EDITORIALS

Haven't Got Time for the Pain

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Haven't Got Time for the Pain

*I haven't got time for the pain
 I haven't got room for the pain
 I haven't the need for the pain
 Not since I've known you...¹*

In 2007, Philip Longman argued in his book that the “Best Care Anywhere” could be found at the Veteran’s Health Administration (VA).² Although the declaration was met with some snickers from the media and the lay public who had been conditioned to remember their grandfather’s VA Hospital of the 1970s, there is truth to the argument that the VA has outperformed even the best public hospitals in terms of common quality indicators.^{3,4} Central to Longman’s argument is the existence of what few in the business will dispute is the best information technology system in medicine today.^{2,5}

Despite a health care system that provides doctors with routine screening data on pain, the work by Zubkoff and colleagues in this issue of *JGIM* suggests that providers seldom utilize this information to tailor their health care plans.⁶ Perhaps, as Carly Simon crooned, health care providers simply “Haven’t got time for the pain.”

But do the findings reported by Zubkoff et al. imply failure of a decade-long campaign to make pain the “fifth vital sign” or merely reflect poorly chosen quality measures? A high quality indicator is one where the numerator and denominator are clearly defined and the best available evidence suggests a correct course of action. The four pain quality indicators examined in this study were: (1) Did the health care provider note the presence of pain? (2) Did the provider characterize the quality of pain? (3) Was the degree of pain control noted? (4) Was there intensification of pain treatment?

Let’s consider the chosen quality indicators in the following three case vignettes:

- Case 1: A 56-year-old patient with sarcoma presents to your outpatient clinic with 4/10 pain. He looks uncomfortable.
- Case 2: A 24-year-old otherwise healthy male with a history of substance abuse who presents with 6/10 pain and feels cheated because his application for being service connected has recently been denied. The patient is angry.

Case 3: A 52-year-old working professional with a history of a T10 disk avulsion that leaves him with positional neuropathic pain. An extensive workup completed by his non-VA affiliated pain specialist and trails of multiple medications have left the patient stating that the impact of the treatment on his executive cognitive function is worse than the 4/10 pain that he experiences when he overdoes it. He is visiting for a routine blood pressure check, medication refill, and has no other complaints.

In the first case, the majority of providers would agree that inaction on all four of the quality indicators reflects a substantial problem that should be rectified. Nevertheless, even in this case, there are occasions where the targeted goal for persons with advanced cancer might very well be more than zero. If the first patient came into the office appearing comfortable and reporting pain scores of 3–4, there may be nothing more to do.

The same conclusion on the quality indicators would certainly not be reached in the other two cases. The difficulties inherent in managing pain in persons with substance abuse are complex and often need the expertise of the multidisciplinary team. In this case, the interpretation of whether the four QIs were met really is dependent on whether a pain assessment was done at a previous visit and whether a care plan had been formulated. Clearly, any change in the treatment approach needs to be carefully considered in this population and may not be warranted despite vehement complaints by the patient. This is an important concern given nearly one-half of the patients in this sample had a history of substance abuse.

Finally, the third case reflects the unfortunate situation where we must acknowledge the limits of our current treatment approach for pain. There are some cases (particularly with neuropathic pain) where the medication side effects on executive cognitive function can limit their usefulness and patients may decide that non-pharmacologic treatment (or no treatment) is the best course of action. If pain is not the focus of the visit, should providers be held responsible for documentation?

These vignettes are not intended to dismiss the highly relevant findings presented in this paper or the well-intentioned “fifth-vital sign” program at the VA. It is well known that providers have long dismissed pain management in a variety of clinical settings.^{7,8} The conclusions reached in the paper go further than simply indicating whether providers utilized the screening tool by assessing whether their perceptions, as measured by the Numeric Rating Scale (NRS), played a role in their pain management. Yet, the stark question is why are

health care providers not acting on patients' report of a numeric rating scale that would suggest severe pain?

Rather than rush to blame health care providers, we urge that these results represent an important opportunity to improve through rapid cycle quality improvement.⁹ Important first steps include the collection of additional data to better understand the patients' perceptions of their pain management. Furthermore, it is important that we assess why health care providers are not incorporating NRS scores—particularly for moderate to severe pain—into their treatment decision making. One of the outcomes of this additional effort may be refinement of the quality measures, practice redesign to remove barriers to health care providers delivering state-of-the-art pain management, or both.

In conclusion, auditing pain is not as simple as measuring whether an ACE inhibitor has been initiated in a diabetic or whether aspirin is being used after a myocardial infarction. It is not all or none. When considering pain, it is imperative that we consider patient-centered measures such as whether or not an individual patient's goals for pain management have been met and what their perceptions of the quality of their pain management are. The VA has led the country in the implementation of the electronic medical record. These results present a new challenge, an important one that the VA should take on—improving pain management in the outpatient setting. Indeed, the health care providers must have time for assessment of pain and formulate an individualized care plan that is consistent with the best available evidence regarding the management of chronic pain in the outpatient setting.

Disclaimer: The opinions expressed in this article are those of the two authors and not the Veterans Affairs Administration or the United States government.

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