



PAIN MANAGEMENT

Understanding End-of-Life Pain Management

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The effect of uncontrolled pain at the end of life is substantial. Although cancer is the diagnosis most associated with pain and the need for pain control, patients with non-malignant diagnosis including heart disease, COPD, Alzheimer's Disease, CVA and AIDS suffer from pain as well. Due to the aging population, primary care physicians will see a need to increase their understanding and knowledge base of end of life pain control.

Statistics in Pain Control

- Studies reveal that older people rate "important pain problems" as high as 50%
- "Substantial pain" ranges from 45-80% in long term care (LTC) residents
- 1 in 4 LTC residents receives NO treatment for daily pain
- 1 in 3 outpatients with cancer pain state that the pain "interferes" with ADL's
- 90% of patients with advanced cancer describe their pain as "significant"
- 40% of cancer patients describe their pain as "undertreated"

Legislative Remedies in Pain Control

Due to the problems of pain associated with end of life and the increased interest in legalizing assisted suicide, some regulatory agencies have intervened. For example, in the state of Vermont, Senator Douglas Racine introduced Senate Bill S.0281 on February 29, 2008, which states Status of Aid-in-Dying Legislation S.144, an act relating to patient choice and control at end of life, has been introduced in the Vermont Senate in early April 2009. The same bill was introduced in the Vermont House later in the month; its number is H.455 <<http://www.leg.state.vt.us/docs/2010/bills/Intro/H-455.pdf>>. Its sponsors include Democrats and Republicans.

Aid-in-Dying legislation will bring the Oregon Death with Dignity Act to Vermont and will:

- Guarantee that all adult Vermonters have a full range of legal end-of-life choices
- Assure that mentally-competent persons who are terminally ill have the right to choose the manner and timing of death
- Allow a terminally ill, mentally-competent person to avoid the pain of a prolonged dying process by self-administering legally prescribed medication

Barriers to Effective Pain Control

- Inadequate education and training in pain management
- Inadequate pain assessment by clinicians
- Patient reluctance to report pain
- Reluctance to prescribe opioid analgesics
- Patient reluctance and fear of opioid analgesics
- Fear of “respiratory depressant” effects of narcotics
- Undertreatment of specific patient groups
- Pain control and age groups

Inadequate Training & Education

Studies and surveys of physicians indicate that education and training, beginning with medical school, have failed to address techniques for pain assessment and treatment. This is evidenced by the deficient amount of information found in leading medical textbooks for end-of-life care on the topic of pain management.

Inadequate Pain Management by Clinicians

Among 107 interviewees, 80 percent listed pain and symptom management to eliminate needless suffering as the most pressing priority. Public testimony at September, 2000, hearings of the Michigan Commission on End of Life Care echoed this concern. Significant numbers of patients, caregivers, and professionals cited ineffective pain management as one of the state's most serious problems in end of life care. Noting the broad consensus, the Commission's final report declared inadequate pain and symptom management to be "a public health issue that requires the highest level of professional and regulatory attention" (Michigan Commission on End of Life Care, 2002)

Patient Reluctance to Report Pain

Patients may be reluctant to report pain to their physicians fearing that they may be viewed as "complainers" or "malingerers". They may also recognize increased pain as a sign that their illness is progressing and may use this as a defense mechanism for their denial.

Reluctance to Prescribe Opioid Medications

A limited understanding of opioid pharmacology causes some health care professionals to be fearful of causing addiction, premature patient death, respiratory depression, DEA reviews and regulatory scrutiny. These concerns can interfere with the physician to adequately control a patient's pain near or at end-of-life. The reality is that these factors have been scientifically disproved, which suggests that an aggressive approach to pain control may serve the patient, and physician, best.

Patient Reluctance or Fear of Opioids

Patients may view the need for opioids as a sign of approaching death. They may also associate opioids with a high risk of addiction or fear being labeled as a "drug addict". Some fear that taking opioids too soon, will render the drug ineffective when it's "really needed".

It is important to understand the difference between physical dependence and addiction. Addiction is a psychological “need” or dependence in which the patient exhibits behaviors characterized by a craving for the drug and will go to great means to obtain the drug for reasons other than pain relief. Unlike addiction, physical dependence is an unavoidable, expected physiological adaptation to opioid usage. Scientific studies have revealed that addiction should be an irrelevant concern for terminally ill patients or ones experiencing chronic, severe pain.

Addiction can also be confused with “clock watching”. In the majority of cases, patients labeled as “clock watchers” are not seeking drugs. They are seeking adequate pain control. The fear of “running out” of medication or watching the clock for the next dose are NOT signs of addiction. What this likely indicates is inadequate pain relief or a history of poor pain control.

Although 50 percent of terminally ill patients have moderate to severe pain, only 30 percent of them wanted additional treatment from their physician in one study (Weiss, Emanuel, Fairclough, & Emanuel, 2001). These are explanatory factors:

- About one third of terminally ill patients cited a desire to avoid the side effects of opioid analgesics. They preferred to balance pain and troublesome side effects.
- About one third are reluctant to take pain medicines because they fear addiction. Families may fear this as well.

The American Medical Association Council on Scientific Affairs (1995) adds these factors:

- Patients may be reluctant to report their pain. Some may be stoic. Others may wish to avoid facing the possibility that increased pain means progression of the disease.
- People may hold the common misconception that taking too large a dose early on will prevent the drug from being effective when they really need it.

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Fear of Respiratory Depression

Opioids have a suppressant effect on the respiratory center, however, tolerance to the effects of opioid analgesics develop very quickly and early in the course of treatment. Usually, within a few days of starting opioid treatment, the threshold dose for respiratory depression far exceeds the analgesic threshold.

Opioids are also effective in the treatment of severe dyspnea and air hunger, and are used frequently and safely in palliative care for these symptoms. Patient receiving chronic opioid analgesia to control pain usually requires 1.5 to 2.5 times their regular dose of analgesia to control the sensation of air hunger with no negative effects to the respiratory status. Accordingly, there is no basis for the fear that giving the next dose to an actively dying patient will hasten death.

Undertreatment of Specific Patient Groups

Literature reflects that certain patient groups are at a higher risk for poor pain control, which is many times attributable to stereotyping. Minority patients are 3 times more likely to have uncontrolled pain than non-minority patients. And, women are assumed to "complain" more or exaggerate their pain, therefore statistics show that women are 1.5 times more likely to have uncontrolled pain than men.

Pain Control & Age Groups

Elderly patients are almost 2.5 times more likely to have uncontrolled pain than younger patients due to being viewed as "confused" or "less credible", and the fact that physicians may fear that the elderly may not tolerate opioid treatment as well as younger patients. Older people also tend to under report their pain and those with dementia may not be able to verbalize their symptoms of pain and healthcare professionals may have difficulties in assessing pain in the confused or demented patient (Davies & Higginson, 2004a). Similarly, the younger population may be viewed as "drug seeking" or "recreational drug users" and may not receive adequate pain control as a result.

Effective End-of-Life Pain Management

Hospice professionals can be your best resource for understanding end-of-life pain management. They are trained extensively in pain control and symptom control associated with the end-of-life. There are many resources found on the web to assist a healthcare practitioner with end of life pain control. The National Cancer Institute at www.cancer.gov, the American Cancer Society at www.cancer.org are a few.

Resources

- To find a Crossroads Hospice in your area, or to speak to a professional regarding pain control visit www.crossroadshospice.com. A clinical director and / or medical director will be happy to assist you with any pain control issue you may be experiencing with your patient.
- Reference: 20 Common Problems in End of Life Care-Barry M. Kinzbrunner, Neal J. Weinreb, Joel S. Policzer. 2002-McGraw-Hill Medical Publishing Division.
- End of Life in Michigan: Needs Assessment Report

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