Undermedication for pain: An ethical model

Ethical decision making for, and with, clients experiencing pain and needing narcotic analgesia is especially problematic as evidenced by research findings. This article demonstrates the application of Greipp's model to ethical decision making for clients experiencing pain. Particular attention within this model is given to learned potential inhibitors of the nurse as they influence the outcome (decision). The application of this model to decision making and pain management will generate further scientific inquiry by identifying the areas of breakdown in ethical decision making for and by clients experiencing pain so that remediation strategies may be planned.

Mary Elizabeth Greipp, EdD, RN, FAAN
Associate Professor and Chairperson
Nursing
Rutgers, The State University of New Jersey
Camden, New Jersey

PAIN CONTROL is a contemporary ethical issue of great importance because of the devastating and dehumanizing effects of pain upon clients and families. In the words of Lisson, "Disease can destroy the body, but pain can destroy the soul."[1(p649)] There has been a notable increase in the literature of writings on the topic of ethics and ethical decision making. Since research has demonstrated the need for safer and more effective pain management, a closer analysis of existing practices may be beneficial. It is this author's belief that most professional nurses will agree on the need for a code of ethics but fail to see its application in daily practice, especially in planning care for those individuals experiencing pain.

"Prolonged pain destroys the quality of life. It can erode the will to live, at times driving people to suicide."[2(p27)] It is a well established fact that clients experiencing pain continue to be undermedicated almost 20 years after the landmark research by

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Marks and Sachar.[3] The unanswered question is why this continues to be a problem considering the recent advances in pharmacotherapeutics and related therapies. Do nurses consider those decisions involving how and when to medicate for pain within the domain of ethics?

Greipp's Model of Ethical Decision Making was designed and developed to illustrate an overall conception of the interaction between nurse and client within an ethical framework (see Fig 1).[4] The model lends itself to a close examination of the multiple factors that enter into the ethical decision-making process—descriptive, normative, and metaethics. The model is based on general systems theory and is compatible with the extensive work done by Leininger and her theory of transcultural caring.[5]

This author will apply Greipp's model to ethical decision making for clients experiencing pain. Particular attention within this model is given to learned potential inhibitors (personal experiences, professional experiences, belief system, and culture) of the nurse as they influence the outcome (decision) of the interaction. The application of this model to decision making and pain management will generate further scientific inquiry by identifying the areas of breakdown in ethical decisions for and by clients experiencing pain so that remediation strategies may be planned.

LITERATURE REVIEW

Morgan[6] has written about American opiophobia, the customary underutilization of opioid analgesics, and claims that physicians undertreat severe pain to a significant degree based on their irrational and undocumented fear that appropriate use of opioids will lead to addiction. Based on research findings listed in this article, it seems safe to conclude that many nurses also suffer from American opiophobia.

Research studies documenting the undertreatment of pain with narcotic analgesics can be found in the literature dating from 1972. Selected ones are summarized in Table 1.[3,7-20] Many of these studies identify nurses' lack of knowledge, and poor assessments or judgments as contributing to this problem. Study methodologies included interviews, surveys, questionnaires, and chart reviews.

Other corroborating evidence supporting nurses' lack of knowledge about narcotic analgesia and inadequate nursing assessments of patients experiencing pain can be found in studies by Watson (1987)[21] and Camp and O'Sullivan (1987).[22] McCaffery and colleagues in 1990 presented data gathered from 2,459 nurses around the country and analyzed it to determine current nursing knowledge about pharmacologic management of pain.[23] Their findings demonstrated a significant lack of nurses' knowledge regarding definition of narcotic and opioid and drug classification.

Citations that discuss discrepancies between observers' and patients' ratings of pain and factors influencing nurses' and patients' perceptions of pain include works by Mason (1981),[24] Teske, Daut, and Cleeland (1983),[25] Taylor, Skelton, and Butcher (1984),[26] Dudley and Holm (1984),[27] Myers (1985),[28] and Davitz and Davitz (1985).[29]

Perry presented an interesting perspective as a consultant-liaison psychiatrist on a large burn service.[30] It is his belief that undermedication for pain cannot be adequately explained by lack of knowledge, insensitivity, or fear of addiction alone. He

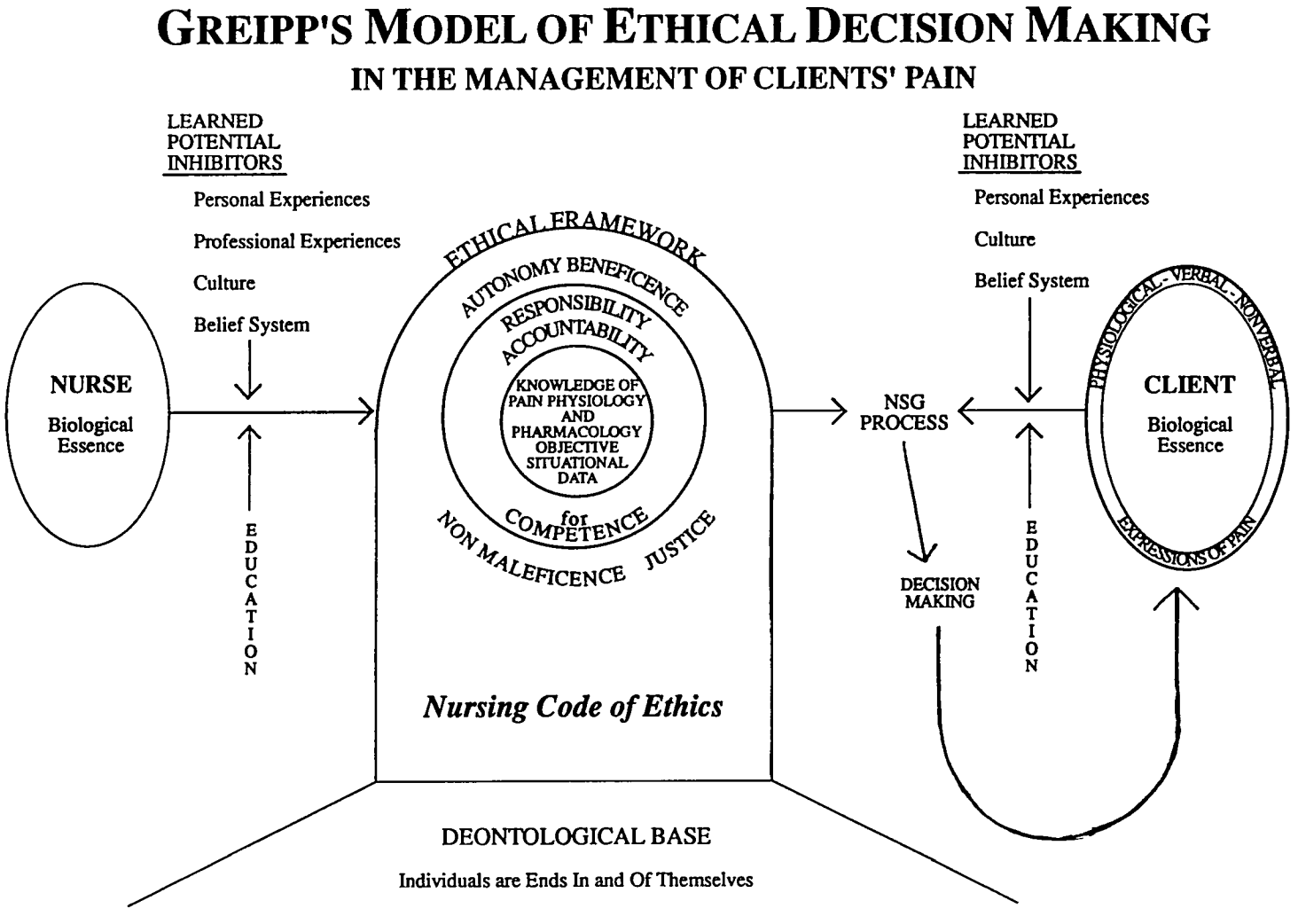

Fig 1. Greipp's model of ethical decision making in the management of clients' pain.

Table 1. Studies documenting undertreatment (analgesic) of pain

Researchers	Year	Subjects	Causative Factors			
			Knowledge deficit	Faulty judgment or assessment	Fear of addiction	Cultural differences and attitudes
Marks & Sachar (3)	1973	37 Adult Pts. 102 Physicians	X		X	
Hunt, Stollar, Littlejohns, Twycross, & Vere (7)	1977	13 Adult Pts. 13 Nurses	X	X		
Charap (8)	1978	26 Physicians	X	X	X	
		13 Nurses	X	X	X	X
Cohen (9)	1980	109 Adult Pts				
		121 Nurses	X	X	X	
Streltzer & Wade (10)	1981	270 Culturally Diverse Adults		X		X
Fox (11)	1982	30 Adult Pts.				
		72 Nurses	X	X		
Weis, Sriwatanakul, Alloza, Weintraub, & Lasagna (12)	1983	81 Adult Pts.				
		57 Physicians	X	X		
		70 Nurses	X	X		
Mather & Mackie (13)	1983	170 Children	X	X		
Beyer, DeGood, Ashley, & Russell (14)	1983	50 Adult Pts.		X		
		50 Children		X		
Schechter, Allen, & Hanson (15)	1986	90 Adult Pts.		X		
		90 Children		X		
Schechter & Allen (16)	1987	112 Physicians	X	X	X	
Donovan, Dillon, & McGuire (17)	1987	353 Adult Pts.	X	X		
Ketovuori (18)	1987	22 Adult Pts.	X	X		X
		62 Nurses				
Choiniere, Melzack, Girard, Rondeau, & Paquin (19)	1990	42 Adult Pts.				
		42 Nurses	X	X		
Carr (20)	1990	21 Adult Pts.		X		

hypothesized that for both staff and burn patients, the pain serves to maintain self-object differentiation and reassurance that the patient is alive. He claims that developmental observations and psychoanalytic theory support his hypothesis of the individual's unconscious need for pain.

GREIPP'S MODEL OF ETHICAL DECISION MAKING AND PAIN MANAGEMENT PRACTICE

Fig 1 is an illustration of Greipp's model to be used in the management of clients experiencing pain. The model makes evident the power of potential inhibitors to negatively affect decisions, often resulting in undermedication for pain.

Major concepts and definitions

1. *Nurse: Biological essence.* An individual with physical and mental characteristics and capabilities attributable to parentage, growth, and developmental factors, and who has been educated in a professional nursing program to plan and deliver health care to individuals and families experiencing pain.
2. *Client: Biological essence.* An individual with physical and mental characteristics attributable to parentage, growth, and development factors and who is in need of pain relief. The client's needs for pain management will be communicated in physiologic, verbal, and nonverbal expressions of pain.
3. *Learned potential inhibitors.* These are defined as the nurse's and client's psychosociocultural variables that may enhance the person's interactions with others relative to pain experiences. The model is concerned with their potential to "inhibit" the person's interactions with others relative to pain experiences and potentially affect the quality or "rightness" of health care given and received.
   - *Belief system.* The basic set of values and assumptions that the person holds to be true regarding pain, suffering, treatment, analgesia—may or may not be based on fact (truth). A person's learned belief system may be contrary to the ethical framework of the model. For example, a nurse may not be able to accept the tenet that clients should be self-determining by virtue of the ethical principle of autonomy. A nurse may believe that the habituating potential of narcotics outweighs the client's right to decide when to be medicated.
   - *Culture.* Learned and shared set of symbols, meanings, values, and sanctions that are attributed to pain and suffering and that guide the behavior of the members of the cultural group.
   - *Personal experiences.* All of an individual's pain experiences (direct and indirect) from birth to the present, including family, education, and employment.
   - *Professional experiences.* Those experiences with others suffering pain that have been gained through the

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professional role of the nurse and the specialized knowledge achieved in that role.

4. *Education.* General or specific teaching and learning that effects a behavior change. In the model, education relative to pain may be purposeful or incidental. Education is necessary to change psychosociocultural variables.
5. *Ethical framework.* The International Council of Nurses' Code of Ethics[31] and the American Nurses' Association (ANA) Professional Code for Nurses[32] are the framework that contains four essential ethical principles, in addition to the responsibility and accountability for competence.
   - *Autonomy.* The ethical principle that supports self determination by the client.
   - *Beneficence.* The ethical principle that directs the nurse toward doing good for the client.
   - *Nonmaleficence.* The ethical principle that guides the nurse in avoiding actions that will harm the client.
   - *Justice.* The ethical principle that directs the nurse to respect clients' rights and to seek fair treatment.
   - *Responsibility and accountability for competence.* The ANA Code of Ethics mandates that professional nurses accept the responsibility and accountability for professional competence. Nurses must keep updated about pain physiology and analgesics in order to make informed and effective judgments and decisions with, and for, clients experiencing pain.
6. *Deontological base.* A fundamental belief in, and respect for, one's obligations to other human beings—one's duty. A belief that individuals are ends in and of themselves.
7. *Nursing process.* This is the nursing profession's "scientific method." The nursing process focuses on the independent actions of the nurse as problem solver and includes client collaboration to the extent that the client is willing and able to participate.
8. *Decision making.* Ideally, a collaborative process, based on sound information; within the realities of the client's world; where problems and conflicts are defined and delineated; and resolution is guided by ethical principles which respect the individual as an end in and of himself or herself.

Underlying assumptions

1. All clients experiencing pain share a need for pain relief.
2. Nurses act as "data analyst/decision maker" on a daily basis.
3. All nurses practice within a code of ethics.
4. Decision making is a complex process subject to variations imposed by people, situations, and environments.

APPLICATION OF THE MODEL

This ethical decision-making model begins on the left side of the diagram with the nurse. The nurse as part of self takes learned potential inhibitors to the ethical framework. The potential inhibitors as defined may instead act to enhance the process. They are powerful to the degree that they enlighten or bias the nurse as caregiver. Descriptive ethics is embedded in culture, values, and belief systems. What the caregiver believes to be true about pain and suffering will affect how this individual approaches

care planning and pain management practices. If a nurse believes that it is impossible to eradicate postoperative pain, a reasonable assumption is that this will not be a nursing priority for this practitioner as evidenced by such behaviors as administering narcotic analgesics every 4 to 6 hours rather than every 3, failure to seek a more effective (different) analgesic combination, and not reporting ineffectual pain relief to the prescribing physician.

If a nurse thinks that narcotic analgesia is not as effective for a client with a substance abuse history, then that nurse may conclude that the client has to forfeit the right to pain relief. This is not to be confused with the ethical principle of nonmaleficence, avoiding harm to clients. There have been instances in which a client with a known drug abuse history had narcotics prescribed and they were not administered, or were not administered as frequently, because the nurse was fearful of respiratory depression or addiction. It is possible that nurses working with such clients form biases as a result of this dependency and the aggressive behavior that is sometimes demonstrated by this group of clients. In both of these instances the client is denied adequate analgesia because of "inhibitors" on the left side of the model, notably, the nurse's fears, beliefs, and biases.

If a nurse is part of a culture group that believes that a certain amount of pain is part of everyone's life, or that suffering builds character, that person may be expected to demonstrate intolerance of those who freely express their pain and demand analgesia. Cultural differences in response to pain have been explored in the literature.[33-35]

A nurse's personal experiences with pain (either one's own, or those of a close family member or friend) can be expected to sensitize the practitioner. This can be in the way of generating expectations or assumptions about what the client is suffering or how the client is, or should be, reacting. What the nurse has been taught theoretically about pain and management and how it was presented can influence how the nurse incorporates this learning cognitively and affectively.

Professional experiences can dramatically influence the affective learning domain. If professional experiences have been primarily with acute pain clients in whom pain relief was obtained, the nurse will tend to have a more positive outlook on pain management. However, nurses working with chronic pain clients at times experience an overwhelming sense of failure when faced with clients' reports of unrelenting pain despite a plethora of narcotic medications and treatment modalities. A sense of pessimism may prevail and can be harmful if the nurse takes the position of "why give the medication if it doesn't work anyhow?"

The learned potential inhibitors may enhance the interaction between nurse and client and facilitate ethical decision making. For example, the nurse who has witnessed the beneficial effects of physical and mental pain relief obtained by terminally ill clients from narcotic analgesics may be expected to prioritize pain relief measures and be less hesitant about administering these drugs.

When examining existing attitudes and beliefs about pain, causation, and decision making, one has to study the psychosociocultural influences on the nurse caregiver and related groups. These potential inhibitors are integral parts of the self and cannot be excised as the nurse approaches the ethical framework. In referencing the model it is important to note that education can be utilized to counterbalance

or remediate cultural biases that may adversely affect the quality or "rightness" of nursing care for the client in pain.

In order to be able to make professional ethical decisions the nurse must progress through the ethical framework—normative and metaethics. At the very center of the framework is professional knowledge needed for practice with pain clients, specifically, knowledge of the physiology of pain and pharmacologic agents used for analgesia. It is also imperative that the nurse have knowledge of relative situational data. There is abundant research evidence documenting nurses' and physicians' lack of knowledge and understanding of analgesics.[3,7–9,11–13,16–19,23] This deficit would be located in the center of Greipp's model. By its location within the center of the framework, basic knowledge is shown to be a requisite component of professional practice and all ethical decisions. This center knowledge core is surrounded by responsibility and accountability for competence, which are mandated by the professional codes of ethics.

Other essential components of the ethical framework are the four general ethical principles of autonomy, beneficence, nonmaleficence, and justice, which are inherent in the nursing codes of ethics. The nurse must believe in and apply these principles in order to make ethical decisions. The total ethical framework rests on a deontological base, which necessitates an inherent belief in the nurse's obligations as a practicing professional. The nurse has to take into consideration all of this information during interactions with the client. In a manner of speaking, this framework becomes an inseparable part of nursing practice.

Nurses must actively seek to relieve clients' pain to be beneficent. Nurses must work with clients and physicians to achieve safe and effective client analgesia to be nonmaleficent. Efforts to relieve pain must be ongoing and extended to all clients in order to be just. Nurses must allow clients the right to self-determine when they need analgesia to guarantee the client autonomy.

The nurse must believe in and apply these principles in order to make ethical decisions.

Moving to the right side of the model, the client with needs for pain relief also takes learned potential inhibitors into the interaction (nursing process and decision making). The client's belief system is very important. Personal experiences and culture greatly affect how the client will respond to pain, suffering, treatment, and caregivers. For example, if the client thinks that asking for medication will annoy the nurses, then the nurse can expect this client to suffer in silence. Conversely, some clients believe that dramatics will serve them well in securing more attention and more frequent medication administration, and the nurse can expect to see more acting out behaviors. The learned potential inhibitors are counterbalanced or modified by education. Nurses need to identify "inhibitors" in order to plan educational interventions for clients so that they are well prepared to make informed and ethical decisions on their own behalf.

Using the nursing process, the nurse collaborates with the client (and significant others) in devising the client's plan of care within this decision-making model. As can be noted from the model, the nurse is responsible for the application of ethical principles. The results of the decision revert

back to the client as the recipient of care. Additionally, the nurse uses the model in making day-to-day decisions when prioritizing care for groups of clients, for determining how and when to medicate clients, and how and what to teach.

DISCUSSION

The application of Greipp's Model of Ethical Decision Making to the care of clients experiencing pain clarifies the ethical process in two ways: by defining essential ethical principles within the center of the model, and by delineating relevant variables on both the caregiver's and care recipient's sides that can dramatically alter the outcome of the decision-making process. The value of this application for the practitioner lies in its diagrammatic structure, which assists in identifying areas of weakness in the decision-making process. The model makes evident the power of potential inhibitors to contribute to the violation of basic ethical principles and to negate the framework, thereby denying clients their rights to safe and effective pain relief. All of the causative factors identified in the research studies cited in this article can be located within Greipp's model. Locating the violation is essential before planning remediating strategies.

Having examined relevant literature and having applied Greipp's model to further examine the problem of undermedication for pain, one finds the implications for nursing very clear. There is an overwhelming need to further educate nurses about narcotic and other analgesics and their use in providing safe and effective pain relief for clients of all ages, from all cultures, who are experiencing pain. Individual nurses must take the moral and ethical responsibility for self-assessment of knowledge and competence levels on a periodic basis and for planning ways to remedy deficiencies.

Nursing must continue to stress the ethical nature of all decisions involving self and others, which virtually encompasses all of nursing practice. Nursing must find ways to make its practitioners more cognizant of the powerful potential of "learned potential inhibitors" to enlighten or bias nurses as caregivers.

"There is nothing in human experience more central than our capacity to feel, and no aspect of this so crucial as our capacity to suffer, perhaps more particularly to suffer from extremes of physical pain."[36(p281)] Pain continues to be an ethical problem because it is subjective and qualitative in nature, with the potential to dehumanize its victims, who are dependent upon caregivers for objective assessments and knowledgeable, timely, compassionate, and effective care.

Each professional nurse, by virtue of the ANA Code of Ethics, carries the responsibility for right behavior and right knowledge. Accepting anything less for those recipients of care experiencing pain is to condemn them to needless suffering and perhaps spiritual devastation.

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