

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 *aching* and *throbbing* or *burning* and *sore* (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. Depart-

ment 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

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