GUESTEditorial

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The Evolution of Pain Management Nursing

During the first half of my nursing career, my focus was in the maternal-child health care field. My husband's career in the U.S. Air Force required multiple transfers to various areas in the U.S., and with each move I took a new job within that specialty. I approached the management of pain in my patients without much regard and fought it with the most common weapon in the arsenal at the time: intramuscular (IM) opioid injections. Most patients were immobile and highly dependent on nurses for the first 48 hours of opioid pain management, largely because they were too nauseated or sedated to do much else.

In the late 1980s, my husband was transferred to Louisiana, where I worked on a gynecology unit in the largest private hospital in the state. Around this time anesthesiologists nationwide began to provide infusion therapies, such as intravenous (IV) patient-controlled analgesia (PCA) and epidural analgesia, for the management of postoperative pain. Many of my patients underwent major gynecologic surgery and received these therapies. I was immediately struck by the improved level of comfort and functional outcomes of those who had IV PCA or epidural infusion therapy compared with traditional IM opioids. With minimal coaxing, the women were up and about, performing their self-care activities and ambulating in the hallways. Rather than lying in a hospital bed for 2 days, they were ready to go home.

It did not take long for me and the other nurses on my clinical unit to appreciate the large interindividual differences in patients' analgesic requirements, and that with some fine-tuning of the analgesic dose (titration), we could maximize their comfort, reduce adverse effects (AEs), and improve their functional abilities. Phone calls to anesthesiologists requesting orders to add nonopioids and increase or decrease analgesic doses were common.

The improvement in patients' comfort and AE profiles on that gynecology unit was led by an incredibly insightful anesthesiologist, Lex Hubbard, who suggested that I work with his group to expand the nurse's role to nurses on all of the clinical units in the hospital. I agreed, and over the next 4 years we developed and implemented a well-organized acute pain service that provided superior pain management to the majority of patients with acute pain in the hospital. The overriding goals of the service were to improve functional outcomes and reduce length of stay. Key to these goals was the multidisciplinary development of criteria by which nurses made decisions about analgesic dose based on patient response (a precursor to today's range orders).[1] The concept that we could dramatically impact patient care through individualized goal-setting and teamwork became a reality. Soon, nurses and anesthesiologists in other areas of the country began to do the same in their hospitals as we were doing in ours. By virtue of their assessment skills and 24-hour, 7-days-a-week presence, frontline nurses were increasingly recognized as the patient's primary pain manager, a role that has withstood time and has expanded over the years.[2,3] The American Nurses Association has long identified the provision of comfort measures and prevention of pain as nursing responsibilities, and State Boards of Nursing have supported nurses in the expansion of their role to meet these responsibilities.[4]

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With the success of acute pain services in the 1990s, the door was opened to addressing chronic pain of both cancer and noncancer origins. Anesthesiologists and pain service nurses were consulted in

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the inpatient setting to optimize cancer pain treatment regimens and address acute pain in patients with underlying chronic pain. Many anesthesiologists sought specialized training to open chronic pain centers so that they could offer interventional pain treatments. Along the way, nurses were essential to these early efforts to improve quality of life and rehabilitate people with chronic pain.

In 1990, coinciding with the advent of acute and chronic pain services was the founding of the American Society for Pain Management Nursing (ASPMN). Seventy nurses from around the country attended the organization's first meeting in 1991. In 1992, as president of ASPMN, I assigned a task force to investigate role delineation and the possibility of specialty certification. In 2005, 13 years later, nurses from all over the country sat for the first exam to achieve certification in pain management nursing. Today, the ASPMN Annual Meeting draws an attendance of more than 500 nurses; the organization will celebrate its 23rd meeting this year.

In 1999, the VHA became the first major health care system to make the treatment of pain a priority by designating pain as the "5th Vital Sign."[5] This preceded the historic release of comprehensive pain standards and subsequent surveys of inpatient pain practices by the Joint Commission in 2001.[6] In 2009, the VHA issued a directive establishing a Stepped Care Model for Pain Management and provided renewed focus on the treatment of pain.[5] Nurses continue to be key to the success of these types of ambitious multidisciplinary approaches to pain care.

Since its founding in 1980, nurses have served on the Board of Directors and Advisory Board of the American Chronic Pain Association (ACPA), a consumer-based organization that educates and helps people with chronic pain establish peer support groups. Throughout 2013, the ACPA will launch its Veterans in Pain Event program, which will focus on teaching veterans with pain in various areas of the country how to become facilitators and establish support groups for other veterans with pain.

Clearly, the role of nursing in the provision of pain care has matured over the past 30 years. In addition to being responsible for pain assessment, administration and titration of analgesics, implementation of nonpharmacologic strategies, and monitoring effects of pain treatments, nurses provide pain education to patients and their families, nursing staff, physicians, pharmacists, and ancillary staff. Nurses serve on, and often codirect, pain committees within their institutions. In both the inpatient and outpatient settings, advanced practice nurses collaborate with physicians to direct and provide comprehensive pain services. Others have made pain research their life's work.

While writing this editorial, I remembered my evolution as a nurse who has cared for people with pain her entire professional life and imagined the endless possibilities after witnessing the link between pain control and improved patient outcomes. The nurse's role in pain management has evolved from simple analgesic administration to appreciating the multifactorial nature of pain and the many AEs when it is undertreated or mismanaged. The evolutionary process continues as we are presented with advances in our understanding of pain and its optimal treatment. One constant, however, is that whether we are providing analgesics to enable a patient to deep breathe and ambulate after surgery or coordinating a comprehensive rehabilitation program for people with chronic pain, nurses are, and always will be, with the patient at every step as primary pain managers. ●

Author disclosures

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