

Virtual Mentor

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CLINICAL CASE

Why Must Pain Patients Be Found Deserving of Treatment?

Commentary by Jay M. Baruch, MD

Dr. Maier entered the small curtained room in the emergency department and introduced himself to the patient, Mrs. Winter. Then he asked whether the fourth-year medical student with him, Miss Malloy, could be present for the encounter.

“I suppose so,” Mrs. Winter said. “But I can’t promise that I won’t be cranky. I’m in considerable pain.”

“Tell me about it.” Dr. Maier said.

Mrs. Winter explained that her doctor, Dr. Caruso, had diagnosed fibromyalgia about a year ago. She was generally tired, had low energy, and almost always had some pain in her shoulders, neck and head. But the pain flared up from time to time. Right now, her neck was so sore that she couldn’t move it; it even hurt when she walked. When this happened, she said, she just had to give in and spend a few days on the sofa “knocked out” until whatever had caused the painful episode resolved. She used the word “resolved.” Mrs. Winter gestured with her hands as she spoke, letting her manicured finger tips hover over the areas she mentioned as she described the pain. Her several gold bracelets lent a jingling flourish to the account.

When Dr. Maier asked Mrs. Winter to rate the pain from 1 to 10, compared to the worst she had experienced, she said, “8.7. Of course I’ve had worse or I wouldn’t have been able to get here. But I certainly couldn’t wait until Monday to see Dr. Caruso.”

Dr. Maier asked Mrs. Winter a few more questions about the nature of the pain, then examined her to determine whether some injury or inflammatory condition unrelated to her diagnosis could be the cause of her current pain.

Dr. Maier said he had found nothing to indicate that Mrs. Winter was experiencing anything different from the flare-ups she described having had in the past. “What does Dr. Caruso usually prescribe?” he asked.

“He usually gives me Tramadol,” she said. “Twenty-four will get me through the duration of the bout.”

“Well, this is Saturday,” Dr. Maier said. “Suppose I give you a prescription for 10 to get you through Sunday night, and you can call Dr. Caruso on Monday, if you are still in pain. Shall I ask our desk attendant to call this in for you?”

“No. That’s ok. I’ll just stop at the drug store on my way home. I was hoping to avoid making another trip to the doctor on Monday,” Mrs. Winter said. “But if that’s all you can prescribe, I guess I’ll see how I feel by then.” Mrs. Winter winced again as she stepped carefully from the table.

Dr. Maier shook her hand; Miss Malloy said, “Thank you for allowing me to observe. I hope you feel better.”

As Dr. Maier finished his notes and carried the chart to the center desk, Miss Malloy ventured quietly, “Mrs. Winter didn’t get the third degree like Mr. Washington did this morning.”

“What do you mean?”

“You remember Mr. Washington—with the toothache? You asked him what pharmacy he used, and did he always use the same one, and why didn’t he call his dentist for the medication, and had he tried Tylenol. Then you told him to get ibuprofen at the drug store.”

“You mean the gent that looked as though he’d slept in his clothes?”

Commentary

Easing pain strikes me as an elemental human endeavor. But, as this case illustrates, doing so can be complex and nuanced in ways that much of medical treatment is not. The case tells of two emergency department (ED) patients with complaints of pain. The woman with fibromyalgia was treated kindly and left with a narcotic prescription for her pain. The “gent” with the toothache, we’re led to believe, was interrogated and left to find pain relief on his own. The medical student was puzzled by the disparate treatment—medical and personal—for two patients experiencing severe pain.

Inadequate pain treatment, termed oligoanalgesia, was recognized by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 2001 as a public health problem [1]. Across health care settings, pain is undertreated; the ED is no exception [2-6]. Physicians and nurses consistently underestimate the pain experienced by ED patients [7], which means that some leave the ED with little if any relief.

Several explanations have dominated the discussion on the widespread causes of inadequate pain management—fear of liability and regulatory sanctions, fear of turning patients into addicts, concerns about drug diversion, and insufficient knowledge about pain treatment [8-10]. But even if these obstacles were surmounted,

I believe oligoanalgesia would persist [11]. The assessment and treatment of pain present many challenges to clinicians, none greater than the profound and unexpected personal feelings these activities evoke. Objective reason and best intentions are often undermined by emotion, intuition, and bias. Treating pain demands medical expertise; treating the *person in pain* demands ethical sophistication because the culture of the ED and the culture of pain often engage each other in an oppositional manner that undermines compassionate care.

Why Understanding Pain Is so Difficult

The ability to tolerate pain ranges widely from person to person. People attach different meanings to the pain, and their lives can be disrupted in profound ways that might seem incongruent to their level of pain. Pain affects relationships, job performance, and the ability to think and reflect clearly; it eventually steals one's identity, autonomy, and capacity to feel any sense of control over the present and future.

Pain is ineffable. Dispassionate but well-intentioned attempts at definition by experts fail to capture the intensity of the experience. The International Association for the Study of Pain defines it as “an unpleasant sensory and emotional experience associated with real tissue or potential tissue damage, or described in terms of such damage” [12].

The patient's experience of pain must be validated and given legitimacy by physicians before it can be treated. But the medical model, with its locus on objectification and identification, is a woefully inadequate strategy for assessing and treating pain, for the sensitive probing of its possible meanings, and for appreciating the relationship between pain and suffering. The task is even more challenging in emergency medicine, which involves caring for strangers under tense circumstances.

JCAHO declared that pain assessment should be considered a “fifth vital sign,” deserving a space beside pulse, respiratory rate, blood pressure, and temperature in the medical record. But there are dangers in translating another's subjective experience onto a scale, a graph, a row of faces ranging from extremely happy to downright miserable [13-17]. Recording data doesn't make the pain empirical, verifiable, or true. It doesn't ensure an appropriate response. What's more, objective language risks stripping pain of the very contextual elements necessary to understand it.

Because the experience of pain is subjective, the only way to fully understand it is through the patient. If we approach pain management from the perspective of power relations, the physician must, to some degree, be submissive to the patient and his or her story and respond with a measure of empathy and trust. Offering pain relief is not only a highly beneficent act, it promotes welfare of persons, fosters their autonomy, and forges trust in the profession.

Anonymity, Uncertainty, and Emotions in the ED

In *The Body in Pain*, Elaine Scarry captures in a single sentence the uncomfortable predicament facing patients in pain and caregivers entrusted to treat them. “To have pain is to have certainty; to hear about pain is to have doubt” [18].

Most patients in pain come to the ED searching for relief and find themselves in a strange, busy, overcrowded place. Often they are frightened and lost in their pain. Their presence in this hostile environment is generally not recognized as testimony to the severity of their pain, which, indeed, it is. Many people experience headaches, but only a small percent leave their homes for treatment in the ED [19]. An empathic attitude that recognizes the rescue role of the ED would regard a patient with fibromyalgia or a man with a toothache and think, “Of course they’re here, they’re in *pain*.” Often, the approach is a less welcoming insinuation, “What do you *really* want?”

The patient’s motive and character get worked-up and analyzed. What can be causing this unexpected level of pain? Is his complaint legitimate? Is she bearing the pain well? Is she being overdramatic? Questions of motive invariably lead to concerns about drug-seeking behavior. Such character judgments compromise communication and trust between physicians and patients, a grave consequence when the problem being treated is rooted in subjectivity. The ineffective treatment and unrelieved pain that may result paradoxically put the patient at risk for an iatrogenic complication—pseudoaddiction [20], leading to requests for higher dosages or a change to a stronger medication, behavior that gets perceived as manipulative and evidence of addiction.

Rarely in clinical medicine does the desire for a readily available treatment serve as a reason to dismiss a symptom. If a patient with a history of recurrent urinary tract infections tells the emergency physician which antibiotic has been effective in the past and which were not, the physician is usually appreciative. But if the same patient has sickle cell disease or a migraine headache and informs the staff that Dilaudid usually works, he or she risks being stigmatized as a drug abuser. And the act of not-acting changes the patient’s condition. Insensitive or inadequate attention to pain devalues the patient. For a profession that pledges to “do no harm,” oligoanalgesia borders on egregiously unethical conduct [21, 22].

The Addiction/Diversion Specter

Narcotic medications are not necessarily expensive and have a high probability of controlling pain. Their greatest potential harm involves constipation and nausea and vomiting, not addiction and risk of drug diversion. Yet drug diversion is a serious problem, as is feeding the habit of a patient with addiction. In 2002, close to 30 million persons aged 12 or older had used prescription pain relievers nonmedically in their lifetime, and about 1.5 million persons aged 12 or older were dependent on or abused prescription pain relievers [23].

This data is of concern, but to what degree should it impact legitimate prescribing practices, especially when appropriate narcotic use in patients without abuse histories rarely results in addiction [24]? The behavior of street addicts can't be the measure for predicting the risk of narcotic use for patients in pain. The street addict uses drugs to escape life. The patient in pain wants to return to his or her previous role and activities [25]. When faced with subjectivity and uncertainty, is it better to err by undertreating patients bearing legitimate pain or to risk being duped by a drug seeker? We overtreat many conditions—examples include the liberal use of antibiotics for ear infections, pharyngitis, and bronchitis and of cough suppressants with unproven efficacy in relieving coughs [26-28]—and these treatments are not without risks and complications.

There are many treatments for pain that don't include narcotics. But knowingly using inferior treatment that offers questionable medical benefits is difficult to defend medically and ethically. At the very least, great therapeutic value can be found in the simple act of respecting and honoring the storyteller.

Disrobing the Patient and Physician

Providing pain relief makes significant demands on physicians. The emotional space between doctors and patients can become uncomfortably close, difficult when no prior relationship exists, and especially challenging when the patient might be unlikable or has an injury or illness resulting from socially unacceptable activities.

Physicians cannot treat pain effectively and compassionately while hiding behind the white coat. Their character, prejudices, and life experiences are reflected in their receptivity to patient's stories and in their treatment decisions. Personal feelings infiltrate the crevices of clinical acumen. It's not *a* patient with fibromyalgia, but *this* particular patient with fibromyalgia at this moment.

In my years of emergency medicine practice, I've observed how patients in pain are sometimes "sized up" and "diagnosed" with a pain stereotype—drug seeker, addict, wimp, histrionic, manipulative, or just crazy. When working through uncertainty, people unknowingly reach conclusions or make decisions based on heuristic strategies [29]. ED physicians encounter patients who are seeking drugs for illicit means. These patients can be difficult, ingratiating, demanding, and threatening. Unfortunately, patients in pain risk being perceived by the degree to which they resemble these notorious, easily recalled, stereotypes [11].

These value judgments are as subjective as the patient's pain, and can compromise care in profound and insidious ways. Blacks and Hispanics, for example, are more likely than others to receive no analgesia for extremity fractures in the emergency department [5].

Workplace pressures between physicians and nurses also impact the treatment of pain. Suppose, for example, the triage nurse believes that a patient with a toothache is seeking drugs. If the physician says, "It's easier to treat him. If he's a drug seeker,

so be it,” the nurse may openly disagree. Soon, the physician gains the reputation as soft, or a sucker, and, in the process, loses the staff’s respect. The opposite situation—the nurses believe the physician is cheap with pain medication—can be more damning.

Two Pain Patients in the ED

Sure, patients can be difficult, but physicians are human, too, and at risk for being equally difficult. I’d be curious to know if the physician in our case scenario, Dr. Maier, was equally attentive and empathic when listening to the two patients’ stories. He treats Mrs. Winter kindly, in a manner that wouldn’t make us think this is anything but his usual demeanor, until the student speaks up. Dr. Maier gives Mrs. Winter a prescription for enough pills to last until her own doctor can see her and coordinate her pain management. We aren’t given much personal information about the two patients. We’re told about her vocabulary, her manicured nails, and her gold bracelets. She has a private physician. With these details, I’ll venture a guess that she belongs to a socioeconomic class with which Dr. Maier might share a certain affinity. Perhaps he knows Dr. Caruso, her physician. He appears eager to find an acceptable solution. If he held any suspicions about her motivation—he did prescribe only 10 ten pills—he definitely gave her the benefit of the doubt.

I wonder whether the “gent”—the term itself colloquial and derogatory—ever had a chance with this doctor. Why did he receive the “third degree?” We’re told he looked like he slept in his clothes. Was he homeless? Was he unkempt? What did he smell like? What was the color of his skin? Did he seem to be in pain? Was his toothache thought to belong to his other struggles and unworthy of stronger medication? Did this patient have a history of frequent visits to the ED for a toothache, with the assumption made that he was a drug seeker, or unmotivated to get definitive care? Does he have the dental insurance required by area dentists, the money for co-payments, or a means of transportation? How did the “gent” feel when he was summarily dismissed? He was twice harmed. First, he wasn’t given attention or respect, and he left the ED with his pain untreated. What if at some future date he develops chest pain, or experiences other worrisome symptoms like difficulty breathing or a severe headache? Will this experience make him reconsider going to an emergency department?

How does Dr. Maier in our case scenario answer the student, who astutely noted that two patients, not widely dissimilar in their need for pain relief, were treated differently? Was he aware of his disparate actions? Will he give serious thought to what the student noticed? Physicians must reflect upon how their personal feelings insinuate themselves into encounters with patients and influence clinical decisions. The experience of pain is extremely personal, both for patients and physicians entrusted to treat them. In the end, we must negotiate that fog between certainty and doubt with compassion and respect.

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Jay M. Baruch, MD, is an emergency physician and director of the ethics curriculum at the Warren Alpert Medical School of Brown University in Providence, Rhode Island. His first book of short fiction, *Fourteen Stories: Doctors, Patients, and Other Strangers*, was published in 2007 by The Kent State University Press.

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