

## **Type of Article**

Short Communication

## **Title**

How Does the Opioid Crisis Impact the Treatment of Patients with Pain Management Needs? Questions for Future Research.

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## **Title**

How Does the Opioid Crisis Impact the Treatment of Patients with Pain Management Needs? Questions for Future Research.

## **Abstract**

While the opioid crisis is of concern, are the pain management needs of some patients going unmet? Based on our experiences as health advocates for a patient experiencing pain, the attempts made to address their pain, and the barriers encountered, we submit questions for future research. The first question is how can a patient's pain be adequately treated given the hesitation of doctors to prescribe pain medication due to the opioid crisis? The second question asks if a nurse should be able to deny a patient pain medication prescribed by a doctor? The third question considers if clear communication between the patient, family, nurses, and doctors is really sought or do some actors find the deniability provided by communication barriers advantageous? Context is provided as to how these questions were formulated.

## **Keywords**

Communication, Healthcare, Opioid Crisis, Pain Management, Pain Medication

## **Introduction**

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For approximately two years we had multiple experiences as family members and the primary health advocates of a female family member dealing with increasing pain management issues while a patient at a senior care facility. The patient had multiple diagnoses that contributed to continuous moderate to severe pain and consistent episodes of excruciating pain. Both the patient and the family found what they would characterize as a reluctance from many actors at the facility to try to treat the patient's pain to her satisfaction. Reflection on this situation has led us to consider questions that might be beneficial for future research.

### Discussion

#### **Question 1: How can a patient's pain be adequately treated given the hesitation of doctors to prescribe pain medication due to the opioid crisis?**

Doctors may fear criminal prosecution and malpractice lawsuits if they are viewed as overprescribing opioids [1]. Given this situation, the pain management needs of many patients may be going unmet due to the focus on the fear of possible addiction and prosecution. The double crisis of opioid addiction and not meeting the pain management needs of patients is of concern [2-4].

Adjacently, who should decide if a patient's pain management needs are being met? Should it be the patient, the patient in agreement with the patient's family or health advocate, the nursing staff who see the patient periodically (one to three-day shifts), or the doctors who see the patient even more infrequently?

From our perspective, healthcare staff devalued the patient's and health advocates' assessment of her pain when an adjustment to the pain management plan was requested. The patient expressed many times that comfort, specifically pain alleviation, was her top priority. Declarations were made to healthcare staff many times about the patient's pain with requests to increase treatment to relieve or at least reduce the patient's pain. Any changes in the pain treatment plan that occurred seemed overly cautious indicating a reluctance to increase pain medication.

In an attempt to address the opioid crisis, the "*CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016*" was published [5]. While the goal of this publication was well-intentioned, it is attributed to leading to a greater suffering of pain by patients [6]. It should be noted that some doctors may be applying these guidelines incorrectly. The guidelines are clear that they should not be used in situations related to palliative and hospice care. This has led us to another question - was our family member viewed as a standard care patient instead of a palliative care patient? At the time, we thought there was agreement that the situation was one of palliative care but now wonder if that was how it was defined by facility staff. Stephens, Hunt, Bui, Halifax, Ritchie, et al. found that many patients who are eligible for palliative care services are not receiving them. [7].

While visiting the office of another healthcare provider, we were made aware of the implementation of an opioid consent form where the patient acknowledges that taking opioids may lead to addiction. In retrospect we wish we would have been provided this option when trying to address the patient's pain if staff had addiction fears.

#### **Question 2: Should a nurse be able to deny a patient pain medication prescribed by a doctor?**

Eventually, the patient was placed in hospice care. The doctor of the hospice agency changed the pain treatment plan to better alleviate the patient's pain. The decision for the

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patient to be accepted into hospice care appeared to receive mixed reception among the nursing staff. It was extremely alarming to the patient and to us as their health advocates when one nurse refused to provide the patient with the pain medicine ordered by the hospice doctor because, in her opinion, the patient did not need it. This occurred even though the previous pain medication orders had been deleted from her chart. Therefore, the patient was deprived of pain medication during this nurse's shift. This led to a meeting with the director of the senior care facility. While we were successful in having this nurse removed from overseeing the patient's care in the future, we were shocked when the facility director indicated the nurse had the authority to withhold pain medication prescribed by a doctor, requested by the patient, and requested by the patient's health advocates.

This led us to question if some nurses purposely withhold or intentionally delay ("slow walk") pain medication. Is this a practice to punish certain patients? Is it a way for a nurse to subversively substitute and enforce their assessment of a patient's health needs over the assessment of others? During the patient's time at the facility there were delays of 30 minutes, an hour, or longer to receive pain medication. At the time we attributed the situation to staffing issues but now wonder if the delay by some nurses was purposeful. If this impression is accurate, it leads to the question of why are requests for pain medication are not given priority by the nursing staff?

### **Question 3: Is clear communication between the patient, family, nurses, and doctors really sought or do some actors find the deniability provided by communication barriers advantageous?**

When examining communication in healthcare Riah states:

*Communication difficulties are not isolated to providers lacking "people skills" or patients with language or comprehension deficits. Nor is the problem exclusive to communication that is misspoken or misunderstood: errors often occur because information is unrecorded, misdirected, never received, never retrieved, or ignored. Every mode and system by which patients and caregivers share health-related information is vulnerable to failure. [8, para 3]*

While the facility used a computer program in the administration of medicine, it lacked a patient portal that could be used by the patient and family to review patient information, test results, and send messages to facility staff. Sometimes this lack of communication seemed purposeful in that it provided a way for staff, particularly the doctor's staff, to claim they were unaware of the patient's or health advocates' concerns.

The patient and health advocates also requested many Situation, Background, Assessment and Recommendation (SBAR) notifications be filed about the same situation. From the perspective of the patient and the health care advocates they often did not receive a response from this action.

The health advocates had limited conversations with the nurse practitioner at the facility and never with the facility's primary care physician. We were informed that all health advocate communication was expected to go through the nurses' station or quarterly care plan meetings. There also appeared to be a disconnect in communication between the nurses and the nurse practitioner. The nurses stated they were instructed to submit an SBAR and wait until the nurse practitioner reported in for the day. One of the few times we spoke to the nurse practitioner they said the nurses were instructed to contact them directly if a patient's pain persisted beyond a specified time period. Communication seemed even more disconnected on weekends. As we have contemplated this situation, we have questioned that if the communication difficulties were not purposeful why were they

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allowed to continue? Did the communication barriers result from the actors involved, inefficient communication protocols, improper training regarding communication protocols, the lack of funding or unwillingness of the facility to institute a patient portal for communication, or a combination of these and other possible factors?

### Conclusion

The goal of this account is to bring attention to the questions presented in an attempt to improve pain management in the lives of those living with pain in senior care facilities. We would be remiss if we did not acknowledge that many caring, dutiful staff members worked at the senior care facility of the patient and diligently tried to provide her with the best possible care. However, there were issues, particularly with pain management. If the questions generated by these experiences have been resolved by other facilities it would be beneficial for a best practices model to be provided to the senior care industry.

We were fortunate in that the patient could articulate her levels of pain to us. In many situations patients, particularly patients in senior care facilities, are unable to do so. Patients may also not have someone to advocate on their behalf which our family member did. These scenarios create other questions for research that this paper does not address.

### Acknowledgement

None

### Conflict of Interest

Since these research questions have been generated based on our observations related to a family member's specific situation one could consider it a conflict of interest. However, going through this process in this way provides us with a unique perspective of the situation as family members and health advocates.

### References

1. [Furrow BR. \(2001\) Pain management and provider liability: No more excuses. \*Journal of Law, Medicine, & Ethics\* 29\(1\): 28-51.](#)
2. [Bennett K. \(2017\) The opioid epidemic and untreated pain: Ethical tensions. \*Johns Hopkins Nursing Magazine\*.](#)
3. [National Institutes of Health. \(2014\) \*Pathways to prevention workshop: The role of opioids in the treatment of chronic pain\*.](#)
4. [NIH National Heart, Lung, and Blood Institute. \(2017\) \*Opioid crisis adds to pain of sickle cell patients\*.](#)
5. [Centers for Disease Control and Prevention. \(2016\) CDC guidelines for prescribing opioids for chronic pain - United States, 2016. \*Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report\* 65\(1\): 1-49.](#)
6. [Anson P. \(2017\) Survey finds CDC guidelines harming patients. \*Pain News Network\*.](#)
7. [Stephens CE, Hunt LJ, Bui N, Halifax E, Ritchie CS, et al. \(2018\) Palliative care eligibility, symptom burden, and quality-of-life ratings in nursing home residents. \*JAMA Internal Medicine\* 178\(1\): 141-142.](#)
8. [Riah H. \(2015\) When communication fails us. In \*CRICO Strategies, A division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated. Malpractice risks in communication failures: 2015 annual benchmarking report\*. Boston, MA, USA.](#)