COMMUNICATION CHALLENGES

Knowing versus understanding

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It was a moment of new-mom pride. My first son had just learned his numbers and I liked to show off how smart he was. "Show us how you can count to ten, Stevie." His grandparents were visiting from out of town, and they nodded encouragingly. I was excited for them to see what I'd taught Stevie. Stevie tucked his hands into a fist and swayed as he counted, "one, two, three, four, five, six, seven, eight, nine, and ten." He clapped his hands when he said ten, just as I always did. I had taught him his numbers and was so proud. A few minutes later as we sat around chatting, my father-in-law asked Stevie, "Hand me two cookies." That was when I saw the difference between knowing and understanding. Stevie could not pick out two cookies or five cookies because numbers were nothing more than something to recite to interested relatives. Stevie knew his numbers but he didn't understand them.

THE CHALLENGE

We nurses are often the ones who teach patients about the Numeric Rating Scale (NRS) for rating their pain, the old, "Rate your pain from one to ten, ten being the worst pain you can imagine." We are trained to measure everything from blood pressure and temperature readings to the color and quantity of urine. So it makes sense that we have a way of measuring pain. We easily assume that using the rating scale numbers is a means of being objective, and to an extent it is. But there are variables that we cannot always account for, and without taking them into consideration it can give us a false sense of security in our use of the NRS. If we only ask our patients to rate their pain without putting it into context, it can be like when my son recited his numbers. It looked like he knew his numbers, but it turned out he didn't.

Our reliance on the NRS may mean there are times when we are undertreating pain in spite of the best of intentions. We routinely ask patients about their pain level, and we chart their report. Depending on the number, we may ask if they need more pain medication. We believe our patients understand the number system; after all, use of a pain scale is a standard of care. And we taught them. When they tell us a high number, we consider whether to medicate. Our assessment includes looking at the patient, but a patient may look comfortable even when they are not. They may be distracted by family or may have their own ideas of when to take medications. For patients who cannot express pain, we are instructed to "assume pain is present" if we believe we would feel pain in the same situation. With many of our oncology patients, including those who can articulate their level of pain, we might also assume pain is present if they are in a condition that would be considered to be painful. Bony mets, for example.

How do we communicate beyond the barriers? The barriers may belong to the nurse, the patient, or the family and friends who are with the patient. Recently I saw a man in for a consult for XRT. He had prostate cancer with mets to his spine. He reported difficulty with sleep and ADLs because of pain. But he also reported a reluctance to take any medication. His wife nodded her head as he revealed this to me. Their agreement about the usefulness of pain medications was a conspiracy of sorts. They both bought into it, but it was Mr. Jones who bore the weight of their joint decision. He was suffering, but was so afraid of taking Percocet that he accepted the suffering. We discussed what taking more medication would look like, and he then nodded as if what I said made sense. One educational session seemed to make the difference.

To be an advocate for our patients, we need to be sure we set mutual goals. Too often we set the goal we believe the patient should achieve rather than the goal the patient wishes to achieve. Another patient, Mr. Smith had an inoperable spread of his cancer to his mouth/jaw. XRT was not an option. He refused more chemo. When we first met, he had a large protruding area along his right jaw line. It was reddened and I immediately assumed it had to be painful. We discussed the pain scale, which he reported being familiar with, then he rated his pain as 3 out of 10. I tried a different tack. What was his comfort goal? He insisted he was at his goal. He gave no visual signs of discomfort, but I was certain he did not understand the pain scale. A few weeks later he was admitted to the hospital for failure to thrive. By then the tumor had fungated through the skin. He reported that he was comfortable enough and did not need anything more than Tylenol, which he took mostly for the headaches he had.

Prior to his hospitalization, he and his wife had chosen a multilevel assisted care facility. He wanted to move in so he could die there; that way his wife would be settled. We explained that hospice could be arranged for the facility and they would help keep him comfortable. Still he refused. Mr. Smith returned one more time to the hospital when he had a GI bleed. His mandible was visible by then. In my mind, he had to be in agony. He continued to refuse hospice. He said repeatedly, “I don’t need it.” I still felt we were undermedicating him. On the morning that he transferred to the facility, I thought it was worth a final reminder to him that pain medication was available. He nodded, “I know. I really do know.”

One principle of pain assessment is that we do not have to believe a patient’s report of pain, but we do need to accept it.

THE DISCUSSION

On the surface these two cases are very different. The first was a case where time spent with the patient and family explaining the importance of adequate pain management resulted in a change in behavior. The second represents a case where it seems that no amount of time and education resulted in a change. Knowledge does not necessarily convert to action. But after the fact, when I had a chance to reflect on both cases, I remembered that one principle of pain assessment is that we do not have to believe a patient’s report of pain, but we do need to accept it. I assumed Mr. Smith did not understand my instructions because he did not start taking pain medication. I kept thinking that with more knowledge he would understand and then change his behavior. The communication challenge was about accepting Mr. Smith’s report of pain. It was about me understanding what I thought I knew. It was about accepting his choice. ■

Discussion question

1. Think about the last time you were surprised that a patient did not seem to understand your instructions about pain management. What did you change in an attempt to clarify your instructions?

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