Changing Attitudes About Pain and Pain Control in Emergency Medicine

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Emergency department (ED) lore has countless humorous and often self-deprecating stories about the treatments of pain and the seekers of pain relief encountered on a daily basis. A culture of suspicion, limited research, diverse and often difficult patient populations, and challenging clinical environments have plagued our specialty in its approach to analgesia. Additionally, the limited use of advances in analgesia by other medical specialties has afforded emergency medicine the opportunity to lead the efforts for effective patient pain management.

As emergency physicians, our focus is often on the underlying diagnosis of painful complaints; however, the single-minded attention on the diagnosis of the underlying cause of pain has resulted in ignoring the pain that prompted the patient to seek care in the first place. Analgesia is often an afterthought to diagnosis and disposition. To improve our treatment of pain in the ED, a fundamental change in the way we practice is required. Treatment of pain should parallel the search for diagnosis of a patient’s underlying condition, and has now become the standard of care. Pain is now considered the “fifth vital sign,” and should be addressed in the same manner as other time-sensitive events we manage every day. For example, response to pain can be likened to the approach and treatment of myocardial ischemia. Today’s well-trained ED physician would not ignore or fail to appropriately treat a 55-year-old male who has substernal chest pain suffering from an acute MI with nitrates, aspirin, beta-blockers, and angioplasty or thrombolytics. Why does other pain not warrant a similar emergent response, such as the hip pain of a 67-year-old female after a fall, the neck pain of a 22-year-old male after

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a rear-end motor vehicle accident, or the back pain of a 35-year-old male after lifting a couch? Is it difficult to change the focus from the diagnosis of the hip fracture, the cervical strain, or the acute muscle spasm to the treatment of the pain that brought the patient to the ED? Emergency medical personnel should consider changing focus from the immediate diagnosis of the pain to the immediate relief of the pain. The first step in changing provider attitudes in pain management is the acknowledgment and accurate measurement of the initial pain experienced by the patient. Subsequent measures of patients’ responses to analgesics are needed to assess treatment adequacy and to guide further therapy. With these changes in attitudes, providers can enhance not only overall care and satisfaction for the patients, but also job satisfaction for the providers.

“Oligoanalgesia” in the emergency department

Pain is the most common chief complaint of patients presenting to the ED [1]. This is not surprising to anyone working in an ED. What is surprising is the fact that emergency physicians have not established themselves as champions in the treatment of acute pain. In 1989, Wilson and Pendleton coined the term “oligoanalgesia in the ED” to describe the poor treatment by emergency physicians for patients presenting with pain [2]. In this landmark paper, 44% of patients in the ED with pain received analgesic medication. In addition, underdosing of narcotic analgesics was common. Since 1989, awareness of inadequate analgesia within the setting of emergency medicine has increased. The findings of the proceedings from the first international symposium on pain research in emergency medicine were published in the Annals of Emergency Medicine in 1996 [3], and report this increase in awareness of pain and use of adequate analgesia in the ED. Despite this increase in awareness and attention, there is little evidence that oligoanalgesia in the ED has changed significantly over the last 15 years. Four articles from various practice settings since 1989 report that only 30% to 63% of patients presenting with pain received analgesic medications within the ED [4–7].

Recent federal guidelines require the assessment of pain for all patients, including those presenting to the ED. This regulatory incentive should be expected to increase the assessment of pain; however, Singer and colleagues [8] found that undertreatment of pain in the ED is common, even when providers recognize the severity of pain.

Research and pain management in the emergency department

A lack of research and practice guidelines for the emergency physician has been reported as one reason for poor treatment of pain in the ED [9]. In 1996, Afilalo and coauthors [10] reported finding 60 articles on pain and
emergency medicine in a literature search, representing 1.7% of the research in emergency medicine at that time. Performing a similar search in 2003 with PubMed using the same search terms (pain and emergency medicine, emergency medical services, or emergency department) revealed 318 articles, an increase of over 400%. The few pain treatment initiatives published have shown modest results. In the United Kingdom, Goodacre and Roden [11] described the use of a pain protocol to improve analgesia for ED patients who have fractures. Those receiving analgesia increased from 9% to 31%. A pediatric pain protocol showed an improvement from 34% to 55% of patients receiving pain medication within 30 minutes of arrival [12]. Another triage pain protocol showed an improvement in the time to analgesia for patients who have acute musculoskeletal pain, but no differences in the mean pain intensity at discharge [13]. Similarly, an educational intervention showed no change in the percentage (56% preintervention and 54% postintervention) of patients receiving analgesia in a large-volume ED [14]. Based on these conflicting study results, it is unclear if the recent increased research efforts have truly made significant progress in the clinical treatment of pain within the ED.

Patient attitudes: expectations and satisfaction with pain treatment in the emergency department

If an increase in research does not result in improved pain management, we should consider factors related to the patients themselves. It is recognized that in the postoperative setting, patients have low expectations for pain relief. This results in overall high levels of patient satisfaction with pain management, despite high levels of postoperative pain [15]; however, ED patients do not appear to share these low expectations for pain relief. ED patients expect mean pain relief of 72%, and 18% of ED patients expect complete (100%) relief of their pain [16]. ED patients also expect analgesia soon after ED arrival. The mean expectation for time to analgesic administration for ED patients is 23 minutes, compared with actual mean time to analgesic administration of 78 minutes [4].

Patient satisfaction correlates poorly with initial pain intensity, discharge pain intensity, and change in pain intensity between presentation and discharge [17–20]; however, patients who report that their needs for pain relief have been met in the ED have higher mean satisfaction (83/100), than those in whom needs for pain relief are not met (51/100) [4]. Overall, these findings suggest that pain intensity and pain relief in the ED indirectly impact patient satisfaction. Meeting patient expectations for pain relief likely plays a larger role than absolute pain intensity or change in pain intensity. In addition, an attitude or expression of caring about the patients’ pain may be as meaningful as providing the pain medication itself [21–24]. This may explain in part the seemingly contradictory findings that whereas
only 45% of ED patients in pain receive analgesic medication, 70% report that their needs for pain relief were met at discharge [4].

**Barriers to treatment of pain in the emergency department: ethnic, cultural, and gender bias**

Physician and nursing attitudes may have a disproportionate impact upon the treatment of pain for various subgroups within the ED. Todd reported that both Hispanic and Black patients who have fractures are less likely to receive analgesia in the ED than non-Hispanic whites [25, 26]; however, several recent reports have demonstrated no differences in analgesic treatment among minority groups [27, 28]. Raftery and coworkers [29] reported that female patients describe more pain and receive more analgesic medication than male patients in the ED; however, female patients do not appear to have different expectations for pain relief when compared with male patients [16]. Cultural bias in the expression of pain and cultural differences between patients and practitioners may also influence attitudes toward the treatment of pain in the ED setting. This has not been extensively studied. Todd et al [30] reported no differences in physician estimates of pain between Hispanic and non-Hispanic white patients who have long bone fractures, concluding that other explanations for the differences in treatment between these two groups must be found. At a minimum, this requires understanding that differences in cultural norms for the expression, reporting, and expectations for the treatment of pain exist and must be considered when treating pain in patients from other cultures.

**Barriers to treatment of pain in the emergency department: the emergency department environment**

Another potential barrier to treatment of pain in the ED is the environment of the ED itself. Chisholm and coauthors [31] eloquently reported on the number of interruptions and the nature of the multitasking that are seen in the ED. Over a 180-minute period, emergency physicians experience a mean of 30 interruptions and 20 events requiring them to switch tasks. The number of interruptions and breaks in task correlated with the number of patients simultaneously managed. This environment might be expected to contribute to poor pain management; however, an analysis of the number of physicians per patient, nursing staff per patient, physicians per acuity-weighted patients, and nursing staff per acuity-weighted patients found no differences in the percentage of patients who received pain medication while present in the ED [32]. This suggests that emergency physicians do a poor job of providing analgesia, regardless of whether the emergency department is busy or slow. The response that “it is too busy” remains a poor excuse for not providing pain relief in the ED.
The nursing and physician dichotomy of assessment and treatment of pain may also play a role in the poor treatment of pain in the ED. Beel and coworkers [33] found that ED patients who had fractures were willing to have nursing staff administer pain medication before physician evaluation; however, in most departments, the process of pain medication administration requires a large number of independent steps, and represents a formidable obstacle to timely analgesia. These steps may include patient presentation and registration, nursing assessment and triage, placement in a treatment room, primary nurse assessment and documentation, physician evaluation, physician ordering of pain medication, nursing obtaining pain medication, and finally, after these seven independent steps, nursing administration of pain medication. Overcoming this process requires that analgesia be given a high priority for triage and treatment at the earliest phase of a patient visit to the ED.

Barriers to treatment of pain in the emergency department: opioids

Opiophobia (prejudice against the use of opioid analgesics) is used to describe another barrier to the use and prescription of narcotic analgesics. Regulatory and licensing concerns, suspicion of “drug-seeking” behavior, concern for addiction or dependence, and lack of follow-up or continuity of care produce a culture in which adequate treatment of pain is difficult to achieve. Weinstein and colleagues [34] found that working physicians have significant opiophobia, display lack of knowledge about pain and its treatment, and have negative views about patients who have chronic pain. Emergency physician rating of suspicion for drug addiction correlates poorly with drug abuse screening testing [35]. Many ED physicians suspect drug-seeking behavior among patients in pain, particularly in high-risk urban environments. In addition, patients who do not respond to analgesia are viewed with an increased suspicion of drug-seeking behavior [36]. Clinically, this often results in a patient exhibiting pseudoaddictive behavior, with demands for analgesia and increased demonstrations of pain. The typical reaction of ED personnel to this scenario is often a refusal of analgesia rather than a chance to relieve the pain causing the behavior.

The typical “limited prescription” for opioid analgesia at ED discharge may also reflect an attitude of opiophobia. A prescription for one to two hydrocodone/acetaminophen tablets every 4 to 6 hours as required by pain, dispense #20, will last less than 2 days if the maximum dose is taken as directed. The common beliefs that the primary care physician should prescribe all opioids, or that limiting the number of pills dispensed will “ensure” follow-up are poor excuses for the undertreatment of pain after ED discharge. Reluctance to prescribe opioids also results in few prescriptions for long-acting opioids following ED discharge; however, the scheduled use of long-acting opioids with as-needed dosing of short-acting opioids for breakthrough pain is well-established, and results in
better pain control when compared with as-needed dosing alone. The benefits of sustained release opioids in improving pain control have also been shown to be superior to as-needed dosing of short-acting opioids for pain relief in the 3 days following anterior cruciate ligament (ACL) repair [37]. As the treating physicians for a large number of severely painful diagnoses, emergency physicians have the opportunity to embrace the principles used in postoperative settings, and to provide analgesia with both a long-acting analgesic and an as-needed medication when making a discharge plan for pain management.

Barriers to treatment of pain in the emergency department: emergency department culture

There is a large arsenal of analgesic choices available to emergency physicians. Similarly, the range of painful afflictions seen by emergency physicians spans the scope of all medical specialties. One is left to wonder why everyone receives the same doses of morphine, and why discharge options are limited to short-acting combination narcotics and ibuprofen. The preprinted prescriptions found in many EDs for ibuprofen and hydrocodone/acetaminophen work for many, but not all. The prevailing attitude of one-size-fits-all is not an effective strategy for pain control. The convenience of preprinted prescriptions and the drive for efficient discharge of patients often leaves ED discharge lacking in pain management. The lack of follow-up may also contribute to a false sense of adequate treatment. The skepticism of the staff toward a patient who calls back to the ED after returning home with inadequately controlled pain presents yet another barrier to effective pain management. How is the patient who calls back to the ED needing “something more” for pain triaged at your ED? Is he turned down by the clerk, chastised by the registered nurse, or told that he will have to return to the ED and wait to see the doctor? The prevailing mindset is “patients abuse the ED system” rather than “the ED pain management system is broken and needs repair.” As an example, meperidine continues to be used more commonly than all other abortive therapy for treatment of migraine headache in the ED. This occurs despite strong recommendations against the use of this agent [38]. Does this behavior result from the attitude that this is really what the patient wants, or is this just the fastest and easiest way to get the patient out of the ED? We must consider changing our mindset to embrace educational opportunities for providing appropriate and medically sound analgesia.

Barriers to treatment of pain in the emergency department: provider education

Pain management is infrequently taught within the medical school framework, and the treatment of acute pain, which is typically encountered
in the ED, is almost never given a format for formal teaching. This lack of education was demonstrated in a survey of medical students as freshmen and then repeated as seniors. Weinstein et al [39] found that prejudice toward the use of opioid analgesics had increased during the 4 years of medical school training. Emergency medicine residency training focuses upon the diagnosis and treatment of the underlying medical or surgical causes of pain; the treatment of pain is often secondary to establishing a diagnosis. When pain relief is addressed, it is often inadequate, with little regard to pathophysiology and the pharmacology of analgesics available. On a positive note, an educational intervention performed within an emergency medicine residency program framework resulted in significant improvement in pain relief for ED patients [40].

Changing the practice patterns of established physicians remains extremely difficult. Nationwide distribution and publication of practice guidelines for the treatment of chest pain and back pain have shown poor results in changing behavior among working physicians [41,42].

These findings suggest that opportunities to affect change in behavior and improve treatment of pain in the ED should focus on medical students and residency training programs. Unfortunately, effective training tools to change attitudes about pain and pain control among practicing physicians have yet to be described.

**Consequences of inadequate pain management in the emergency department**

The ED is both the first and last resort medical point of access for many traumatic and nontraumatic painful conditions. This is true for patients who have acute and chronic pain. It is easy to fall into the belief that “pain never killed anyone” and attend to other pressing issues in the ED; however, relief of pain is one of the primary physician responsibilities, and one of the greatest services that a physician can provide to a patient. This is an opportunity that is often ignored or overlooked by emergency physicians. Many of us have heard and now ignore the wisdom of Albert Schweitzer:

“"We must all die. But that I can save a person from days of torture, that is what I feel is my great and ever-new privilege. Pain is a more terrible lord of mankind than even death itself."

Beyond the relief of suffering, however, inadequate treatment of acute pain has also been shown to contribute significantly to the development of chronic pain [43,44]. Opportunities to save lives within the ED are rare, but opportunities to relieve pain are nearly infinite within the practice of emergency medicine. A change in attitude regarding pain may allow emergency physicians to take advantage of these opportunities.

Treatment of pain in the ED and the prescription of opioid analgesics is often a source of mistrust and dissatisfaction for both the patient and the emergency physician. A paradigm shift that challenges the prevailing culture
and focuses on the relief of pain will result in improved care for the patient, and improvement in satisfaction for both the patient and the physician.

Summary

Oligoanalgesia continues to be a large problem in the ED. An attitude of suspicion, a culture of ignoring the problem, and an environment that is not conducive to change in practice combine to present formidable obstacles for effective pain management in the emergency setting. Overcoming these obstacles for effective analgesia in the ED is not beyond the capabilities of the individual ED, the emergency physician, or the specialty of emergency medicine. Changing the attitudes of emergency medical providers about pain assessment and management will require attention in several areas of research, education and training.

Oligoanalgesia remains a global problem within emergency medicine; however, this awareness is often not felt to be present “in my ED.” Individual ownership of the problem may contribute to improvements in pain control. The last 15 years have seen a substantial increase in ED research focused on pain and pain management. Continued research efforts and focused clinical application of these efforts are still required. A better understanding of patient needs and expectations for pain relief, as well as continued efforts at patient education regarding pain, will also improve our treatment of pain in the ED. Recognition by providers of the ethnic, cultural, and gender differences in the expression, reporting, and expectations for treatment of pain should also continue to be a priority in changing attitudes toward pain and pain control. These goals must be realistic within the chaotic and unpredictable environment that defines emergency medicine. Practical and time-sensitive approaches to pain and pain management will continue to be a challenge to enact and enforce in our EDs.

The stigma of opioids, in combination with the transient nature of the emergency physician/patient relationship, may be the largest hurdles to overcome for effective pain management not only in the ED, but also following ED discharge. Improvement in provider education of the realities, myths, and misunderstandings of opioid management may provide insight into this problem.

The consequences of oligoanalgesia in the ED are not insignificant. To improve our treatment of pain in the ED, a fundamental change in attitude toward pain and the control of pain is required. This is unlikely to occur until pain is adequately addressed and treated appropriately as a true emergency.

References


