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WHY IS PAIN STILL UNDER-TREATED IN THE EMERGENCY DEPARTMENT? TWO NEW HYPOTHESES

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KEYWORDS: Philosophy, Medical; Acute Pain; Emergency Medicine; Pain Management; Ethics; Oligoanalgesia

ABSTRACT

Across the world, pain is under-treated in emergency departments (EDs). We canvass the literature testifying to this problem, the reasons why this problem is so important, and then some of the main hypotheses that have been advanced in explanation of the problem. We then argue for the plausibility of two new hypotheses: pain's under-treatment in the ED partly owes to (1) an epistemic preference for signs over symptoms on the part of some practitioners, and (2) some ED practices that themselves worsen pain by increasing patients' anxiety and fear. Our argumentation includes the

following logic. Some ED practitioners depart from formal guidance in basing their acute pain assessments on observable features rather than on patient reports of pain. This is potentially due to an epistemic preference for signs over symptoms which aims to circumvent intentional and/or unintentional misrepresentation on the part of patients. However, conducting pain assessments in line with this epistemic preference contributes to the under-treatment of pain in at least three respects, which we detail. Moreover, it may do little to help the practitioner circumvent any intentional misrepresentation on the part of the patient, as we explain. Second, we examine at least four ED practices that may be contributing to the under-treatment of pain by increasing patient anxiety and fear, which can worsen pain. These practices include the failure to provide orienting information and the partial objectification of patients required to problem-solve along lines pre-established by modern medical science. We conclude by touching on some potential solutions for ED practice.

INTRODUCTION

Across the world, pain is under-treated in emergency departments (EDs). In this article, we begin by summarising the literature that testifies to this problem and then outline the reasons why this problem is so important. We then canvass some of the main hypotheses that have been advanced in explanation of the problem, including the outdated notion that preserving pain assists diagnostically. We then outline two new hypotheses that we go

on to elaborate in full and whose plausibility we argue for: pain's under-treatment in the ED partly owes to (1) an epistemic preference for signs over symptoms on the part of some practitioners, and (2) some ED practices that themselves worsen pain by increasing patients' anxiety and fear. We conclude by explaining how basing pain assessment on signs rather than symptoms presents several disadvantages, and may do little to help the practitioner circumvent any intentional misrepresentation on the part of the patient. We also touch on some potential solutions for ED practice when it comes to the problem of increasing patients' anxiety and fear. For simplicity, we focus on pain that is severe, acute and not post-operative, cancer-related or chronic.

THE PROBLEM

Over the last 25 years, a substantial body of scientific literature has arisen testifying to the under-treatment of pain in the ED. In 1989, Wilson and Pendleton coined the term 'oligoanalgesia' to characterise the problem of analgesia being apparently 'forgotten'; they found that 56% of studied patients received no analgesic medication in the ED despite having been admitted 'with a variety of acutely painful medical and surgical conditions'.¹ While ED clinicians have expressed doubts about the

¹ Oligoanalgesia in the Emergency Department. *Am J Emerg Med* 1989; 7: 620-623: 620.

persistence and pervasiveness of the problem,² which ‘is often not felt to be present ‘in my ED’’,³ systematic failures to adequately treat pain in EDs continue to be observed and studied across countries and sub-populations.⁴ In 2007, the first prospective, multi-centre study confirmed earlier observations, finding that

pain in the ED continues to be poorly treated. Our population reported high levels of pain intensity, both on ED arrival and at discharge, with relatively small changes in pain intensity scores during the ED stay.⁵

² S.M. Green. There Is Oligo-Evidence for Oligoanalgesia. *Annals of Emergency Medicine* 2012; 60: 212-214; S.H. Thomas. Management of Pain in the Emergency Department. *ISRN Emergency Medicine* 2013: 19.

³ D.E. Fosnocht, E.R. Swanson & E.D. Barton. Changing Attitudes About Pain and Pain Control in Emergency Medicine. *Emerg Med Clin North Am* 2005; 23: 297-306: 5.

⁴ Ibid.; Thomas, *op. cit.* note 2; S.H. Johnson. The Social, Professional, and Legal Framework for the Problem of Pain Management in Emergency Medicine. *J Law Med Ethics* 2005; 33: 741-760; J. Ducharme. The Future of Pain Management in Emergency Medicine. *Emerg Med Clin North Am* 2005; 23: 467-475; T. Rupp & K.A. Delaney. Inadequate Analgesia in Emergency Medicine. *Ann Emerg Med* 2004; 43: 494-503; R. Sinatra. Causes and Consequences of Inadequate Management of Acute Pain. *Pain Med* 2010; 11: 1859-1871; M.L. Neighbor, S. Honner & M.A. Kohn. Factors Affecting Emergency Department Opioid Administration to Severely Injured Patients. *Acad Emerg Med* 2004; 11: 1290-1296.

⁵ K.H. Todd, et al. Pain in the Emergency Department: Results of the Pain and Emergency Medicine Initiative (PEMI) Multicenter Study. *J Pain* 2007; 8: 460-466: 464.

Indeed, Venkat et al. have argued that ‘concerns surrounding ED pain management have reached a crisis level that should be considered an ethical issue in the profession’ of emergency medicine.⁶

While much of the literature testifying to pain’s under-treatment in the ED has emerged from the United States, the problem is conceivably global. For instance, studies have also emerged from Canada,⁷ Australia,⁸ the Netherlands,⁹ Israel,¹⁰ Costa Rica,¹¹ the Caribbean,¹² and South Africa.¹³

⁶ A. Venkat, et al. An Ethical Framework for the Management of Pain in the Emergency Department. *Acad Emerg Med* 2013; 20: 716-723: 716. For a similar argument not specific to the ED, see B.A. Rich. A Legacy of Silence: Bioethics and the Culture of Pain. *Journal of Medical Humanities* 1997; 18: 233-259.

⁷ Todd, et al., *op. cit.* note 5; J. Ducharme & C. Barber. A Prospective Blinded Study on Emergency Pain Assessment and Therapy. *J Emerg Med* 1995; 13: 571-575; Rupp & Delaney.

⁸ M. Fry, S. Bennetts & S. Huckson. An Australian Audit of ED Pain Management Patterns. *J Emerg Nurs* 2011; 37: 269-274; A. Holdgate, S.A. Shepherd & S. Huckson. Patterns of Analgesia for Fractured Neck of Femur in Australian Emergency Departments. *Emerg Med Australas* 2010; 22: 3-8.

⁹ S.A. Berben, et al. Pain Prevalence and Pain Relief in Trauma Patients in the Accident & Emergency Department. *Injury* 2008; 39: 578-585.

¹⁰ Z. Zohar, et al. Pain Relief in Major Trauma Patients: An Israeli Perspective. *J Trauma* 2001; 51: 767-772.

¹¹ T.J. Jantos, et al. Analgesic Practice for Acute Orthopedic Trauma Pain in Costa Rican Emergency Departments. *Ann Emerg Med* 1996; 28: 145-150.

¹² C. Macpherson & D. Aarons. Overcoming Barriers to Pain Relief in the Caribbean. *Developing World Bioethics* 2009; 9: 99-104.

Indeed, the problem may well be exacerbated in some countries, where ‘political conflict, social dislocation, and inadequate availability of analgesia conspire to make the relief of acute pain sporadic at best’.¹⁴

The under-treatment of pain in the ED is a significant medical and ethical issue. Pain is the most common reason why people present to the ED, being the primary reason for between 42%¹⁵ and 78%¹⁶ of patients. Moreover, access to adequate pain management is increasingly conceptualised and promoted as a human right.¹⁷ The IASP has made a formal declaration, asserting the right of all people to have their pain acknowledged, to be informed about how their pain can be assessed and managed, and to have access, without discrimination, to appropriate pain assessment and

¹³ R.-M. Jansen. Inadequate Treatment of Pain: Time for the South African Courts to Redress This Human Rights Violation? *Medicine Law* 2010; 29: 497-522.

¹⁴ F. Brennan, D.B. Carr & M. Cousins. Pain Management: A Fundamental Human Right. *Anesth Analg* 2007; 105: 205-221: 206.

¹⁵ M.J. Pletcher, et al. Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in US Emergency Departments. *JAMA* 2008; 299: 70-78.

¹⁶ P. Tanabe & M. Buschmann. A Prospective Study of ED Pain Management Practices and the Patient’s Perspective. *J Emerg Nurs* 1999; 25: 171-177.

¹⁷ Jansen, *op. cit.* note 13; Brennan, et al., *op. cit.* note 14; M.J. Cousins, F. Brennan & D.B. Carr. Pain Relief: A Universal Human Right. *Pain* 2004; 112: 1-4; S.H. Johnson. Relieving Unnecessary, Treatable Pain for the Sake of Human Dignity. *J Law Med Ethics* 2001; 29: 11-12; D. Lohman, R. Schleifer & J.J. Amon. Access to Pain Treatment as a Human Right. *BMC Med* 2010; 8: 8.

management from adequately trained health care professionals.¹⁸ There can be no doubt that this right is asserted partly in view of the now widely acknowledged consequences of under-treating pain. Under-treated acute pain contributes to poorer physical and mental health outcomes and increases the risk of chronic pain.¹⁹

Pain does not need to be under-treated. There is rarely any good clinical reason for under-treating pain – for example, for deferring or completely avoiding the use of pain medication in cases of severe, acute pain. In particular, the use of pain medication need not be deferred for the purpose of preserving clinically important symptoms and signs and thereby assisting diagnosis. Fosnocht has observed that to under-treat pain in the service of diagnosis reflects outdated thinking.²⁰ Most of the time, there is no need to prioritise diagnosis above pain management: therefore, ‘[t]reatment of pain should parallel the search for diagnosis of a patient’s underlying condition, and has now become the standard of care’.²¹

Why, then, is pain nonetheless under-treated in the ED? One answer is that Fosnocht’s standard of care is not always met: some practitioners are outdated in their thinking, holding onto the view that under-treating pain

¹⁸ International Pain Summit of the International Association for the Study of Pain.

Declaration of Montreal: Declaration That Access to Pain Management Is a Fundamental Human Right. *J Pain Palliat Care Pharmacother* 2011; 25: 29-31.

¹⁹ Sinatra, *op. cit.* note 4.

²⁰ Fosnocht, et al., *op. cit.* note 3.

²¹ *Ibid.*: 297.

assists diagnosis.²² For example, in 2001, Zohar et al. found that ‘The belief that pain assists diagnosis was the main reason (78.6%) for withholding analgesia’ from major trauma patients in Israeli EDs.²³ More recently, Todd et al. wondered whether the observed failure to reassess pain intensity after ED arrival ‘perhaps mirrors our traditional view of pain as a diagnostic indicator rather than an outcome deserving of attention in its own right’.²⁴

Numerous other hypotheses have been advanced concerning pain’s under-treatment in the ED. Many have centred on inadequate pain assessment on the part of practitioners. There is clear evidence that ED practitioners systematically under-estimate patients’ pain.²⁵ At least three explanations have been offered for this under-estimation. First, practitioners can have an outdated understanding of pain, approaching pain as proportional to tissue damage and under-appreciating the role of individuating factors, such as a patient’s expectations and emotions.²⁶ Second, social distances between

²² Berben, et al.: 584.

²³ Zohar, et al.: 767.

²⁴ Todd, et al., *op. cit.* note 5, p. 444.

²⁵ A.J. Singer, et al. Comparison of Patient and Practitioner Assessments of Pain from Commonly Performed Emergency Department Procedures. *Ann Emerg Med* 1999; 33: 652-658; L. Marquié, P.C. Sorum & E. Mullet. Emergency Physicians’ Pain Judgments: Cluster Analyses on Scenarios of Acute Abdominal Pain. *Qual Life Res* 2007; 16: 1267-1273; V. Guru & I. Dubinsky. The Patient Vs. Caregiver Perception of Acute Pain in the Emergency Department. *J Emerg Med* 2000; 18: 7-12.

²⁶ D.B. Morris. 1991. *The Culture of Pain*. Berkeley: University of California Press; E.J. Cassel. 2004. *The Nature of Suffering and the Goals of Medicine*. 2nd edn. Cary, NC, USA: Oxford University Press.

practitioners and some patient sub-populations (for example, by virtue of racial and ethnic differences) can impair pain assessment and management.²⁷ Finally, practitioners can suspect patients of drug seeking and consequently of fabricating or exaggerating their pain.²⁸ The addictive nature of pain medications, especially opiates, has given rise to at least two further hypotheses for why pain is under-treated in the ED. First, practitioners can practise defensive medicine, being overly cautious of the legal ramifications of providing addictive pain medications.²⁹ Second, patients can refuse and fail to request analgesic for fear of iatrogenic addiction.³⁰

Pain's under-treatment in the ED may also partly owe to two types of gaps: gaps in the evidence base concerning pain and its treatment, and gaps in the medical curriculum. (The medical curriculum constitutes one central means by which to translate an evidence base into practice. Clinical guidelines constitute another.) For example, gaps in the evidence base have been filled when it comes to the true frequency and severity of acute pain episodes

²⁷ C.R. Green, et al. The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain. *Pain Med* 2003; 4: 277-294; J.H. Tamayo-Sarver, et al. Racial and Ethnic Disparities in Emergency Department Analgesic Prescription. *Am J Public Health* 2003; 93: 2067-2073.

²⁸ Johnson, *op. cit.* note 4.

²⁹ *Ibid.*

³⁰ *Ibid.*; Tanabe & Buschmann, *op. cit.* note 16; J.S. Martin & R. Spirig. [Pain Prevalence and Patient Preferences Concerning Pain Management in the Emergency Department]. *Pflege* 2006; 19: 326-334.

related to sickle cell disease. Practitioners have tended to believe that sickle cell pain is ‘the exception rather than the rule’, but evidence now suggests that the opposite is true.³¹ Practitioners seem to have under-estimated the frequency of pain episodes because, most of the time, patients have simply managed their often-significant pain at home. And this under-estimation may have contributed to practitioners wrongly regarding patients frequenting the ED with sickle cell pain as ‘difficult’.³² In short, pain’s under-treatment may partly owe to medicine’s limited, still-improving understanding of pain and its treatment. Gaps in the medical curriculum have also been highlighted amid calls for change. For instance, Macpherson has observed that, astonishingly, ‘[m]edical curricula and textbooks typically omit information on how to relieve or prevent pain’.³³ In view of this, she has argued that ‘[p]ain management should be introduced in preclinical curricula and reinforced during clinical education in both rich and poor nations’.³⁴ Others have taken care to add that practitioners ought to be vested not only with the technical knowledge and skills to reduce pain,

³¹ W.R. Smith, et al. Daily Assessment of Pain in Adults with Sickle Cell Disease. *Ann Intern Med* 2008; 148: 94-101.

³² E.J. Bergman & N.J. Diamond. Sickle Cell Disease and the ‘Difficult Patient’ Conundrum. *Am J Bioeth* 2013; 13: 3-10.

³³ C. Macpherson. Undertreating Pain Violates Ethical Principles. *J Med Ethics* 2009; 35: 603-606.

³⁴ *Ibid.* See also Macpherson & Aarons, *op. cit.* note 12.

but also with the understanding that pain is not merely symptomatic of, and of secondary importance next to, some more objective medical condition.³⁵

Despite the fact that a range of hypotheses have been advanced for why pain is under-treated in the ED, Johnson has argued that disappointing results from interventions designed to improve ED pain management suggest that ‘the reasons and root causes ... are still not well understood’.³⁶

There are at least two further possible reasons why pain is under-treated in the ED. These two reasons may underlie others, particularly helping to explain why ED practitioners systematically under-estimate patients’ pain levels. The two reasons are worthy of investigation in their own right, but they may also help to explain why other reasons have yet to be acted on in ways that substantially improve pain management in the ED.

First, an epistemic preference for signs over symptoms on the part of some practitioners may result in delays in the use of pain medication, in the systematic under-estimation of patients’ pain, and in patient perceptions of distrust on the part of their practitioners. These perceptions of distrust lead onto the second further possible reason why pain is under-treated in the ED. ED practices may themselves worsen patients’ pain by increasing patients’

³⁵ D. Resnik & M. Rehm. The Undertreatment of Pain: Scientific, Clinical, Cultural, and Philosophical Factors. *Medicine, Health Care and Philosophy* 2001; 4: 277-288; W. Ruddick. Do Doctors Undertreat Pain? *Bioethics* 1997; 11: 246-255.

³⁶ Johnson, *op. cit.* note 4, p. 743. For a list of hypotheses not specific to the ED, see Resnik & Rehm, *op. cit.* note 35.

anxiety and fear. Practitioners may not be sufficiently aware that anxiety and fear worsen pain, and that patients' anxiety and fear can be increased by practitioners appearing to distrust patients, withholding information that could otherwise help to orient patients, and objectifying patients under what Foucault termed 'the medical gaze'.³⁷ The rest of this article develops this argument.

THE ARGUMENT

1. An epistemic preference for signs over symptoms

Internationally endorsed clinical guidelines advise practitioners to base their acute pain assessments on the patient's report, for the reason that pain is highly individual and therefore cannot be inferred solely from the mechanism of injury, the extent of tissue damage, or any other observable feature:

Self-reporting of pain should be used whenever appropriate as pain is by definition a subjective experience ... There are no objective measures of 'pain' but associated factors such as hyperalgesia (eg mechanical withdrawal threshold), the stress response (eg plasma cortisol concentrations), behavioural responses (eg facial expression), functional impairment (eg coughing, ambulation) or

³⁷ M. Foucault. 1989. *The Birth of the Clinic: An Archaeology of Medical Perception*.

London: Routledge.

physiological responses (eg changes in heart rate) may provide additional information.³⁸

However, there is evidence that some ED practitioners do not base their acute pain assessments on the patient's report, assigning more importance to features that they can directly observe. Marquié, Sorum and Mullet found that ED clinicians 'appeared to act, in rating patients' pain, as if they were readjusting each patient's rating in response to its degree of 'discordance' with the other information'.³⁹ That is, if a patient reported severe pain but demonstrated less-than-expected pain behaviour, for example, then the ED clinician seemed to revise down the patient's pain rating in proportion to the difference; the greater the difference, the more the ED clinician revised down the patient's own pain rating. Similarly, Bijur et al. found that ED practitioners 'do not use patients' self-reported pain as the major indication for use of opioid analgesics'.⁴⁰ Instead, ED practitioners seemed to attach

³⁸ P.E. Macintyre, et al. 2010. *Acute Pain Management: Scientific Evidence*. 3rd edn. Melbourne: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine: xx, 37. This document is promoted as 'the foremost English-language resource of its type worldwide' (Ibid.: iii). It is recommended by the American Academy of Pain Medicine and endorsed by the IASP and professional colleges in the UK, Ireland, Malaysia, Singapore and Hong Kong.

³⁹ Marquié, et al., *op. cit.* note 25, p. 1270.

⁴⁰ P.E. Bijur, et al. Lack of Influence of Patient Self-Report of Pain Intensity on Administration of Opioids for Suspected Long-Bone Fractures. *J Pain* 2006; 7: 438-444: 442.

more weight to observable features, such as the mechanism of injury, for patients with fractures were ‘more likely to receive opioids than patients with comparable degrees of pain but without fractures’.⁴¹

Evidence that, contrary to formal guidance, at least some ED practitioners do not base their acute pain assessments on the patient’s report can potentially be explained by an epistemic preference for signs over symptoms. That is, some ED practitioners may put greater epistemic store in signs than in symptoms, seeing signs as objective but symptoms as subjective and, therefore, of lesser import. To understand this, it is helpful to briefly explicate the symptom-sign distinction as it is typically applied.

Symptoms are experienced then reported by the patient to a practitioner, who records them as part of a history. By contrast, signs are obtained via observation on the part of a practitioner, with observation taking the form of a clinical examination or diagnostic test. Along these lines, pain is a symptom, but tenderness is a sign, for it is elicited by the practitioner during clinical examination. There are signs (for instance, a palpable mass) void of corresponding symptoms, and vice versa (for instance, a headache). Both symptoms and signs require interpretation. But conceivably more interpretation is required in the case of symptoms, insofar as the practitioner must sometimes translate what the patient says into terms tractable to current medical knowledge, while signs are already elicited in these terms. Furthermore, symptoms can be unintentionally misrepresented. For

⁴¹ Ibid.

instance, the patient can describe them imprecisely or remember them incorrectly. Symptoms can also be intentionally misrepresented: they can be fabricated, exaggerated or hidden by the patient, whereas signs typically cannot. Tenderness is atypical here: with effort on the part of the patient, tenderness can be fabricated, exaggerated or hidden, so a practitioner may opt to distract the patient as a means of shoring up confidence that the tenderness elicited is not being intentionally misrepresented – that it is serving as a typical sign.

In the case of acute pain management in the ED, the practitioner may, for example, begin by basing their pain assessment on the mechanism of the medical problem, as indicated by observation, clinical examination and diagnostic tests. The patient history (qua record of symptoms) simply serves to guide the clinical examination and diagnostic tests (which produce signs). In undertaking clinical examination, the practitioner specifically looks for what a patient cannot misrepresent, such as tenderness elicited under distraction, as indicated by involuntary pain behaviour, such as physical movements and facial expressions. Distracting the patient while examining them can increase the practitioner's confidence that the patient's pain behaviour is indeed involuntary and thereby not fabricated, exaggerated or hidden. The practitioner may then adjust their pain assessment (up or down) according to the quality and, in particular, involuntariness of the patient's pain behaviour beyond the clinical examination proper, the patient's own report of their pain, any accumulating

oddities or inconsistencies in the patient's account, and the pain assessments of fellow practitioners.

Alternatively, a practitioner may simply accept the patient's report of pain (qua symptom), having no epistemic preference for signs over symptoms that would lead them to do otherwise. Such a practitioner may, for example, then adjust their pain assessment (up or down) only in the event that a very different pain level is strongly suggested by one or more signs (such as tenderness elicited under distraction) or other pieces of information (such as the patient's pain behaviour outside of the clinical examination proper). Even then, the practitioner may only be willing to adjust their pain assessment up, in recognition of some patients' stoicism, and not down, refusing to act on a suspicion of drug seeking for fear of denying pain medication to someone in pain. Moreover, the practitioner may be highly selective in the signs and other pieces of information that they allow to inform their pain assessment. For instance, a practitioner may disregard facial expressions if these could issue from nausea more than pain. The approach outlined in this paragraph seems more in line with clinical guidelines than the approach outlined in the previous paragraph.

At least three adverse consequences result from ED practitioners not basing their acute pain assessments on the patient's report out of an epistemic preference for signs over symptoms.

First, delays in the use of pain medications occur. Pain assessment of the kind exemplified in the first example often takes an appreciable amount of time, and can even be inconclusive. This may result in delays before effective pain medication is employed, or even in the complete denial of effective pain medication. Pain medication delays and denials can both constitute forms of under-treating pain.

Second, not basing pain assessment on the patient's report often results in pain levels being under-estimated, not over-estimated, as indicated by empirical research testifying to practitioners' systematically under-estimating pain levels.⁴² In turn, this under-estimation will lead to under-treatment, for instance in the form of under-medicating for pain.

Finally, openly conducting pain assessments that focus on observable features rather than the patient's report can result in the patient perceiving distrust on the part of the practitioner. The patient can reason that, in not having their pain report accepted at face value, they are distrusted by the practitioner. This perception may be correct, for the practitioner may distrust the patient, for instance, suspecting drug seeking. Alternatively, the patient's perception may be incorrect, for the practitioner may be enacting an epistemic preference for signs over symptoms that is devoid of any suspicion of patient dishonesty (intentional misrepresentation). Instead, the epistemic preference may rest on a concern to circumvent any unintentional

⁴² Singer, et al., *op. cit.* note 25; Marquié, et al., *op. cit.* note 25; Guru & Dubinsky, *op. cit.* note 25.

misrepresentation in the patient's report of pain. Whether correct or incorrect, the patient's perception of practitioner distrust is problematic in view of its consequences: it can induce or increase patient anxiety and fear, which in turn can worsen the patient's pain. This leads onto the second reason why pain may continue to be under-treated in the ED.

2. ED practices themselves worsen pain by increasing patients' anxiety and fear

A second reason for why pain may continue to be undertreated in the ED lies in the possibility that ED practices are themselves worsening patients' pain. Current pain science suggests that anxiety and fear can worsen pain,⁴³ and some ED practices may themselves be worsening pain by increasing patients' anxiety and fear. We hypothesise that at least four ED practices may be doing this.

First, ongoing pain can itself be cause for anxiety and fear. In this respect, under-treating pain can initiate a vicious cycle, in which pain escalates.

This is one argument against delaying pain medication, for instance, and we explained above how delays follow from a practitioner not basing their

⁴³ Macintyre, et al., *op. cit.* note 38; D.D. Price. Psychological and Neural Mechanisms of the Affective Dimension of Pain. *Science* 2000; 288: 1769-1772; P.J. Quartana, C.M. Campbell & R.R. Edwards. Pain Catastrophizing: A Critical Review. *Expert Rev Neurother* 2009; 9: 745-758.

acute pain assessment on the patient's report out of an epistemic preference for signs over symptoms.

Second, we also explained above how the patient can perceive distrust on the part of the practitioner when the practitioner does not accept the patient's report of pain at face value, and how this perception can increase patient anxiety and fear. Indeed, there is evidence that, if a practitioner suspects that a patient is exaggerating their pain, then the practitioner will provide pain medication but its effectiveness will be reduced.⁴⁴ This is conceivably because the practitioner's distrust is perceived by the patient and, being interpreted as something of a threat, results in increased anxiety and fear and, in turn, worsened pain.

Third, ED practitioners sometimes do not provide information that could otherwise help to prevent or reduce patients' anxiety and fear. There is evidence that ED practitioners do not provide patients with enough information to put them at ease:

The complex, discontinuous and fragmented nature of ED consultations can result in loss of knowledge transfer, inadequate and confusing explanations and interpersonal insensitivity to the patient ... Often patients do not have a clear understanding of how

⁴⁴ J. Miner, et al. Patient and Physician Perceptions as Risk Factors for Oligoanalgesia: A Prospective Observational Study of the Relief of Pain in the Emergency Department. *Acad Emerg Med* 2006; 13: 140-146.

long a procedure will take, how long an absence will be or what will happen to them next. The patient can therefore experience the ED as a journey to a foreign land—disorienting, confusing and alienating.⁴⁵

The withholding of such orienting information, be it intentional or unintentional, will often increase patient anxiety and fear. Take the example of an ED patient who receives no effective pain medication because of the potential for harmful side effects, but is not told this reason. Ongoing pain can itself be cause for anxiety and fear, but especially so in the absence of information as to why the pain is not being treated. For instance, the absence of such orienting information can lead the patient to question how much the practitioner does and can care about them, and how far the practitioner would and can go for them. In this way, the unexplained under-treatment of pain can itself worsen pain by increasing patients' anxiety and fear, again initiating a vicious cycle.

Finally, ED practitioners objectify the patient in a particular way, and this can be cause for patient anxiety and fear. Foucault characterised modern medicine in terms of 'the medical gaze', which objectifies the patient in terms of a complex array of parts and mechanisms.⁴⁶ Approaching the

⁴⁵ D. Slade, et al. 2011. *Communicating in Hospital Emergency Departments. Final Report — Executive Summary*. Sydney: Sydney University of Technology: 7, 21. See also R. Body, et al. Not All Suffering Is Pain: Sources of Patients' Suffering in the Emergency Department Call for Improvements in Communication from Practitioners. *Emerg Med J* 2015; 32: 15-20.

⁴⁶ Foucault, *op. cit.* note 37.

patient partly as a complex array of parts and mechanisms constitutionally risks a split or ‘bifurcation’ between different modes of human engagement: one mode is purely ‘curative’, aimed at efficiently correcting damaged parts and awry mechanisms, while the other mode is ‘caring’ and compassionate in the richer, more traditional senses, focused on the person.⁴⁷ In other words, ‘management’ of the patient – or, more precisely, of the complex array of parts and mechanisms with which the patient is partly identified – can be distinguished from a ‘care’ that attends more to the whole person of the patient and, indeed, draws more on the whole person of the practitioner. Bishop et al. have observed this split in the intensive care unit, and conceivably it occurs also in the ED. Other writers have observed of the ED ‘a culture that supports significant detachment from patients’⁴⁸ and missed opportunities ‘to build rapport and create relationships with patients’.⁴⁹ These features may be attributed partly to pressures specific to the ED, but also to the broader character of modern medicine, as studied by Foucault.

The objectifying approach described above can enable the practitioner to more efficiently problem-solve along lines pre-established by modern medical science, especially under time and staffing constraints. However, it can also produce in the practitioner a behaviour and comportment that the patient can experience as objectifying and dehumanising, namely as a lack

⁴⁷ J.P. Bishop, J.E. Perry & A. Hine. Efficient, Compassionate, and Fractured: Contemporary Care in the ICU. *Hastings Cent Rep* 2014: 36.

⁴⁸ Johnson, *op. cit.* note 4, p. 743.

⁴⁹ Slade, et al., *op. cit.* note 45, p. 7.

of care, thereby inducing or increasing patient anxiety and fear. Moreover, this experience for the patient can conceivably be intensified by a patient's pain giving rise to a deeply felt need, not only for pain relief, but for compassion as a human being who is suffering.

ED patients and practitioners are usually strangers to one another, never having been in a therapeutic relation to one another.⁵⁰ Therefore, their trust in one another depends on purely immediate and localised acts. In this respect, ED practice necessarily contrasts with the ideal of primary care. ED patients and practitioners have not had the time to build the kind of trust that can serve as a ballast against subtle acts and omissions which might be cause for distrust, and thereby for anxiety and fear for the patient. In this respect, the ED encounter is a comparatively fragile thing, and ED patients are especially vulnerable.

If, as we have argued, ED practices can themselves worsen pain by increasing patient anxiety and fear, then the use of pain to monitor both a patient's condition and the effectiveness of their pain management is problematic. In other words, the pain story gets so complicated that it is hard to use it clinically. This is because pain severity can track, not only the patient's condition and pain management, but also how the patient is responding to the ED and its practitioners. This problem is exacerbated if, due to particular ED practices, the patient feels more pain but nonetheless

⁵⁰ R.M. Ratzan. Ethanol and Embrace: Emergency Medicine and the Health Care Giver-Patient Relationship Revisited. *J Emerg Med* 2003; 24: 335-339.

shows less. Early research on how perceiving a ‘social threat’ influences a person’s pain and associated facial expressions suggests that this may occur in some situations.⁵¹ A social threat turns on how one is treated by others or, more precisely, on what others will seemingly allow one to suffer. If particular ED practices can result in a patient ‘feeling more pain but showing less’,⁵² then it is not surprising that practitioners often observe inconsistencies between the patient’s pain report, pain behaviour and clinical signs. As discussed earlier, these observed inconsistencies result in practitioners revising down patient’s pain ratings and thereafter under-treating pain.⁵³

CONCLUSION

We have argued that there may be at least two hitherto-unexamined reasons why pain continues to be under-treated in the ED. First, an epistemic preference for signs over symptoms on the part of some practitioners may be resulting in delays in the use of pain medication, in the under-estimation of pain levels, and in patient perceptions of practitioner distrust which can themselves worsen pain by way of increasing patients’ anxiety and fear. Second, a number of ED practices may be worsening patient’s pain by

⁵¹ P.A. Peeters & J.W. Vlaeyen. Feeling More Pain, yet Showing Less: The Influence of Social Threat on Pain. *J Pain* 2011; 12: 1255-1261.

⁵² Ibid.

⁵³ Marquié, et al., *op. cit.* note 25.

increasing patients' anxiety and fear. In principle, these practices can be changed for the better, or at least tempered in their adverse effects.

First, there is usually no good clinical reason for delaying or denying effective pain medication. By contrast, there are good reasons for the ED practitioner to base their acute pain assessment on the patient's report, in line with formal guidance. Basing pain assessment on signs rather than symptoms presents several disadvantages, as touched on above, and no persuasive advantages. For instance, it may do little to help the practitioner circumvent any intentional misrepresentation on the part of the patient.

While drug seeking is fairly common in the ED, accounting for one fifth of all ED visits,⁵⁴ patient deception is very difficult to detect: one review found that practitioners correctly identified actors only 10% of the time, with some patients being mistaken as actors.⁵⁵ Moreover, a practitioner may do well to trust patients as a matter of principle,⁵⁶ and may refuse to risk delaying or denying pain medication for a patient in pain, reasoning that the wrong of this delay or denial outweighs the harm of feeding an addiction.

⁵⁴ Zechnich and Hedges estimated that while only 2.4% of ED and urgent care patients were drug seekers, this small proportion of patients accounted for 20% of all visits (2.4% = 30/1259, while 20% = 379/1889). A.D. Zechnich & J.R. Hedges. Community-Wide Emergency Department Visits by Patients Suspected of Drug-Seeking Behavior. *Acad Emerg Med* 1996; 3: 312-317: 314.

⁵⁵ B. Jung & M.M. Reidenberg. Physicians Being Deceived. *Pain Med* 2007; 8: 433-437.

⁵⁶ W.A. Rogers. Is There a Moral Duty for Doctors to Trust Patients? *J Med Ethics* 2002; 28: 77-80.

There is rarely any justification for withholding orienting information from the patient. Such explanations as may be offered tend to focus on time and staffing shortages, and these are matters which require remedial action at a hospital or government level. By contrast, ED practitioners are commonly justified in partially objectifying the patient to better problem-solve along lines pre-established by modern medical science. Indeed, this practice seems endemic to the whole of modern medicine. However, in principle, the adverse effects of this practice, being a potential source of patient anxiety and fear, can be ameliorated. For instance, a practitioner can take care to knowingly and openly oscillate between contrasting modes of human engagement, one 'caring', the other more narrowly 'curative'.⁵⁷ Alternatively, a practitioner can seek to exhibit the first mode of engagement while conforming to the second in their underlying thought processes, though questions clearly follow as to how successfully they will be able to do this and whether they ethically ought to wear such a mask.

We hope to at least provide ED practitioners, in particular, with argumentation that can enhance their reflective understanding of their practice and therein their capacity to share this understanding with their patients. If our argumentation is sound, then sharing such orienting information may help to remove at least one potential cause of pain's under-treatment in the ED.

⁵⁷ Bishop, et al., *op. cit.* note 47.

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