Psychosocial Aspects of Pain Management:  
A Conceptual Framework for Social Workers on Pain Management Teams

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ABSTRACT. To have a significant impact in the arena of pain management, social workers must be able to articulate social work values and concepts clearly, productively, and compellingly as assets in overcoming identified barriers to pain relief. A literature review concerning vulnerable populations, identified barriers, and related social policies explores alternative perspectives that social workers can bring to a multi-disciplinary team’s efforts to improve the delivery of pain management technology. The article offers a beginning framework for discussions about the profession’s potential contributions. The goal of these discussions is to contribute to encouraging a more pronounced involvement of social workers in pain management issues. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.]

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Health care literature clearly describes serious shortcomings in the treatment and assessment of pain in all clinical settings (American Geriatric Society, 1998; Bernabei et al., 1998; Dotson, 2000; Ducharme, 2000; Ferrell, 1997; Gaston-Johansson, Johansson, & Johansson, 1996; McCaffery & Pasero, 1999; Pargeon & Hailey, 1999; Salerno & Willens, 1996; Weinstein et al., 2000). Although medical science proposes that the pharmacology and technology is available to relieve up to 90% of all pain, studies consistently show that up to 80% of elderly people in nursing homes and 50% of patients in acute care settings suffer unnecessarily from severe unrelieved pain (Gaston-Johansson, Johansson & Johansson, 1996; McCaffery & Pasero, 1999; Pargeon & Hailey, 1999). Medical literature that describes this discrepancy recognizes that, “Well-described barriers, both psychological and educational, contribute to our providing inadequate pain relief” (Ducharme, 2000, p. 592).

One approach to improving pain management services is to identify and address barriers that prevent readily available medical technology from being fully utilized to relieve pain. Interestingly, the barriers to effective pain management described in medical literature relate more to the misinformed personal beliefs of health care providers (i.e., fears about creating addiction in patients and a tendency to assign culpability to patients), undeveloped and inadequate industry policies (i.e., lack of assessment standards), and dysfunctional social mores (i.e., the stigma attached to opioid use even in cancer patients) than to inadequate medical science (Jacox et al., 1994). Thus, the social work profession has a definite role in addressing these types of barriers, constructed from psychological, social, and cultural elements.

On social work’s role in pain management, Glajchen, Blum & Calder (1995) actually consider that, “Under-treated and unnecessary pain represents a failure on the part of the multidisciplinary team, including the social worker, to respond appropriately to the needs of cancer patients” (p. 200). Social workers, utilizing social work values and an empowerment approach, can offer a distinct perspective with which to analyze and overcome many of the identified barriers to effective pain management. The profession’s perspective also forms an alternative theoretical framework, defining barriers in a way that a medical model perspective is less likely to consider.

To have a significant impact in this arena, social workers must be able to articulate social work values and concepts clearly, productively, and compellingly as assets in overcoming identified barriers to pain relief. A literature review concerning vulnerable populations, identified
barriers, and social policies explores how inclusion of a social work perspective provides theoretical alternatives to the “medical model” approach in defining a philosophy of pain management and overcoming barriers. A literature review concerning vulnerable populations, identified barriers, and social policies explores how inclusion of a social work perspective provides alternative theories about how to overcome barriers to pain management. Empowerment practice principles provide a framework with which to create a more thorough understanding of the barriers, potentially improving the effectiveness of ongoing efforts by social workers and multidisciplinary teams to improve equitable access to pain relief. The goal of these discussions is to contribute to encouraging a more pronounced involvement of social workers in pain management issues.

**LITERATURE REVIEW**

**Vulnerable Populations.** Social work is a profession grounded in service to vulnerable populations. That is, the profession’s reason for being is to advocate for individuals and groups oppressed by social institutions. Traditionally, the profession of social work perceives that social institutions tend to maintain power imbalances, often at the expense of women, children, elderly people, and minorities. Social work seeks to expand opportunities for and with people whose opportunities are limited by the oppressive elements of social institutions (Ross, 1998).

Studies that reveal inequitable pain management for women, elderly people, and minorities generally identify a series of myths and misunderstandings held about the people in these categories (Bernabei et al., 1998). Infants and children had been perceived, until recently, as not even having the same capacity to feel pain (Salerno & Willens, 1996). Elderly people were thought to have significantly decreased sensitivity to pain (Salerno & Willens). Finally, pain expressed by women and minorities is still often dismissed as anxiety or as due to cultural differences (Salerno & Willens). The impact of these myths is unrelieved pain.

While the effects of these myths can be readily challenged through research and education, the fact that these myths exist and impact care as they do may indicate that relationships between health care providers and consumers are especially prone to creating vulnerability for consumers. This vulnerability is exacerbated by both the patient’s illness
and a dynamic in the ethic of caring (Olsen, 1993). First, when people are in pain they may be less able to represent themselves, their values, and their needs coherently and convincingly. Second, the dynamic of caring, described as a connection between a provider and patient fostered by specific characteristics of each patient evokes a dilemma when certain characteristics impede a sense of caring on the part of the provider. For example, a patient who smoked or has AIDS because of high-risk behavior is perceived to warrant less compassion and care than does someone who was a victim of an accident. The patient’s perceived responsibility falls somewhere on a “continuum of culpability” and that, in turn, influences how health care providers perceive and care for a patient (Olsen, 1993, p.1698). The dynamic of vulnerability, as a function of how providers perceive consumers, indicates that providers need to be aware of how consumer characteristics may create bias in care giving. The very act of seeking health care services and entering relationships with health care providers can be considered to increase vulnerability for the consumer.

**Barriers to Effective Pain Management.** The literature offers several ways to categorize the barriers to effective pain management. A strong resource with which to build a foundation for social work’s role in pain management is available in the Management of Cancer Pain Clinical Practice Guideline (AHCPR, 1994). The guideline identifies barriers to effective pain management related to health care professionals, to patients, and to the health care industry as a system. It is significant that not one of the barriers indicate a lack of analgesic capability in medical science. Instead, the identified barriers all relate to knowledge, perceptual and policy challenges.

A significant issue regarding the barriers in the AHCPR guideline is that medical science is not implicated. That is, providers supposedly have the drugs and methods available to relieve most pain. Instead, providers, patients, and the health care system are each charged with several shortcomings. Providers have “inadequate knowledge,” “poor assessment” skills, “fear of patient addiction,” and “concerns about regulation of controlled substances” (AHCPR, 1994, p. 17). Patients are reluctant to report pain because they “fear that pain means the disease is worse” (p. 17). Patients are also reluctant to take pain medications that are offered because of the stigma of being considered an addict. The health care system gives low priority to treating pain and imposes financial and regulatory barriers. These barriers represent characteristics of the individuals and systems involved with pain management.
Seven specific barriers were identified in a study by Brockopp et al. (1998). The barriers include; “lack of knowledge, non-facilitative attitudes, inconsistent leadership, poor working relationships, cultural and religious biases, physicians’ fears of legal repercussions, and a lack of resources.” These barriers share common etiology that pain management has a low priority status in health care organizations and professions. The study proposes that the low priority status of pain management will undermine any efforts to overcome the more specific barriers. The study concluded that, “Priorities must change before the management of pain can be seriously addressed” (p. 232).

Additionally, Payne (2000) describes the importance of distinguishing between physical pain and a more holistic sense of suffering. Another barrier is the failure to assess suffering and identify differences between symptom distress and existential distress. This is a significant issue in achieving an overall good pain management outcome. Understanding the whole person is essential to achieving a desirable outcome, even with the perfect analgesic. (p. S13)

The importance of incorporating the patient’s perspective and holistic needs into attempts to relieve pain is crucial. Medical plans of care should consider how patients’ experiences with both illnesses and treatments relieve and create suffering. People suffer emotionally, socially, and spiritually, as well as physically (Welk, 1990). Contemplation of barriers to pain management should include a more comprehensive model of suffering, including the impact of physical pain, social isolation, fear, and despair, so that efforts address a more comprehensive and relevant view of service to the patient.

In sum, barriers to effective pain management can be described as characteristics of the roles and systems involved, as a lack of priority in the health care industry, and as a myopic view of the patient’s experiences and needs. These descriptions provide opportunities for more focused interventions. Consideration of the multi-dimensional nature of inadequate pain management fosters a more comprehensive approach. A significant aspect of the social work profession’s role in pain management is to participate in the formation of contemporary and effective policies that overcome psychological, social, and cultural barriers, with particular attention to the experiences and needs of vulnerable populations.

Social Policies Regarding Pain Management. Three areas of social policy that impact pain management are important to include in this dis-
Discussion; (1) the Joint Commission of Accreditation for Healthcare Organizations’ (JCAHO, 2001) new standards for pain management, (2) federal regulations, and (3) issues related to physician-assisted suicide (PAS). The new JCAHO standards have introduced a source of external accountability for health care organizations. Federal regulations are currently responding to dilemmas of increased abuse of certain medications used for pain. The increasingly prominent issue of PAS can be viewed as an outcome of poor pain management. That is, people who believe that health care providers cannot relieve their pain may advocate for PAS as the only way to get relief.

The JCAHO’s standards on pain management focus on the assessment and reassessment of pain, on patient education about their rights and role in the relief of their pain, and on documentation of assessment and education activities. However, JCAHO does not provide standards about actual treatment methods or outcome expectations. An interesting dilemma arises with the distinction between assessment and treatment activities. Health care organizations and nurses are essentially responsible for the ongoing pain assessment, patient education, and documentation processes, while physicians are responsible for treatment decisions. Thus, while hospitals and nurses have increased accountability under the new standards, physicians’ primary activities in pain management do not.

Federal regulations related to pain management have to do with managing the use of scheduled drugs. Media accounts of increased abuse reveal the difficulty of minimizing abuse of narcotic drugs while not impeding their legitimate use for pain relief (Kalb, 2001). A “principle of balance” needs to be employed to evaluate legislation (Joranson et al., 1999). The principle of balance is defined as, “that government policies to prevent misuse of controlled substances should not interfere with their uses for the relief of pain.” Studies do show that physicians interpret federal and state laws in ways that inhibit how they use controlled substances for pain management (Joransen & Gilson, 1999). The concept of balance recognizes that abuse and appropriate use will always be diametrically related. Thus, efforts must continue to be made to keep pain medications reasonably available for pain management.

The prominence of the issue of physician-assisted suicide is often understood as the public’s reaction to a lack of consistent pain relief (Mitchell, 2000; Preston, 2000). Studies show that people fear severe and unrelieved pain more than they fear death (McCaffery & Pasero, 1999). Other studies show that people who requested PAS withdrew that request when their pain was relieved (McCaffery & Pasero, 1999).
Relationships between providers and consumers of health care services are the arena in which decisions are made about how to deal with difficult chronic illnesses and the accompanying pain and suffering. If the relationships do not foster a full understanding of the patient’s experiences and situation, patients may feel there are no real alternatives to the suffering that begins to erode not only their quality of life, but also their very identity as individuals. Pain precludes the ability to fulfill the roles that make up an individual’s identity. In the context of this discussion, the growing interest in PAS could be understood as an outcome measure to health care providers’ inability to convey competence in relieving pain.

Literature Review Summary. Pain management is a multi-faceted problem. Characteristics of vulnerable populations, dynamics of the interactions between providers and consumers, a low priority status, a myopic view on suffering, and various social policies are examples of issues that have been addressed in the literature. These are all issues that social work theory and expertise can, and should, engage with as advocates for the vulnerable patient populations.

EMPOWERMENT APPROACH IN PAIN MANAGEMENT

An empowerment approach in social work practice is described in the literature as idiosyncratic (distinct to the situation) and multi-dimensional (requiring conceptual development at multiple levels) (Macdonald & Macdonald, 1999; Manning, 1999; Miley & DuBois, 1999; Ramon, 1999;). Although these qualities predispose the framework of empowerment thinking to a pluralistic society, they also complicate actual implementation of empowerment concepts. Miley and DuBois (1999) articulate the challenge as an effort “to translate the assumptions of empowerment, human systems and change into processes that provide a framework for day-to-day social work practice” (p. 5). Manning (1999) adds that, “Empowerment, as a theory and a field of practice, offers an approach that expands and extends the abilities of people to cope with and impact the systems that affect their lives” (p.102).

Research on Interventions Based on Empowerment Theory. Manning offers a review of three research projects that describe consumers’ experiences with empowerment-based intervention models. The first study (Manning & Suire, 1996 as cited in Manning, 1999) revealed the central impact that stigma and other attitudes have on limiting empowerment for human service consumers. Structured communication was
offered as a mechanism to overcome barriers caused by stubborn stereotypes. The second study (Manning, Zibaalesee-Crawford & Downey, 1994 as cited in Manning, 1996) was based on the research question, “What is the experience of empowerment for consumers with serious and persistent mental illness?” (p. 106). Interestingly, while the study was based on interviews with persons who had mental illnesses, institutionalization as a socialization process that requires compliance and dependency, pressuring consumers to “... conform to the role of the patient” is also a common experience for patients hospitalized for general medical care (Manning, p. 109). This second study emphasizes the use of genuine delegation to promote the sharing of power. The final study (Manning, Parsons, & Silver, 1997, as cited in Manning, 1999) identified authenticity, power, opportunity, relationship, and connectedness as important dimensions of empowerment intervention models. These dimensions of consumer experience are supported in an empowerment model that accounts for the attitudes, values, and beliefs of the providers. Consumer leadership, consumer participation in community goals, and purposeful generation of a wide range of life experiences, characterizes program structures that support these dimensions for consumers. Empowerment models rely on a variety of methods that serve to form partnerships between consumers and providers.

Two other sources that discuss research in empowerment intervention models are considered here. First, Staples (1999) provides an extensive list of facilitating techniques and references that are “well documented in the empowerment literature” (p. 132). The list gives additional credibility to the efficacy of empowerment theory based interventions. Second, East (1999) summarizes findings from her study, Project WISE (A Women’s Initiative for Service and Empowerment). The project is “based on an understanding that empowerment occurs in three domains–personal, interpersonal, and political” (p. 155). Staples states that “While the measurement of empowerment outcomes will be important, I believe most essentially that we are creating a community narrative that can hopefully affect individuals, policy and practice” (p. 155). Empowerment practice seeks to facilitate the means by which vulnerable and oppressed populations can gain a voice for themselves. This section presents a theoretical framework for social work involvement in pain management through discussion of the values, assumptions, and theoretical elements of an empowerment perspective.

Social Work Values in an Empowerment Approach. Empowerment thinking is a “framework with principles that operationalize the best intent of our social work code of ethics” (Shera & Wells, 1999 p. 472).
The NASW Code of Ethics (NASW, 1999) provides a set of core values that “reflects what is unique to the social work profession” (p.1). These core values should guide social work’s involvement in pain management. An empowerment framework attempts to articulate social work’s core values as preconditions to effective, respectful, and equitable human relationships.

The values of social justice, integrity, and competence relate to a social worker’s responsibility to be proactive within their host institutions. The value of social justice relates to identifying and advocating for populations that receive differential care. Revealing an inequitable distribution of pain relief is a necessary first step, but social workers must also accept the charge of finding ways to remedy the problem. An empowerment framework offers concepts to define inequities from an alternative perspective and may perhaps suggest that the dynamic of vulnerability of patients has a root cause in the paternalistic nature of provider-patient relationships. The value of integrity calls the social worker to proactively define a role for the profession in pain management because of the implications for people’s lives. Integrity requires honesty, but also active promotion of the values of the profession. The value of competence calls social workers to practice within their areas of competence, but also to expand their knowledge base as issues arise that require interventions.

The value of service calls the social worker to promote an altruistic perspective in their host institutions. Quality pain management requires extensive time for thorough initial assessments, consistent reassessments, and consultation activities for difficult pain syndromes. While the value of placing the patient first would be difficult to openly refute, the reality of service encounters may reveal a tendency to favor expediency. Social workers can draw attention to where an organization’s pain policies and procedures fall on a continuum between efficiency and efficacy. Recalling the multi-dimensional nature of empowerment work, social workers need to look for creative opportunities to increase the priority status of pain management services.

One opportunity supported in the literature could be to complete a cost analysis of the financial benefits involved with providing more effective and consistent pain relief. A study completed at the City of Hope Hospital presents a convincing result. The baseline data revealed a cost of $5 million related to pain issues. The organization implemented a pain program and reported savings of $2.7 million (McCafferey & Pasero, 1999). While financial motivation should not be the core factor
to improve pain management, cost saving can certainly be an effective tool to support needed changes.

The value related to the *dignity and worth of the person* introduces an inquiry about the extent to which the health care organization treats patients as objects or as persons. When providers’ efforts focus on the health problem, instead of the person, the treatments provided may actually aggravate suffering for the person. Payne (2000) states that “good overall pain management” accounts for “existential distress” (p. S13). Social work has traditionally promoted consideration of the patients’ holistic needs in the health care industry (Ross, 1997).

Social work promotes the *importance of human relationships* as a primary vehicle for effective and relevant change. Indeed, Shera and Wells (1999) issue a challenge to, “the expert model of practice and suggest(s) that collaboration to establish working alliances with those we serve is more effective and appropriate” (p. 472). Relationship models currently used in the health care industry do not adequately integrate the dynamic of collaboration.

Social work values provide an alternative and relevant context with which to build models for understanding and overcoming the barriers to effective pain management. Social workers are called, by their professional values: to be proactive in work to increase the priority status of pain management, promote the consideration of patient’s holistic needs, and build collaboration into relationship models. Articulation of how inclusion of social work values strengthens relationships in health care is an important responsibility for social workers in health care.

**Assumptions of an Empowerment Approach.** Miley and DuBois (1999) identify assumptions about human systems, change, and empowerment. Three of these assumptions are important to consider here. The first assumption, related to human systems, is that, “Challenges emerge from transactions between human systems and their physical and social environments rather than reside in clients themselves” (p. 4). When initial attempts to control pain fail, patients are often blamed, labeled, and then dismissed as “whiners.” As patients seek attention more assertively, providers begin to label them as a “drug-seekers” and may even start to limit the supply of pain medication. This process of labeling traps the patient in pain and stigma, leaving them with no legitimate recourse for relief. The tendency of providers to label and blame consumers creates increased vulnerability for health care consumers.

The second assumption, related to change, is that, “Collaborative relationships stimulate feelings of power and lead to actions” (Miley &
DuBois, 1999, p. 4). When patients are allowed to fully describe their pain experiences, including their histories of what has worked and failed in the past, the provider’s efforts become more relevant and effective (Thomasm, 1992; Thomasm, 1994). It is also well known that patients who participate and sense more control in the prescriptive process feel more control and can gain a placebo benefit.

The third assumption, related to empowerment, is that, “Multiple factors contribute to any given situation, and therefore effective solutions are necessarily diverse in their approach” (Miley & DuBois, p. 4). Several factors that contribute to ineffective pain management have already been discussed and three additional barriers are considered here. First, various misunderstandings and myths regarding the nature of pain and the methods for relief influence the relationships between physicians and patients (Bernabei et al., 1998; Cleeland et al., 1994). Second, the functional exclusiveness of the roles of nurses as primary assessors of pain and physicians as directors of treatments potentially complicates pain management when communication between nurses and physicians gets strained. Finally, when physicians order pain medications on a PRN (as needed) basis, patients must often convince nurses they need it and then wait until the nurse can get the drug, which can take up to an hour or more (McCaffery & Pasero, 1999).

These assumptions of empowerment social work practice, once again, highlight the importance of considering transactions, collaboration, and a multi-dimensional approach. Social workers in health care settings who propose to utilize an empowerment practice orientation, “must strive, most especially in the face of managed care and other cost-containment strategies, to create humane and empowering environments for the delivery of services and resources to clients” (Miley & DuBois, 1999, p.10). The degree to which human service interventions can be described as both humane and effective depends upon the extent to which the interventions reflect a nonbiased, collaborative approach and a multi-dimensional view of the situation.

**Theoretical Elements of an Empowerment Approach.** One way to construct a comprehensive empowerment framework that supports a full and effective voice with consumers of human services is to integrate three theoretical elements: an ecosystemic perspective, a strengths approach, and a social justice imperative. Accounting for the influence of these three elements in social work practice is thought to foster a comprehensive and productive understanding of the transactions between social institutions and individual citizens. An ecosystems per-
spective considers that “persons and environments are not separate but exist in ongoing transactions with each other” (Miley, O’Melia, & DuBois, 2001, p. 28). The transactions among the elements of a system possess a dynamic nature in which the elements are constantly adapting to each other. This concept has been employed in the discussion about how vulnerable populations possess characteristics that health care providers react to, either positively or negatively. Pain management transactions have been described as problematic because of the patient’s compromised state, the traditionally paternalistic models of relating to patients, and the potential to blame patients for their conditions and suffering. The ecosystems perspective shifts the focus from looking only at characteristics of providers or patients individually to looking at the characteristics of the transactions, which are influenced by many other elements of society as a system. Working to build a theoretical understanding of the transactions, instead of focusing solely on characteristics of individual roles, accounts for the dynamic multi-dimensional nature of pain management.

A strengths approach, in pain management, challenges the paternalistic model of relating to patients. Patients are the experts regarding how pain impacts their lives, how well any pain treatment actually works, and the value of the treatment related to the balance between the relief and the side effects of the treatment. A strengths perspective assumes that the patient can participate meaningfully in the transactions to develop a plan to relieve physical pain and holistic suffering. Paternalism assumes that patients are ignorant about their conditions and about pain relief methods, with the result of excluding them from the process of making decisions. A strengths perspective fosters a broader view that reveals the patient as the only one who can effectively direct the transactions in a way that eases the overall suffering, not just addressing individual physical symptoms. Patient-led transactions will require a shifting of power to the patient. While creating patient led transactions may take more time initially, the opportunity for the patient to define acceptable outcomes potentially increases the efficacy and efficiency of the transactions.

Power imbalances can be approached incrementally or rationally (Imbrogro, 1999). An incremental approach works to form a compromise between conflicting values and needs. In an incremental approach, the prevailing social structures remain unchallenged. On the other hand, a rational approach seeks to “reconcile competitive paradigms by raising the subject of inquiry to a higher level of abstraction” (p. 84). Con-
Conflicting interests are thus perceived as creating opportunities for more inclusive and powerful social policy. The “higher level of abstraction” in the current discussion is a consideration of the multi-dimensional nature of the transactions between providers and consumers and the importance of replacing paternalism with nonbiased collaboration. The charge here is that the paternalistic models currently directing relationships and transactions in health care do not support effectiveness in pain management. Imbrogro states this succinctly in a call for “changing the basis and nature of the existing power relation” (p. 85).

Finally, Ramon (1999) articulates an important distinction between empowerment work with the individual versus empowerment work with collectives. The extent of paternalism in health care relationships may preclude effectiveness of working to empower individual patients. Empowerment work in pain management may need to be considered from a collective perspective. Ramon is actually critical of Western social work’s focus on empowerment of the individual, and states the need for a “re-interpretation of the place of the collective in our lives and of the relationships between individuals in trouble and the rest of us” (p. 45). Ramon adds that this view has “profound implications for the value base of social work” (p. 45). The responsibility for improving these transactions lies with social institutions of health care, not with individual consumers.

**SOCIAL WORK’S STAKE IN PAIN MANAGEMENT**

Social work traditionally defines and creates its own roles in the health care industry based on its values and a social sanction to advocate for vulnerable populations within social institutions (Ross, 1997). Social work’s perspective is a valuable asset for the multidisciplinary team working to overcome barriers in pain management. The endeavor to create a presence for the profession in pain policy and on multidisciplinary teams dealing with pain management requires that social workers identify their professional stake in pain management practice.

Social work’s stake in pain management is evident in its own history in the field of health care and in its stated professional mission. The history of the profession’s stake in health care is a tradition of advocating for vulnerable populations within an increasingly technocratic health care system (Ross, 1997). Literature clearly indicates that vulnerable populations—especially women, children, the elderly, and
minorities—receive less effective pain management (Cleeland et al., 1994; Gaston-Johansson, Johansson & Johansson, 1996; Morgan & Murphy, 2000; Todd, Deaton, D’Adamo, & Goe, 2000; Wolfe et al., 2000). Social workers in the health care industry, particularly those identified as “medical” social workers, should maintain the tradition of articulating the importance of considering patient’s rights and holistic needs when delivering medical care, drawing specific attention to inequities that exist for vulnerable populations.

The mission of the social work profession, as articulated in the NASW Code of Ethics (1999), is to “enhance human well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (p. 1). Unrelieved pain significantly impacts quality of life for individuals. The effects of unrelieved pain include disruption of family life, interruption of role responsibilities, and destruction of careers (Siepert, 1996). Unrelieved pain also has the potential to erode the individual’s sense of self and perceived value of life (Salerno & Willens, 1996). The financial cost of unrelieved pain is often considered to be among the highest in the health care industry (Siepert). For these reasons, social work has a clear stake in identifying and advocating for populations whose already conscribed vulnerable status is exacerbated by illness and by the more pronounced power differences in a typically paternalistic health care system.

The importance of articulating the relevance of social work constructs and values to pain management practice becomes obvious when the nature of the identified barriers is considered. The traditionally paternalistic medical model of relationships in health care creates a dynamic of vulnerability for all patients. Given the increased prominence of physician-assisted suicide, potential changes in federal regulations related to abuse of pain medications, and increased accountability for adequate pain management, the health care industry may be ready to begin construction of new models for the relationships between providers and consumers. The goal of this paper has been to begin exploration of some basic applications of social work traditions, ethics, and theories. Social workers in hospitals can advocate for individual patients, participate in team meetings, facilitate change in institutional systems, and work in legislative arenas to draw attention to both the inequity and inherent system barriers. Current societal demands for improved pain management services create opportunities for studies that explore the implications of these and other theoretical applications. Social work has
both an ethical responsibility and an enormous opportunity to provide leadership in identifying and working to overcome the psychological and social barriers to effective pain management. The contemporary potential for change in the health care industry is enormous when recent financial and moral challenges are considered.

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