Assessing Pain in Today’s Global Society

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According to the U.S. Census Bureau (2006), 54,965,503 people—19.7% of the U.S. population—speak a language other than English in their homes. Of that population, 44.1% speak English “less than well” (U.S. Census Bureau). Because of this, a large number of patients are not receiving adequate health care (Ginsburg, 2007). One area of concern is the difficulty in assessing and adequately managing pain in patients with cultural and language differences (Fink, 2000). Providing interpreters for all the languages spoken in communities across the country is an impossible task. However, simple, useful tools are available to nurses working with this patient population. The booklet discussed in this article, Pain Management for the Non-English Speaking Patient (Hernandez, Kazi, & Virojphan, 2007), provides nurses with access to 18 different interpretations of the pain scale so they can understand and manage patient pain even if a language barrier exists.

Reviewing the Evidence

Assessment is crucial to pain management and plays a major role in the total symptom experience. Reassessment also may be a vital component (McNeill, Reynolds, & Ney, 2007). However, difficulties with communication can be a major barrier to assessment and other areas of care (Kemp, 1985), possibly because the patient cannot speak English or correctly interpret what the healthcare provider is telling them. The patient may not know how to describe the pain in terms generally used in assessments or may not know the difference in meaning between ac hacking and h drobbing or h urting and s or e (Limaye & Katz, 2006). Without written tools, a nurse may have to locate a multilingual staff member or call a service for an interpreter. Using interpreters can be less than optimal because a nurse cannot be sure what the patient is being told. In addition, if an interpreter service cannot be reached over the telephone, the patient continues to suffer from pain while the nurse waits for the interpreter to arrive. Family members are not always available to interpret and those who are may not fully understand the meaning of what the nurse is saying; however, when they do, they are invaluable in facilitating communication between the nurse and the patient.

An American Pain Society (2004) position statement listed several racial and ethnic identifiers for pain research, one being to “develop and evaluate pain assessment instruments that reflect cultural, ethnic, and linguistic diversity” (p. 2). The Joint Commission for Accreditation of Healthcare Organizations (2004) published standards for assessing compliance that include providing educational materials for patients, families, and staff. Fink (2000) suggested offering patients written material, pain rating scales, or figures to which the patient can point.

Over the years, nursing has been charged with helping all patients receive adequate pain control. Continuing education has focused on the proper assessment techniques and appropriate interventions necessary to achieve this control. However, because of the race and ethnicity of certain patient populations, a language barrier may exist (McNeill et al., 2007). Green et al. (2003) and the U.S. Department of Health and Human Services (2004) documented significant racial and ethnic disparities across all settings for all types of pain. One reason for inadequate pain management for minority patients was difficulty in assessing pain because of language and cultural differences (Bonham, 2001; Smedley, Stith, & Nelson, 2003; Sullivan & Eagel, 2005).

Case Study

Mrs. H, an 84-year-old Egyptian patient, was admitted to the oncology unit for treatment of intractable pain from metastatic ovarian cancer. Despite being a citizen of the United States and living in Texas for 20 years, Mrs. H spoke little English. The nursing staff assessed her for pain every four hours, and she consistently told them her pain level was 0 on a 0–10 pain scale. The nurses reported that she was doing well and was a very good patient who never asked for anything. However, as the nursing student assigned to Mrs. H gave morning care, she noticed the patient grimacing and moving very little in bed. The student asked Mrs. H to assess her pain and again reported a 0 rating on a 0–10 scale. When Mrs. H’s nephew came to visit her later that afternoon, the student asked him to discuss pain control with Mrs. H and translate the meaning of the pain scale. The nephew spoke with the patient and found that she believed the pain rating of 0 indicated that she was not getting any relief from her pain. Through the
nephew, the student was able to explain the use and meaning of the pain scale and together she and Mrs. H were able to get her pain under control.

**Personal Experience**

Despite moving to the United States from Thailand 10 years earlier, the student author of this article has found that explaining herself in English can be difficult if not daunting. The following occurred during a visit to the dentist.

It did not take me long to realize that a language barrier does not lead to efficient healthcare delivery. I had a terribly painful toothache that needed a root canal. My dentist asked me to rate the intensity and describe the level of my pain. I was in such pain that I was surprised that I still had enough sense to understand English! I often tell people that I am 10 years old in English and only speak it when needed. “It’s pain!” I inaccurately replied, not knowing what would be the best word to describe my pain. During the procedure, while I was numbed, I began to question how I could be a competent nurse when it was impossible for me to understand the pain my patients were experiencing. Of course, I knew enough to spell and record the pain as patients described it to me, but I would not know the differences between throbbing and gnawing or even between aching and sore. I did not understand giving my pain a number as I didn’t understand what that meant (P. Virojphan, personal communication, October 18, 2007).

**Developing a Multilingual Assessment Tool**

A pain assessment tool was developed because of the authors’ personal and clinical experiences. The booklet contains several examples of pain scales interpreted into 18 languages (see Figure 1). The students who created the booklet were from Thailand, Pakistan, and El Salvador. They collected the necessary written pain descriptions from both online sources and from various individuals at Texas Woman’s University and in the community, such as a local pharmacist. Twelve languages were compiled from among their classmates alone.

The booklet includes samples of various common pain scales, including numeric, analog, the Wong-Baker Faces Scale, and descriptive words. Aun, Lam, and Collett (1986) found that Chinese patients understood the vertical analog presentation more often because Chinese is read vertically. The Faces Scale is useful for older adult patients, those who are cognitively impaired, and those who do not speak English. By providing various scales for each language, patients can use the one with which they are most comfortable.

**Support for the Pain Assessment Tool**

As the authors worked with the community to develop the booklet, they heard comments that reinforced the need. People in the community were very willing to help because they believed it would fill a great need and some even asked which hospital would be using it so they could go there for care.

The booklet was completed and presented to the nursing staff on several units at the clinical site. The response from the nurses was excellent and they all wanted their own copy. The booklet has been used in each unit for patients who had difficulty describing and rating their pain. In a follow-up evaluation by the students, the only request by nurses using the booklet was for more languages to be included.

**Conclusion**

Managing pain has been a goal of healthcare providers for many years. McCaffery’s research into pain management began in the 1960s and her definition of pain as “whatever the experiencing person says it is, existing whenever he says it does” (McCaffery & Pasero, 1999, p. 17) leads nurses to the single most reliable indicator of pain—patient self-reports. Positive strides have been made in how nurses manage pain; however, almost all patients with cancer have some degree of poorly managed pain during the course of their illness. The issue is greatly compounded when nurses cannot communicate effectively with patients. With the variety of racial and ethnic patients in hospitals today, it would be impractical, if not impossible, to have multilingual nurses available at all times. The booklet, however, is a quick and easily accessible tool for assessing patient pain and providing adequate pain medication.

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References


Bonham, V.L. (2001). Race, ethnicity, and pain treatment: Striving to understand the causes and solutions to the disparities in pain treatment. Journal of Law, Medicine, and Ethics, 29(1), 52-68.


