THE UNIVERSITY OF ADELAIDE AUSTRALIA

FONDATION BROCHER

An investigation into the recent history and ethics of treating pain in the emergency department

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Project overview

We propose to conduct six semi-structured interviews with medical practitioners and ethicists.

Our central aim in these will be to uncover and explore the moral logic of treatment decisions made in relation to acute pain and its role in diagnosis in emergency medicine.

When, if ever, is it best to preserve and instrumentalise acute pain in the service of accurate diagnosis? What moral logic is variously deployed in answer to this question?

We also conduct background reviews in, and contribute to conceptualising,

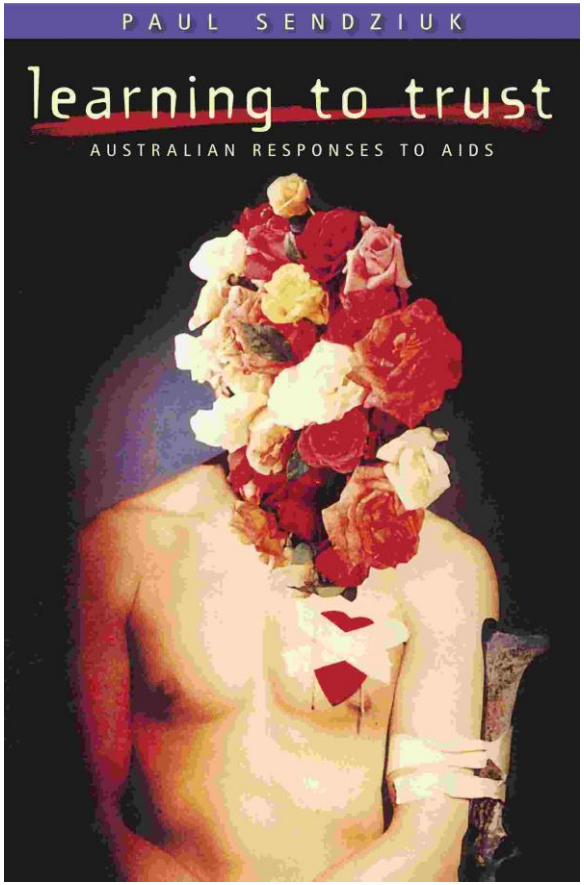
- why pain has been under-treated in the emergency department (ED)
- how meaning and emotion are related to pain

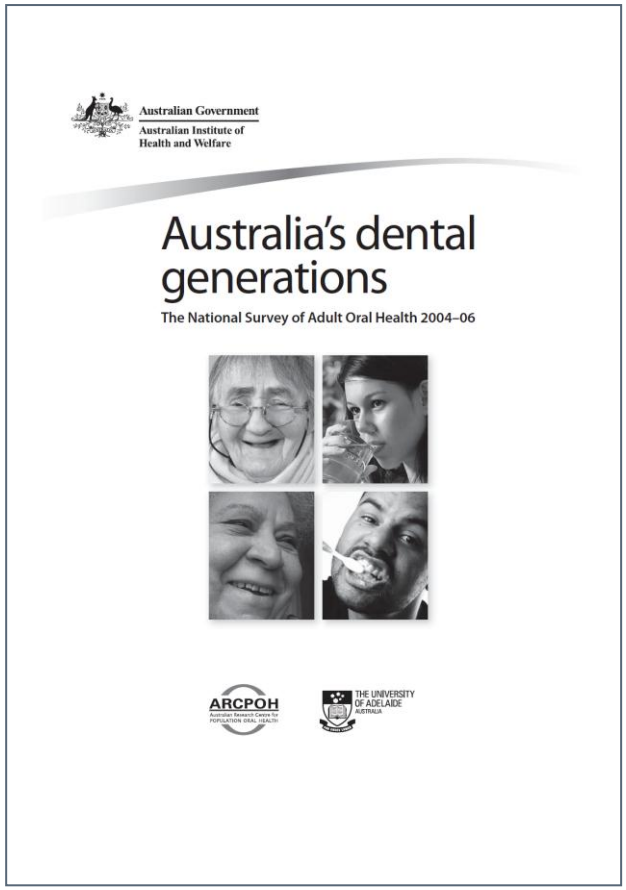
Project origins

- My background in moral philosophy
- A question born of personal experience
  - …against the background of
    - my broader philosophical interest in moral **meaning**, irreducible to **consequences** for, say, flourishing (e.g. ‘the wrong and not just the harm’; the spirit or intent of an act and not just its material consequences; the meaning an encounter can reveal; ‘what have I done?’; ‘what are we here to do and to be?’)
    - my growing engagement with health economics
- Why I invited Paul to the project

Researcher background

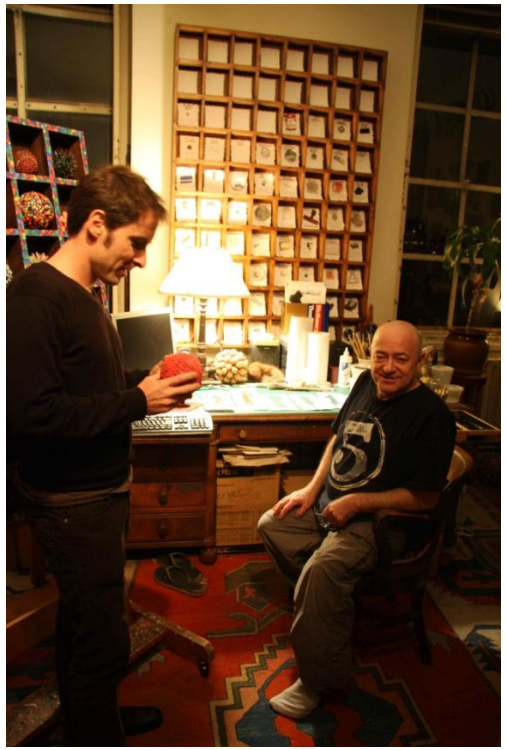
- 15+ years experience researching and writing in the field of the history of medicine and public health





Researcher background

- Histories of public policy making with the purpose of explaining success or advocating reform
- Origins of projects lie in social justice rather than personal experience
- Experience as an oral historian



Research questions

1. How do practitioners approach – both conceptually and practically – pain and its management in emergency departments, especially relative to other clinical priorities, such as diagnosis? (By 'pain' we mean pain that is severe, acute and not post-operative, cancer-related or chronic.)

2. What is the **moral logic** of different approaches? That is, morally speaking, where do they come from and where do they proceed? What are the implications, including the advantages and limitations, of different approaches?

Interview protocol (domains)

- under-treating pain
- priorities
- metrics
- the taught approach
- your feelings
- the patient's feelings and views

Initial hypotheses

1. Sometimes priorities **do** conflict when it comes to (1) alleviating pain and (2) achieving accurate diagnosis or some other benefit for the patient.
2. Diagnosis is prioritised. If pain management stands to impede diagnosis or to risk some longer-term negative health impact, then practitioners will forego pain management, either completely or in proportion to the impediment or risk.
3. Clinicians do this paternalistically (without asking patients what they want), assuming no reasonable alternative or considering patient autonomy to have been compromised by pain.

Initial hypotheses

4. Practitioners conduct a lifetime-aggregate risk/ benefit calculus. In this way, their approach is largely consequentialist.

5. Practitioners vary

   - in the algebraic function they attribute to the 0-10 pain scale

   - in where they 'anchor and adjust' their pain-severity judgements. (There is a spectrum along which varies the degree to which practitioners accept as definitive a patient's report of pain-severity, that is, the 1-10 scale's 'validity'.)

6. Practitioners vary in when they deem pain to have been adequately relieved.

Initial hypotheses

7. Practitioners understand pain to be a physical phenomenon unaffected by thoughts and emotions. As such, practitioners accord little priority to non-pharmocological approaches.

8. Patients can experience their practitioner's approach as objectifying and dehumanising. This can increase both their pain and their felt need for, not only relief, but compassion.

9. Compassion, encouragement, reassurance and orienting information can assist in pain relief (having instrumental value, positive **consequences**). It can also be experienced by the patient as affirming both their value and a sense of human fellowship (having inherent value, positive **meaning**).

The nature and extent of the problem

- Evidence for the historical under-treatment of pain in the ED
  - Wilson & Pendleton (1989): only 44% of patients presenting with pain in the ED received analgesic medication
  - 5 studies (1989-2000): 30% - 63% of ED patients in pain received analgesic medication
  - National Health & Medical Research Council pain management manual (2011): “management of patient pain within the emergency department setting is poor”
  - Patient (dis)satisfaction surveys
  - Our interviewees testify to the practice of under-treatment

Review of possible causes

- Review of the existing literature suggesting causes for the under-treatment of pain in the ED
  - Under-resourced EDs
  - ED practitioner suspicions of drug-seeking and/or concern about opioid dependence
  - Education and training (use of opioids; full range of treatment options; the nature of what pain really is…)
  - Physician and nurse attitudes toward, or preconceptions of, patients of different gender and ethnicity
  - Variation in how patients of different age, gender and ethnicity *express* and *report* pain, and their *expectations* of treatment
  - Problematic pain metrics

(cont…)

Review of possible causes

- Review of the literature suggesting likely causes of under-treatment of pain in the ED (cont.)
  - Failure of ED practitioners to address the *psychosocial dimension of pain* (the emotional, historical and situational context of pain and the meanings that patients ascribe to their experience)
    - 'Bedside manner'
  - Prioritising diagnosis over pain relief

Qualitative methodology

- Why we decided to interview practitioners

Australia	The Netherlands (named institution)
1. ED doctor: junior	4. Anaesthesiologist (named)
2. ED doctor: senior	5. Anaesthesiology (named)
3. ED nurse	6. Ethicist (named)

- Pilot; refining the interview protocol; constant comparison and reflexive journal
- Method of analysis
  - thematic analysis (emerging themes, no formal theory building)
  - …with a Wittgensteinian sensibility, namely attention to 'grammars' (resembles 'discourses')

Early findings (SD, N, JD)

1. Pain is not preserved to aid **diagnosis**. To practitioners, there is no longer real conflict between these priorities. But sensation and awareness are preserved for patient **monitoring** (except in short-lived procedural sedation).
    - *what we're talking about is unexplained, unexpected pain as a trigger for 'Go back and look at that patient again'.* (SD)
2. Diagnosis as such is not prioritised over pain management, but saving a life is (except in a palliative care situation).
3. This is done with what practitioners consider a justified paternalism.

Excerpt

SD My first priority is save a life. So save my life. When you've saved my life, please stop it hurting. When you've done that, then look after my dignity. And it's in *that* order. I don't want to die because someone's busy looking after my dignity.

DC Or pain.

SD Yeah. Ok? But once I've got the pain under control, and the life saved, then I want the dignity looked after. There's my order … when I say the priorities, these are *my* priorities. If it's *my* illness, you save my life first, and when that's reassured, *then* you sort my pain then you sort *my* dignity.

Early findings (SD, N, JD)

4. The approach of practitioners can be described as consequentialist only if short-term pain and distress are themselves considered very important consequences.

5. Practitioners **do** vary

   - in what algebraic function they attribute to the 0-10 pain scale. JD: *How much pain is pain? Is eight-out-of-10 pain **pain**?*
   - in where they 'anchor and adjust'. JD 'anchors' on clinical examination, partly to confirm that the patient is not just seeking drugs. By contrast, SD & N anchor on patient self-report. SD does not adjust at all, thinking that drug-seekers are few and that it is better to feed an addiction than deny someone in real pain relief.

Early findings (SD, N, JD)

6. Practitioners do **not** vary in when they deem pain to have been adequately relieved. *You're going for a substantial reduction in pain so it is now comfortable and bearable.* (SD) Practitioners observe that what is bearable varies considerably among people.

7. Practitioners do understand that pain has a significant affective dimension – it is influenced by emotion, anxiety and expectation. As such, they accord some value to non-pharmocological approaches, particularly reassurance and honest communication regarding reasonable expectations for pain, particularly when it comes to chronic pain and suspected drug-seekers.

Early findings (SD, N, JD)

- Practitioners want to reduce pain, a distressing symptom, to mere tenderness, a non-distressing sign.

- JD simultaneously conducts two different types of diagnosis.

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http://health.adelaide.edu.au/school_phcp/research/grants/hitr.html

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