Veterinary surgeons receive more pain relief education than nurses

You may be surprised to learn that nursing and medical students receive only a proportion of the education about pain and the relief of pain that is given to veterinary surgeons. Despite pain being the most common reason for GP visits, less than one per cent of university education focuses on pain (Briggs et al, 2009).

When I ask nurses for a definition of pain, almost invariably one will paraphrase Margo McCaffery, a pioneer in pain management in the 1980s, and state that “pain is what the patient says it is”. Pain is subjective and cannot be objectively measured using a bedside test. What someone experiences and expresses as pain is a result of their history, genetics, gender and a plethora of other variables including culture and the context of that pain. Pain may be acute or chronic, with the only difference being the duration. Chronic pain is that which tends to persist for longer than three months.

Failure to identify commonly occurring acute pain, such as that arising from leg ulcer dressing, leads to undertreatment and can have adverse effects. Acute pain is a warning sign. Uncontrolled acute pain can delay wound healing, increase the risk of venous thromboembolism, affect sleep, induce fear and increase anxiety.

Chronic pain, such as back pain, is associated with increased activity in the spinal cord in response to hyperexcited nerves. This is known as “wind-up” and may activate the limbic system in the brain, which is associated with fear and emotions. In his 2008 annual report, the chief medical officer reported that 7.8 million people in the UK experienced pain.

I would suggest that undertreated pain implies poor quality of care and can be construed as a form of torture.

Why do we undertreat pain? We need to start with the patient. They may have little or no understanding of their pain management. This may result in low expectations of relief from pain, or they may be reluctant to tell you about their pain. Patients may perceive that reporting pain may result in being seen as a “difficult patient” or they fear that it will increase nurses’ workloads.

As the nurse, how you ask a patient about pain has a direct impact. Asking: “Do you have any pain?” results in a yes or no answer. An open question such as “Tell me about your pain” will elucidate more useful information. You need to know where the pain is, what it is like, how strong is it, what makes it worse and what makes it better. Pain assessment should not be restricted to when you are undertaking the drug round. Pain should be seen as the fifth vital sign and should be assessed and treated alongside other observations. As the patient’s advocate, you need to ensure appropriate medicines – including an appropriate dose and frequency – are prescribed and administered. You also need to assess the effectiveness of any nursing intervention.

The other barrier to effective pain management is workplace culture. You need to ensure this works to your patient’s advantage. If you have adequate resources or restrictive policies, ensure that you contribute to benchmark data collection as this will inform the nursing hierarchy of barriers. Pain is one of the new Essence of Care benchmarks.

The International Association for the Study of Pain has designated October 2010 to October 2011 as the Global Year Against Acute Pain. Hopefully, this will raise awareness of the need for better pain management. Resources are readily available to support practice, including local short courses and free online education, such as Change Pain (www.change-pain.co.uk). So what are you waiting for?

Felicia Cox, MSc, RN, is senior nurse, pain management, Royal Brompton & Harefield Foundation Trust; chair of the R CN London Pain Interest Group; and a co-opted council member of the British Pain Society


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This week in Nursing Practice

Practice Review 10

Postoperative pain 1: understanding the factors affecting patients’ experiences of pain

Many patients experience unnecessary moderate-to-severe postoperative pain. A knowledge of pain physiology can help nurses to address this issue.

Changing Practice 14

Using a campaign to promote safer medicines practice among healthcare professionals

Safe medicines month was launched to alert nurses to essential aspects of medicines administration policy. This article discusses the campaign’s impact.

Guidance in Brief 16

Caring for adults with chronic heart failure: rapid diagnosis and enhanced management

NICE has updated its evidence-based guidance on managing chronic heart failure. This article looks at the implications of these changes for nursing practice.

Innovation 17

Using home telehealth to empower patients to monitor and manage long-term conditions

Self-management of long-term conditions can ease the burden on NHS resources and increase patient independence. This article aims to assess the benefits of telehealth.

Research Report 20

Developing nursing practice, treatment and support services for ageing drug users

Substancemisuserswhostartedtaking drugs as part of the 1960s ‘hippy culture’ are now part of the growing population of older drug users.