innovations to manage pain.
- 7) Stopping opioids abruptly can be dangerous in the presence of physical dependence and should never be condoned. Opioid tapering should be a shared decision between patient and provider (Darnall et al., 2018). Evidence does not yet exist on the ideal tapering plan, but gradual, slow approaches are reasonable and recommended (United States Department of Veterans Affairs, 2016). Tapering should be accompanied by psychological support and non-opioid pain alternatives. Do not allow patient abandonment. Along with suicide risk, homicide is also a possibility. Front line pain clinic staff are under-appreciated victims of the opioid crisis and have been attacked when frustrated patients or families feel mistreated (Phillips, 2017). When tapering seems appropriate, advocate for a plan delivered with compassion that everyone can agree upon.

In this issue of *Pain Management Nursing*, we honor the legacy of Margo McCaffery by highlighting current nursing research on pain assessment, including how multidimensional pain measurement tools can be used in acute care settings. We offer insights on evaluating pain in special populations and settings such as neonates in intensive care units and adults aging in community settings, and we note how family members and spiritual beliefs contribute to the pain experience. Our changing times require an evolving set of skills in pain care management. We urge nurses to follow McCaffery’s model of respect for all by avoiding disparaging terms (e.g., “drug seeker”), speaking up when we hear others use stigmatizing language, and avoid making assumptions about why a person seeks our care. Providing thorough, holistic assessments in a non-judgmental manner that preserves dignity can uncover the true nature of a person’s problem. Today we recognize that a person’s report of pain may not always be precisely what the person says

it is. However, it remains a deeply personal experience that deserves the utmost respect and care. Using the lens of universal compassion that McCaffery embraced, we can uncover and rightly treat the many forms of pain.

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