



ON MY MIND

By Karl Steinberg, MD, HMDC, CMD

Pain Can Be a Total Pain

Benjamin Franklin wrote in a letter to Jean Baptiste Le Roy in 1789, “Our new Constitution is now established, and has an appearance that promises permanency; but in this world nothing can be said to be certain, except death and taxes.” Before Franklin, in 1716 Christopher Bullock had written in his book *The Cobbler of Preston*, “Tis impossible to be sure of any thing but Death and Taxes.” “Death and taxes” is a commonly used phrase to express two inevitable things in life, but I believe there are other inevitable experiences, and one of them is pain.

Since this issue of *Caring* has a special focus on pain and it’s a topic of perennial interest to our readers who try to ameliorate pain in our patients, we’ll consider the subject of physical pain. Also, the clinical practice guideline and pocket guide of AMDA – The Society for Post-Acute and Long-Term Care Medicine have been recently updated (available at <https://bit.ly/painCPG>), and they are great resources for PALTC clinicians.

Pain can be physical, emotional, psychosocial, spiritual, existential, or dwell in other categories, and it may combine multiple domains — resulting in what Dame Cicely Saunders called “total pain.” Some of us may privately quip, “These fibromyalgia patients *are* a total pain,” but the fact remains that each patient’s subjective pain experience is something that we as clinicians can commiserate with and attempt to ameliorate, but we are not living the experience ourselves. We must have the grace to acknowledge that we don’t fully understand all the factors — including past trauma — that play into an individual patient’s lived experience and perception of pain.

While there are physiological correlates of pain, physical pain is largely a subjective phenomenon. Pain scales, while still widely used and certainly of some clinical utility, are not reliable in all patients who can self-report a pain score. Some patients may rate an acute hip fracture a “2,” while others who are lying comfortably in bed dozing off, with a respiratory rate of 10, will say their pain is “11 out of 10.” Of course, part of our sacred responsibility to our patients is to alleviate suffering, and we generally take what our patients tell us about their pain to be accurate.

Some patients are very averse to pain and prefer aggressive measures to minimize or avoid it (including opioids and other potentially sedating, habituating, or otherwise harmful medications). Other patients want to avoid being overly sedated and don’t mind some level of pain if they can remain alert,

awake, and cognitively intact. Still others (just to be clear, not including me) believe they derive a redemptive value from suffering and do not want any medical intervention.

As prescribers, we need to be respectful of our patients’ preferences for pain treatments, practice person-centered care, and use a shared decision-making process. Especially for patients nearing the end of life, we should not be overly stingy with opioids. With chronic pain, the peer-reviewed evidence for the efficacy of opioids has been disappointing, but I suspect all of us prescribers have had patients in whom opioids have been a godsend, the difference between constant misery and a reasonably tolerable existence. For most nursing home residents, concerns about self-administration of escalating doses and possible overdoses do not loom as large as in the community because we have nurses both administering the medications and monitoring for adverse events.


Specific medications may be particularly useful in neuropathic pain, including serotonin-norepinephrine reuptake inhibitors (SNRIs) like duloxetine, anticonvulsants like gabapentinoids, and — if tolerated — tricyclic antidepressants or methadone. Corticosteroids can be exceptionally useful for a variety of pain etiologies but carry significant risks. Patients with severe pain and a history of substance use disorders can present special challenges, and it may be necessary to obtain consultation from specialists in addiction, pain, or palliative medicine. Medications that are less commonly prescribed for typical pain such as buprenorphine, methadone, and even (puzzlingly) low-dose naltrexone have proven especially useful in some of my more difficult clinical scenarios.

We are quick to pull out the (virtual) prescription pad and medicate our patients for pain because that’s what we were trained to do. But we may sometimes forget to consider other approaches. Combining modalities can yield better results than a single strategy. A good body of evidence exists for non-pharmacological interventions in many kinds of physical (somatic and neuropathic) pain, and these should be part of every treatment plan. Many of these techniques are available to residents of PALTC settings, including some manual techniques (via physical therapy), cognitive behavioral therapy, and mindfulness techniques. Even simple things like demonstrating a deep breathing and visualization exercise at the bedside may empower patients with an easy tool to distract them from pain, especially for

people who spend as much time in bed as many of our PALTC residents. And whatever the scientific evidence may be, there is certainly little harm in utilizing prayer if that resonates with our patients.

Active listening and acknowledging the emotional toll of pain on our patients can also strengthen the therapeutic alliance. Being able to articulate that we are sorry the patient is suffering; that we will continue to walk the path with them and seek out solutions together; that we wish we could completely relieve all their pain (but recognize this is probably an unrealistic goal); that we realize it must be difficult for them to bear the pain at times; and that we acknowledge that they are trying — all of these types of statements can serve to relieve at least some of our patients’ stress and anxiety, if not the pain itself.

Pain is indeed inevitable, and it’s especially common in our care setting, but it

does not have to become all-encompassing or make our patients’ lives miserable. Even though patients with severe, chronic, or seemingly disproportionate pain may be a challenge to us as clinicians, it’s important for us to treat each case as a unique and precious soul — and to use shared decision-making and all the tricks in our bag to practice truly compassionate, person-centered care when trying to ameliorate and palliate their pain. And we should always be willing to ask for help when we feel we are falling short. 

Dr. Steinberg was the 2021–2022 president of AMDA – The Society for Post-Acute and Long-Term Care Medicine and is editor emeritus of *Caring for the Ages*. The author’s views are his own and do not represent those of the Society nor any other entity.



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