



## *Making Pain Relief a Priority... Dispelling the Myths about Pain and Pain Management in the Older Adult*

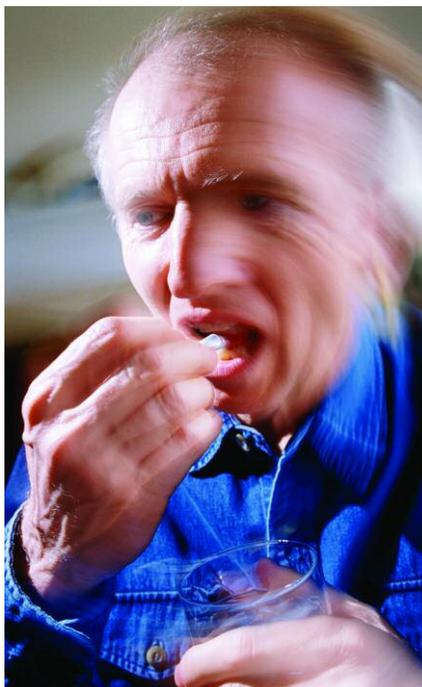
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Despite advances in the assessment and management of persistent pain, clinicians commonly under-appreciate and, as a result, under-treat pain in older adults. Seniors residing in assisted living or long term care settings are especially vulnerable to pain under-treatment. In fact, it has been reported that up to 80% of nursing home residents have significant pain. In ALFs, where residents generally are more independent and less rigorously monitored, the incidence of untreated pain is likely to be high as well. Additionally, there is a high incidence of dementia, cognitive impairment of some degree, and other disabilities that limit residents' ability to self-report pain.

Unrelieved pain can have a tremendous impact on residents' quality of life; it even can contribute to depression and other problems. Many health care providers lack the knowledge and skills to assess and treat pain in older adults. It is widely recognized that pain is a completely subjective phenomenon; therefore, the resident is the expert regarding how much pain he or she is experiencing. Yet, staff—as well as family members and friends—often ignore signs that a resident is in pain or they think that complaints are exaggerated. At the same time, clinicians often are reluctant to prescribe opioid analgesics for older adults with pain, fearing that they will become “addicted” to this medication. Recent Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standards and, increasingly, state regulations are requiring that facilities implement

policies and procedures to ensure the appropriate assessment and documentation of pain, prescribing support, and education for staff, families, and residents around pain and pain management.

Legal and ethical problems regarding pain management can be avoided if staff, practitioners, residents, and families partner to make the identification and treatment of



pain a priority. As a first step in a facility-wide action plan to address the problem of pain, administrators should consider implementing educational programs and discussions to dispel the myths about pain and pain management in older adults.\*

**Myth:** “Dying is always painful.”

**Fact:** Most pain can be effectively treated effectively using oral drugs

that are readily available. As the end of life nears, oral pain medications can be continued by converting to a concentrated oral liquid form or a suppository. Persistent (chronic) pain is best treated by administering pain medications at regular intervals, around the clock. Researchers have found that people in pain actually require *lower* overall doses of pain medications if their pain is prevented by regular dosing, rather than waiting until the resident experiences severe pain and administering medication “prn” (as needed). If pain does occur, it can be relieved safely and rapidly.

**Myth:** “There are some kinds of pain that can't be relieved.”

**Fact:** Accurate assessment and persistence in modifying the treatment plan until the resident is comfortable are the keys to pain management. There are some types of pain that require “multi-modality” (combined approaches) pain relief. Recent advances in analgesia assure that all pain can be relieved by using commonly available medications and/or a combination of approaches that may include chemotherapy, radiation therapy, nerve block, physical therapies, and whatever else is appropriate. In addition, drug therapy using different classes of drugs is beneficial when the individual experiences more than one type of pain.

**Myth:** “Pain medications always cause heavy sedation.”

**Fact:** Most people with persistent pain have been unable to sleep because of their pain. Opioid analgesics

(morphine, codeine, etc.) may produce initial sedation (usually about 24 hours) that allows residents to catch up on their lost sleep. With continuing doses of medication they are able to accommodate the sedating side effect of medication and carry on normal mental activities. Sedation may occur because of other drugs, such as anti-anxiety agents and tranquilizers that have been prescribed for other reasons. Older adults often have kidney, liver, or other problems that interfere with their ability to process and clear some medications. Despite this, they can be safely and effectively treated for their pain. A rule of thumb in dosing is to “start low, and go slow.”

**Myth:** “It is best to save the stronger pain relievers until the very end.”

**Fact:** If pain is not relieved by the lesser strength analgesics (non-opioids like aspirin, acetaminophen or NSAIDs, or weak opioids such as codeine, hydrocodone, etc.) then it is best to change to a stronger analgesic to bring the pain under continuing (24-hour) control. Pain that is only partially or occasionally controlled tends to increase in severity. This leads to two mistaken assumptions: the resident mistakenly fears that the pain is so severe that it can never be controlled; the doctor mistakenly believes that the resident is becoming addicted or is developing tolerance to the analgesic medication. In most cases, an adequate dose of a stronger analgesic (eg, morphine) prescribed on a regular basis usually brings the pain under control.

**Myth:** “Patients often develop tolerance to pain medications like morphine.”

**Fact:** When morphine and other opioid analgesics are prescribed for the management of pain, the dose is sometimes raised to be sure that pain is well-controlled 24 hours a day,

seven days a week. Opioids given to relieve pain generally do not lead to the development of tolerance. Over time, however, some residents will require larger doses to achieve the same physiologic effect. This is sometimes related to development of tolerance, or it might be related to progression of a disease, like cancer. In either case, the need for increasing doses of medication to control pain does not signal addiction.

**Myth:** “Once you start pain medicines, you always have to increase the dose.”

**Fact:** The converse is sometimes true. Once pain is under control and the dose of opioid held at a steady level for several days, the dose of opioid analgesic sometimes can be

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lowered without the pain increasing to previous levels. Doses of opioid analgesics can be raised safely as needed to control increasing pain. Also, the dose can be lowered gradually if pain has been controlled on the same dose for several days. This change in dose to meet resident needs is known as “titration.” The fact that the dose of opioid can be lowered once pain is controlled is one of the paradoxes of treating severe, chronic pain. It does NOT mean that the resident’s pain wasn’t real or that he or she doesn’t need to continue the pain medication.

**Myth:** “To get good pain relief, you have to take injections.”

**Fact:** Until the mid-1970s it was

believed that morphine was not an effective analgesic when administered by mouth, so it was universally administered by injection. We now know that morphine is effective when given by mouth or even by suppository. Residents generally do not like injections, as they are painful in themselves. There are several excellent long-acting opioid analgesic preparations. Morphine and related opioids are available that control pain for 12 hours when used on a regular basis twice daily. Other long-acting opioid preparations available for transdermal (via a patch that is placed on the skin) delivery are available with a 72-hour (3-day) duration of action.

**Myth:** “Pain medications always lead to addiction.”

**Fact:** Addiction is defined as the “overwhelming involvement with obtaining and using a drug for psychic effects.” (American Pain Society, 1989). When prescribed on a regular basis in a dose sufficient to relieve pain, there is no empirically based evidence that opioids lead to addiction. In fact, over-concern about addiction leads to under-treatment of pain, greatly increasing unnecessary suffering for many residents.

**Myth:** “Withdrawal is always a problem with pain medications.”

**Fact:** When prescribed for managing severe, chronic pain there is no problem tapering the dose down and then discontinuing, once pain is controlled. Withdrawal from opioid analgesics is typically not a life-threatening condition as is withdrawal from a number of other commonly prescribed medications, such as barbiturates. The symptoms of withdrawal from opioids are generally mild and fairly easy to manage with commonly available medications. Many residents who receive opioids for severe pain have had their dose adjusted down without experiencing any withdrawal

symptoms. For residents who have received large doses of opioids for a prolonged period of time, the dose should be decreased gradually and in conjunction with careful pain assessment, so that residents do not experience “rebound” pain.

**Myth: “Enduring pain and suffering can enhance one’s character.”**

**Fact:** This myth was developed in the years before we learned to provide excellent pain management, but it is not appropriate today. Suffering does not enhance character or earn people a higher place in the life hereafter; it merely brings about a miserable life, a painful death, and needless anguish in all who see helpless dying people suffer. Suffering occurs on many levels, and residents who are approaching the end of life may suffer because of spiritual distress, social isolation, fears about their illness and death, and anticipatory grief. Hospice care can be very helpful in treating the seriously and progressively ill resident’s “total pain.”

**Myth: “Once you start taking morphine, the end is always near.”**

**Fact:** Morphine does not initiate the final phase of life or lead directly to death. Morphine not only provides relief of severe, chronic pain; it also makes breathing easier. Relief of pain lets the resident relax and sleep. Appropriately dosed opioids do not cloud consciousness or lead to death. Morphine does not kill.

**Myth: “Pain is a solitary phenomenon.”**

**Fact:** Severe chronic pain never occurs alone, but is usually accompanied by a number of other symptoms including (but not limited to) anxiety, depression, fearfulness, insomnia, anorexia (loss of appetite), withdrawal, and thoughts of suicide. All of these symptoms are compounded with memories of pain already experienced, currently

perceived pain, and anticipation of more pain yet to come. Unmanaged (or inadequately managed) severe, chronic pain is a complex problem that needlessly aggravates the symptoms of the underlying disease. Again, hospice care provides comprehensive attention to the multiple domains of suffering that terminally ill residents experience. For residents with severe pain who are not terminally ill, interdisciplinary pain or palliative care teams can assist with creating a plan of care that addresses the resident’s total experience of pain and suffering.

**Myth: “Heroin is needed to provide excellent pain control.”**

**Fact:** Morphine is the “gold stan-

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— dard” for pain management with an opioid analgesic. Heroin is a derivative of morphine that is more soluble in water than morphine and therefore passes from the blood to the brain more rapidly, thus affording the ‘rush’ or ‘high’ desired by intravenous drug abusers. Morphine has a longer period of action and can be safely taken by mouth. New preparations for sustained release make it possible to obtain excellent relief when taken by mouth only twice daily. Combining a long-acting morphine preparation with a short-acting form assures both 24-hour coverage for persistent pain and that the resident’s “breakthrough” pain can be relieved quickly.

**Myth: “People have to be in a**

**hospital to receive effective pain management.”**

**Fact:** It is easier to provide safe, effective relief of severe chronic pain at home than it is in the average hospital. There are fewer medication errors when there is only one resident to receive medications and no other resident emergencies to interrupt the care. Accurate messages regarding pain management can be shared on a regular basis by means of a ‘Comfort Control Chart’ or Pain Diary on which the resident indicates the date, time, pain level, dose of pain medication, and level of pain relief by using numbers (0 to 10) to let the doctor know the adequacy of pain management.

It is important that ALF staff take residents’ complaints of pain seriously and act on them promptly. This requires staff and resident/family education, effective ongoing communication between caregivers and clinicians, and a clear process for reporting pain or suspected pain. Staff should ask residents about pain regularly, believe the resident’s reports of pain, help the resident to keep a pain diary, and communicate unrelieved pain to the primary care provider promptly.

By working together and dispelling the myths surrounding pain management and medications, residents and family members will be more comfortable reporting problems. At the same time, staff will be confident that their response results in relieving pain. ALC

*\*These myths are excerpted from Hospice Foundation of America’s Clergy Education Project Curriculum and reprinted here with permission.*

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