

Competent Treatment in the Absence of a Universal Definition of Pain

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Cunningham raises important issues about the ethical issues facing pain researchers and practitioners and the need to ensure that far more must be done to eliminate needless pain. I suggest that inadequate knowledge and lack of will are more of a problem than lack of agreement about a suitable definition of pain. In the absence of a universal definition, education and legislation are needed to ensure competent treatment, particularly for those whose capacity to communicate is limited. **Key words:** *ethics, pain definition, education, legislation.*

It is gratifying to see that philosophers are beginning to speak to pain scientists and practitioners. Far too few philosophers (two) belong to the International Association for the Study of Pain (IASP). Far too few papers published on pain include terms such as *philosophy* or *philosophical* (fewer than 0.2% of the nearly 80,000 pain papers indexed in Medline for the period 1988–1998). During the past century, the intellectual leadership exerted by philosophers and theologians has largely given way to the authority of scientists, physicians, attorneys, and politicians. The same holds true with regard to considerations about pain.

Cunningham has applied philosophical concerns to our everyday world and has raised some profound issues. Having welcomed Professor Cunningham's presentation and, indeed, enjoyed much of it, does not indicate that she and I are in full agreement. For one, she is harsher than I might like (I doubt whether Anand and Craig set out to "appease" other IASP members; I cannot agree that compassion and ethical responsibility are "anti-scientific notions"; I see no reason to assume

that clinicians consider patients who cannot verbalize their pain as being "morally tainted"). For another, I do not share the political emphasis of the paper (I would rather call a pain report that leads to ameliorative action something like *recognized pain* rather than *politically validated pain*; I am not sure that it is useful to assert, "Objective observers of pain do not understand themselves as potential political validators, only as scientific validators"). We differ throughout on matters of interpretation and emphasis. Still, we agree on two fundamental issues. First, that there are important ethical issues facing pain researchers and practitioners as well as the societies that represent them. Second, that far more needs to be done to ensure that individuals do not suffer needless pain.

The percentage of pain papers in the 1988–1998 period that directly deal with ethical issues (0.5%) is still shamefully meager. It is apparent that ethical matters are not foremost in the pain literature, but they certainly are not entirely neglected. Cunningham should take comfort, as do I, from the published evidence that many pain specialists share her concerns about ethical practice. I believe that she is wrong to conclude that most clinicians are unsympathetic to those who cannot articulate their pain, that a faulty definition of pain is at the heart of patient neglect, and that pain is too complex for us to address fundamental treatment issues.

Cunningham suggests that "pain is so slippery, so close to the edge of chaos" because of "elements like the possibility of multiple, simultaneous subjective experiences in the same person." In my laboratory, as I write, a subject is scaling the apparent intensity and the apparent unpleasantness of graded noxious stimuli and no chaos is evident. The McGill Pain Questionnaire [8], the Multidimensional Pain Inventory [6], and the studies of psychophysical researchers [11] suggest that one can utilize a large range of procedures to assess the sensory, affective, and cognitive components of the pain experience.

I will grant that we are far better able to assess

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subjective experiences in those whose intellectual state and linguistic ability is above average; we will have to work harder to develop valid indices of pain in infants, in those suffering from mental deficiencies, and in others whose communication abilities are compromised. I will grant that there are those who still vainly await a "pain thermometer" that provides an "objective" measure of a person's pain and suffering (one that they hope will come in the form of an electroencephalogram, a thermogram, or a functional neuroimage), while I believe that pain is and will remain a "subjective" experience that no clinician, insurance company, or government agency can ethically dismiss. I will grant that medical personnel are often dismayed and frustrated by individual differences in pain expression, variability in treatment success, and inability to predict outcome (although this should be greatly ameliorated as we develop the ability to tailor treatment to a patient's physiological, biochemical, and psychological characteristics [16]).

I do not, however, place the blame for this on the IASP definition of pain ("an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"), unsatisfactory as it may be. Clearly, we are at a time when disagreements about definitions can have powerful ramifications, as demonstrated by our inability to agree on such apparently simple terms as *is* or *sex* [12]. Still, *sex* goes on. Still, *pain* goes on.

The IASP definition has some nice touches, but it is incomplete and cumbersome. Moreover, I share Cunningham's unhappiness that the definition includes a number of notes, with one that states, "Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons" [9]. That clause suggests that it is logical to accept the null hypothesis, and it marginalizes patients whose underlying physical disorder is difficult to identify. Even fervent believers in the biopsychosocial model might be discomforted by recent findings that a referral diagnosis of "psychogenic pain" frequently misses significant organic abnormalities [5].

The definitional problems, however, do not stop me from conducting my research (even if we had a definition that garnered universal approval, researchers would still need to select operational definitions to inform their choice of measurement tools). They do not stop competent clinicians from treating their patients.

In my professorial role, I also lack definitions of *yellow*, *intelligence*, *love*, *abnormal*, and a host of other terms prominently used by psychologists and others. Failure to adequately define *yellow* (the *Random House College Dictionary* defines it as "of a bright color like that of butter, lemons, etc.; between green and orange in the spectrum") has not blocked researchers from conduct-

ing psychophysical and neurophysiological investigations on a whole host of problems in color vision, including studies of color perception in very young infants [1,15].

The *Random House College Dictionary* definition of pain is not much more satisfactory than its definition of yellow: "bodily suffering or distress, as due to injury or illness." It will not surprise many to learn that things quickly become circular. *Suffer* is defined as "to undergo or feel pain or distress," while *distress* is "acute physical or mental suffering; pain, anxiety, or sorrow." The *Oxford English Dictionary* is not much better. The definition of pain offered there is "A primary condition of sensation or consciousness, the opposite of pleasure; the sensation which one feels when hurt (in body or mind); suffering, distress."

We cannot stop pain investigations while committees search for an alternative definition. Candidate definitions abound (although I am certain that none of these authors really believed that they were offering the definitive denotation): "Pain is what hurts" [3], "pain is a highly complex phenomenon that by its very nature precludes objective assessment" [4], "pain is only an abstract word which has no real existence" [14], and "pain is whatever the patient says it is and exists whenever he says it does" [7]. The last will not help abate Cunningham's concern about young children, the senile, or the comatose. The second and third initially impel us to throw up our hands at the impossibility of the task but, upon reflection, stress the subjective nature of pain. The first may cover all human and lower animal situations but is, of course, hopelessly circular.

I suspect that it is the courts, in concert with the pain societies, that will assume the leadership role in defining pain. While Cunningham and I may disagree about the role of faulty definition as the villain, we agree that many pain patients are being poorly assessed by medical practitioners and, thus, poorly treated. These instances of malpractice seem to be due to inadequate knowledge, inadequate time, inadequate will, and inadequate empathy rather than inadequate definitions. Solving the definition problem, even if achievable, will not solve the more fundamental ones.

The problem of inadequate knowledge is being addressed, in impressive ways, by organizations such as the IASP, the American Pain Society (APS), the American Medical Association, the Project on Death in America, and patient advocacy groups such as Compassion in Dying. Likewise, federal bodies such as the National Cancer Institute and the Agency for Health Care Policy and Research have supported efforts to improve pain treatment for cancer patients. Medical institutions are being asked to integrate adequate pain management into clinical practice [2]. States are establishing statutes,

regulations, and guidelines that mandate pain evaluation and appropriate treatment for acute pain and intractable pain associated with malignancy and for chronic, nonmalignant pain. The APS drive to make pain visible, including routine measures of pain intensity on patient charts as the "fifth vital sign" (which raises the joint responsibility of health care professionals, patients, and the health care system to assure effective assessment and optimal pain management) should remind physicians, nurses, and other providers of the need to attend to pain and should reassure patients and their families that pain relief is a primary goal.

Where advocacy fails, legal sanctions are needed to provide the necessary motivation. The U.S. Supreme Court, in deciding *Vacco v. Quill* (117 S. Ct. 2293 [1997]) and *Washington v. Glucksberg* (117 S. Ct. 2258 [1997]) held that terminally ill patients have a right to receive aggressive pain control. Justice Stevens, in his concurrence on the latter case, stated, "Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly '[a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.'" Increasingly, courts will find that "not to relieve pain optimally is tantamount to moral and legal malpractice" [10]. Increasingly, juries will be made aware that pain and stress can compromise the immune system and hasten death [13]. Cunningham, I, and the readers of *Pain Forum* can take comfort from the realization that those practitioners not guided by ethical concerns will face disciplinary actions and liability exposure for their inattention to the pain of their patients.

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