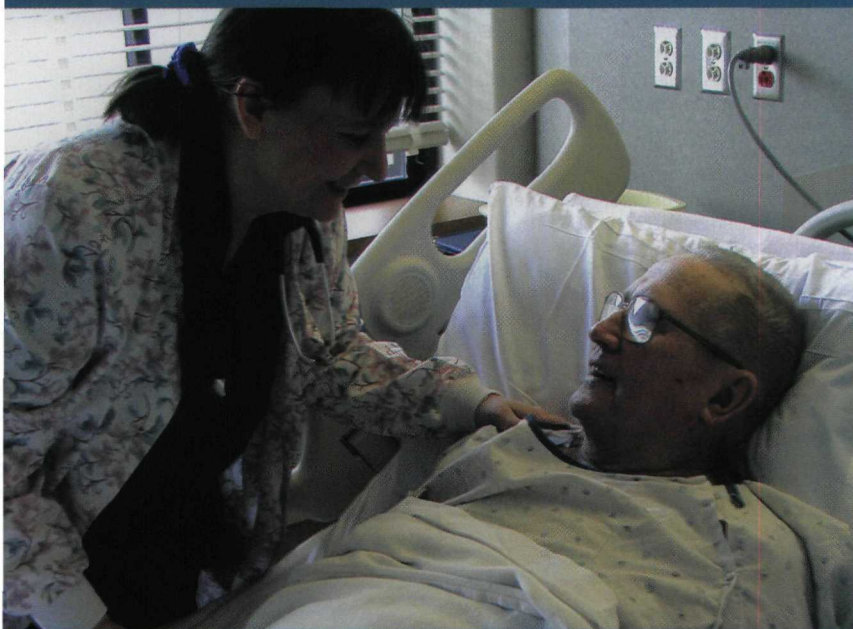


RELIEVING PAIN IN THE ELDERLY



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Health Care Still Lags Behind When It Comes to Managing Pain in Geriatric Patients

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Audrey Hepburn once said, “Remember, if you ever need a helping hand, it’s at the end of your arm. And as you get older, remember that you have another hand. The first is to help yourself, and the second is to help others.”¹ In her 60s and suffering from pain caused by colon cancer, Hepburn demonstrated the strength of her beliefs by publicizing one of her favorite charities, UNICEF. Still, one can’t help wondering: What might she have accomplished if she hadn’t been limited by pain?

Like Hepburn, many older people live with pain. That’s because, as one writer puts it, “Although pain is common in older patients, pain relief is not.”² Pain has been described as “a highly individualized, unpleasant experience involving all aspects of the person, amenable to intervention, yet, when left unattended, resulting in decreased overall quality of life.”³

In 2000, people aged 65 and older made up 12.4 percent of the U.S. population.⁴ Between now and 2011, when the earliest-born of the baby-boom generation reaches that age, the nation will see a rapid growth in its senior citizen population.⁵ It has been estimated that pain occurs in from 45 percent to 85 percent of the geriatric population.⁶ Much of it is undertreated.⁷ A review of the literature suggests other unfortunate trends, as well: Elderly patients are frequently treated less aggressively than younger patients. Also, elderly people with dementia are at increased risk for untreated pain, as are patients in long-term care facilities.⁸

Undertreated pain leads to other problems, including reduced quality of life, decreased socialization, depression, sleep disturbances, cognitive impairment, and malnutrition. For a population already vulnerable because of aging, the costs incurred by more frequent physician visits and hospitalizations can be financially devastating.⁹ Health professionals have a moral imperative to help elderly people in pain. Inadequate pain management in the elderly is not purely a medical issue. It is made worse by entrenched societal, financial, and professional prejudices concerning elderly people. Because it has so many ramifications, pain in the elderly is a multifaceted social problem. Society as a whole needs to solve it. Ironically, pain can frequently be successfully managed with oral medication.¹⁰

Despite various efforts to achieve successful pain management in geriatric patients (the campaign to define pain as the “fifth vital sign,” for example¹¹), many barriers remain. These include health professionals’ lack of knowledge about assessing and managing older people’s pain, fear of “regulatory scrutiny of prescribing practices for

opioids,"¹² and professionals' own attitudes and biases concerning both pain and the elderly. The findings of one study suggest that some nurses do not fully understand pain management, pain, and opioid usage.¹³ Moreover, few psychometric instruments have as yet been standardized to evaluate pain in the older population.¹⁴ Medical and geriatric texts say relatively little about pain management.¹⁵ Many nurses do not feel that their training has prepared them to effectively help patients in pain.¹⁶

The management of pain in geriatric patients can be complicated by the changing physiology that occurs with aging. This includes age-related changes in drug metabolism. For instance, older patients are more likely to develop adverse reactions to analgesic drugs at lower doses.¹⁷ Older people are also more likely to be living with multiple chronic diseases, necessitating many daily medications, thereby increasing the risk of negative drug-disease and drug-drug interactions.¹⁸ Older patients often show atypical presentations of pain. Depression can also play a role in the assessment and treatment of pain. Provider knowledge about the interplay of analgesics' side effects in older people, potential polypharmacy, and clinical presentations requires a level of sophistication that some clinicians simply do not possess.¹⁹

PAIN AND OPIOIDS

Opiophobia—"a failure to use opioid drugs due to overestimation of the risks, resulting in undertreatment of pain"²⁰—is one reason that undertreatment of people in pain still occurs. Providers wary of opioids prescribe dosages on the basis of their estimate of the severity of their patient's disease, not the patient's report of pain intensity.

Unfortunately, health providers and pharmacists are still frequently confused about opioid addiction and dependence.²¹ Provider fears of causing older people to become addicted to opioids are not supported: Fewer than one out of every 20,000 patients prescribed opioids will become addicted to them.²²

The risk of addiction exists primarily for patients who have a history of substance abuse. Older people rarely become substance abusers. As one writer says, "Older patients may be more vulnerable to side effects of medications, but are unlikely to develop new substance abuse related to prescribed pain medications."²³

When it comes to prescribing opiates, misapprehension about regulatory agencies is common. "Many providers will never prescribe opioids for persistent, nonmalignant pain because of the specter of DEA (Drug Enforcement Agency) scrutiny."²⁴ One group of researchers has concluded that "pharmacist confusion over federal and state opioid regulations could be a weak link to getting medications to patients in need."²⁵ Some pharmacists may still be afraid to dispense higher, medically warranted, doses of opioids.²⁶

Providers' experiences also affect their prescribing and administrative practices. In the course of their training, medical and nursing students often have patients they perceive as exhibiting opioid-seeking behaviors. Such experiences cause many such students to take a dogmatic, stubborn stance against opioid prescription.²⁷

CHRONIC ILLNESSES

Many providers already experience heavy demands on their time. Not only do they have a limited amount of time in which to see patients;



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they must then spend hours dealing with required paperwork, including the coding of patient treatment notes needed for reimbursement. When under such pressures, a provider may become impatient with the needs of an older patient suffering from pain secondary to multiple medical problems. Some clinicians dread the complexities involved in the management of pain in geriatric patients, seeing it as an obstacle to efficient patient care.

The dominant curative medical model is another barrier to successful pain management in geriatric patients. Most older people's illnesses are chronic and not necessarily curable. Caring for an older person with an incurable, chronic, painful illness can remind providers of their own mortality. Many older people are afraid of pain because they associate it with death.²⁸

For a number of reasons, many older people choose not to report their pain. Often they are afraid that they will be involuntarily hospitalized or subjected to invasive procedures if they report pain. Sometimes they are simply intimidated by their provider's education, status, occupation, and income. This intimidation can be a barrier to effective pain management, because the older person does not want to burden the provider with descriptions of and discussions about pain.²⁹

Another important barrier to successful pain management is the fact that older people are often misinformed about the aging process, analgesics, pain management, and opioid addiction. They are afraid of analgesics' side effects (such as constipation, injections, and opioid addiction. (Some providers believe, erroneously, that older people have a reduced sensitivity to pain.³⁰) Both older

people and health professionals tend to believe that pain is a normal part of aging. As a result, a vicious cycle of underreporting and undertreatment is often established in the care of geriatric patients.

Successful management of pain is necessary to improve the quality of life of older patients.³¹ Unrelieved pain, it has been said, "contravenes the right of the patient to self-determine his or her health care, and, if severe, can destroy autonomy."³² However, providers face many ethical problems in caring for elderly patients suffering from pain. For example, lack of adequate assessment is a barrier to successful pain management. The professional who performs an inadequate pain assessment may unintentionally disrespect the patient, because creation of an individualized, appropriate plan of care requires knowledge of the patient's perceptions of his or her pain, his or her treatment goals and desires, and how the pain affects the quality of his or her life.³³ Unfortunately, the professional's assessment of the geriatric patient in pain is often rushed and pressured by time constraints or the needs of other, more gravely ill patients.

NEEDED: A PROVIDER-PATIENT PACT

Individualized, comprehensive pain assessment is a benevolent act because it promotes the patient's pain relief. The assessment should include determining the patient's method of coping with pain. Determining the geriatric patient's method of coping with pain suggests treatment strategies and additional referrals.

Tom J. Hicks's description of the pain management problem as a "nurse-patient pact" is wonderful and appropriate.³⁴ Certainly, health



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care professionals should treat their patients as equals. However, the fact that the professional is helping, prescribing for, or distributing analgesics to the older patient may contribute to a hierarchical relationship. Indeed, Sharon LaDuke has noted that critical care providers often paternalistically impose their own values on their patients.³⁵

Another important consideration is frankness. Older patients need straightforward information about their analgesics' side effects, benefits, and interactions. Patients have the right to know, for example, whether their pain medication will cause constipation. They also need realistic information about their illnesses. As La Duke notes, failure to disclose facts about treatment and prognosis or options and delaying a discussion about the patient's preferences until it's too late for his or her participation in decision making constitutes a trespass on his or her autonomy.³⁶ Being truthful with patients is a respectful duty, one that, when carried out, strengthens the provider-patient pact.

Extreme cases of undertreated pain have been described as "maleficent abandonment and torture by omission."³⁷ Overtreatment can also be harmful. An example of maleficent overtreatment is insertion of an intravenous access for analgesics in an older person's arm when such efficacious methods as sublingual morphine have not been tried.

The ethical principle of justice requires that goods and services (such as prescriptions and access to medical care) be equally accessible. However, many older patients experience severe financial, functional, and situational limitations, as well as social isolation. As a result, it is often difficult for them to acquire the pain medications they need.³⁸ To save money on medication, many older patients report that they split their pain pills in half. Because older people are often excluded from research studies, relatively little is known about their responses to pain and pain medication, which is also unjust.³⁹

Fr. Peter A. Clark, SJ, PhD, has described physicians as "moral agents that have an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms"⁴⁰—words that should encourage us medical professionals to reexamine our behaviors. If we hesitate to examine our biases, our views concerning both pain and the elderly, and our professional strengths and weaknesses, we may unconsciously fail to give our older patients adequate pain management, thereby denying them respect and dignity. As one writer has said, "Knowledge and attitudes about pain need to be corrected before behavior can be altered."⁴¹

WHAT CAN BE DONE?

Recognition of the problem of undertreatment



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of pain in older persons prompts the following question: What can be done to solve the problem? Family members and friends can be taught to recognize signs of pain in the elderly. They can also be referred to the available community and medical resources. There are four other things that can be done.

Provider Education Health care facilities can, in their orientations and annual staff educational updates, educate *all* employees (not just the professional staff) about pain, including classes on reportable signs and symptoms of pain in elderly patients. As for professionals, in-service sessions should cover the guidelines of the American Pain Society and the American Geriatrics Society concerning pain in geriatric patients; emphasize geriatric physiology and pharmacology;⁴² and include discussion of end-of-life issues. Materials from the Education in Palliative and End-of-Life Care Project (www.epec.net) could aid sessions on end-of-life issues.

Educational in-service sessions improve the quality of patient care, because they improve providers' pain-management skills and attitudes.⁴³ They also remind professionals of their responsibility to keep current and knowledgeable about aspects of geriatric medicine, such as pain relief.

Patient Education Patient education is also extremely important. When combined with teaching about self-management and coping strategies, it can improve the patient's pain management.⁴⁴ AARP

Undertreated pain in the elderly is today ethically unjustifiable. A wide range of pharmacological, psychological, and other treatments exist to ameliorate it. Society should tolerate pain in the elderly no longer.



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(formerly known as the American Association of Retired Persons) has a speaker's bureau that might be useful in creating community and nursing home educational programs about pain management and geriatric issues for older people. For computer-literate patients, the AARP website offers at least four current, accurate articles about pain management.⁴⁵

Improved Coordination of Regulatory Agencies Physicians often express frustration about the difficulty they have in getting consistent, relevant information from regulatory agencies concerning the prescription of opioids. If providers are to solve the problem of undertreatment of pain, they must have clear guidance from federal and state regulatory agencies and professional boards. And if those agencies and boards are to provide such guidance, they must base their policies on current, accurate, evidence-based knowledge concerning pain, pharmacology, and physiology, especially in relation to the elderly. Moreover, the relevant agencies and boards must also have staff members who are accessible to providers and who can explain those policies clearly.

One trio of writers, although noting improvements in some state medical boards' policies about the use of controlled substances (especially opioids) to control pain, was struck by the anachronistic language found in those policies. "Many policies aimed at providing immunity to physicians for prescribing controlled substances for pain actually contained language that suggests that opioid analgesics are not part of generally accepted medical practice and are to be used as a

treatment modality of last resort," these writers argue.⁴⁶ Such language, they say, represents a serious misunderstanding of optimal pain management and cannot help but complicate the effective management of pain.

Multidisciplinary Teams for Geriatric Care Unfortunately, patients of all ages often receive fragmented health care. This is particularly unfortunate in the case of older people, who frequently have multiple medical problems and functional, psychological, familial, and financial factors that may contribute to pain. However, a multidisciplinary team is equipped to address such issues.⁴⁷ For example, a team approach can be used on such related problems as unrelieved pain, polypharmacy, elder abuse, and a need for additional services.

PAIN RELIEF IS A MORAL IMPERATIVE

Many older people are like the late Audrey Hepburn. Their knowledge, wisdom, and experience *could* be tapped to enrich lives. Unfortunately, pain too often limits their activities. Those limits should be removed. In any case, undertreated pain in the elderly is today ethically unjustifiable. A wide range of pharmacological, psychological, and other treatments exist to ameliorate it. Society should tolerate pain in the elderly no longer. ❧

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