The art of assessing pain

Pain management within the cancer setting still remains a challenge. The art of assessing pain requires teamworking with the patient always at the centre of care. Many researchers have set out to unravel the complexity of pain with the aim of finding better ways to manage it.

Report by: Barry Quinn

Cancer is still perceived by many as a disease that has close associations with pain and death, despite the many advances in care. In reality, most cancer patients will experience some form of pain as they come to terms with living with the illness. Yet pain management remains a challenge; pain is under-reported, misunderstood and often under-treated. Using a creative, team-based multi-modal approach (pharmacological and non-pharmacological), while placing the patient at the very heart of what we do, will enable us to move towards better outcomes and better pain management. The art of pain assessment requires moving beyond the presenting symptom to focus on the whole person and an appreciation of what the pain means to them.

EXPERIENCING PAIN

The etiology of pain is often described as nociceptive, neuropathic or both, and is further classified as acute, chronic, refractory, intractable or breakthrough (Table 1). Yet none of these descriptors adequately capture the human dimension of experiencing pain, and how it can affect the person including their relationship with others, with themselves and with their world. Pain is therefore often described as having physical, psycho-social and spiritual components, which all require attention (Table 2).

Cancer-related pain rarely occurs in isolation from other symptoms and other life events; it is often accompanied by fatigue, sleep disturbance, loss of appetite, anxiety, depression and, in some cases, a sense of being isolated and alone.¹

In her book, Fragile Lives, Beverley McNamara² says that despite the positive changes in healthcare, moving away from...
an approach focused solely on disease, biomedicine still fails to account for the emotional, social, cultural and spiritual complexity of cancer.

Eric Cassell in his book, *The Nature of Suffering and the Art of Medicine*, suggests that a person’s pain is often complex and may be described as suffering when the person feels out of control, when the pain is overwhelming, when the source of the pain is unknown, when the pain is dire, or when the pain is apparently without end. Michael Kearney refers to hidden and less tangible sources of pain, which require the clinical team to address the social, emotional and spiritual components of pain and distress (Figure 1). He rightly asserts that unless these components are considered and addressed, true pain management may not be achieved.

In my own study exploring the process of sense-making among people living with cancer and advanced disease, each person spoke of their experience of pain. While some participants spoke of the actual physical pain of cancer and the treatment(s) required, often their focus was on the more hidden aspects of pain and the impact that having cancer and undergoing treatment was having on their lives. This included the losses they experienced (a body part, fertility, certainty, confidence, choice, control), which were often hidden from public view. Many participants spoke of sometimes feeling separated from those they loved and life itself.

One participant, Nora, a lady in her fifties, living with advanced breast cancer, spoke of her approaching death and her reluctance to leave behind the family she loved. She spoke of the distress the advanced disease and the treatments required were causing her. “The tablets and all were making me so sick... and then you suffered with constipation, everything... and I just wanted to die, I just totally wanted to die…. I was so ill, I thought no, I can’t do this no more, that’s me finished, I am ready to go.”

Another lady, Yvonne, living with leukaemia, spoke of the many intangible losses she was facing, including being separated from her daughter and the life she loved.

“I love being a mother, basically I love my life and I think... the pain of... yes it is the pain... of cancer in a psychological way for me, there is no ending.”

Both Nora and Yvonne’s words reveal

<table>
<thead>
<tr>
<th>Physical</th>
<th>Related to the underlying disease and/or treatment and/or co-morbidities</th>
</tr>
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<tbody>
<tr>
<td>Psychosocial</td>
<td>May include anxiety, depression, loss, fear, sense of being isolated, lack of engagement</td>
</tr>
<tr>
<td>Spiritual</td>
<td>May include loss of meaning, belief, value, certainty, hope, desire to forgive or be forgiven, sense of abandonment, may or may not include religious beliefs</td>
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Table 2. The meaning of pain

Figure 1. Hidden and less tangible sources of pain

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Barry Quinn is Macmillan Lead Nurse for Cancer & Palliative Care at Chelsea and Westminster NHS Foundation Trust, London. He spoke at a packed congress session about his work in the area of pain.

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Adapted (Kearney 1996)
the complexity of assessing a patient’s pain and distress. For many people in this study, a large part of the suffering and distress arose from the personal interpretation of their pain, which was not always visible to others. As a result, many participants felt that people did not understand what they were going through, leaving them feeling ultimately alone.

The art of assessment

Although there are many recognised and validated assessment tools (Figure 2), these alone will not result in a thorough assessment, unless we are willing to engage with these more hidden aspects of pain, and what this means to the individual. The key to the art of assessment lies in both clinical and human skills, requiring sensitivity and humility. This requires the team to create time, to pay attention, to be present and to see the person beyond the symptom (Table 3).

While medicine has tended to focus on the more tangible and treatable forms of pain, there are other less tangible forms of pain which need addressing. Abore et al. suggest that we must be willing to explore our patients’ losses, and perhaps more importantly, if we can tolerate it, we must be present to the depth of their anguish and despair. If we are to truly address a person’s pain, then we need to move away from working in a biomedical model that may avoid, and does not adequately address, the reality of pain and the personal suffering caused by illness.

Research suggests a good assessment calls for a caring practitioner. “Amidst the uncertainty and the painful realities each person had to face, caring was perceived as occurring when another person carried out a simple act of kindness with a caring attitude, which required the other to be attentive.”

Details of the references cited in this article can be accessed at www.cancernurse.eu/magazine