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Undertreatment of pain in older adults: An application of beneficence

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Abstract
Inadequate pain control, especially in older adults, remains a significant issue when caring for this population. Older adults, many of whom experience multiple acute and chronic conditions, are especially vulnerable to having their pain seriously underassessed and inadequately treated. Nurses have an ethical obligation to appropriately treat patients' pain. To fulfill their ethical obligation to relieve pain in older patients, nurses often need to advocate on their behalf. This article provides an overview of the persistent problem of undertreated pain in older adults and explores how nurses can meet this ethical duty through the application of Beauchamp and Childress' three principles of beneficence.

Keywords
Disparities, ethics, nursing, older adults, pain management, patient advocate

More than a decade after pain undertreatment was depicted as a moral outrage,[1] inadequate pain treatment continues.[2,3] Pain relief is possible for almost all patients.[2] Adults above 70 years are the group at the highest risk of the undertreatment of pain.[2]

Nurses have an ethical obligation to appropriately treat older patients' pain.[1] Real change in pain management in elder patients will require more than quality education for nurses. The eradication of the undertreated pain in older adult patients will require an unwavering commitment by nurses to provide pain relief. Nurse pain-management decisions must be based on nursing pain assessments and mutually determined goals set with patients. Pain relief can usually be achieved in older adults through the use of pharmacological or nonpharmacological interventions or a combination of both.

Historically, a primary aim of the nursing profession has been to provide pain relief as part of the alleviation of suffering.[4] However, unrelieved pain is prevalent in patients who are members of specific subgroups, including the elderly.[2,3] Advocacy by nurses is often necessary for patients to receive pain relief.

Beauchamp and Childress proposed that beneficence is a requirement of morality, not only as an intention to do good and prevent pain or harm but also to actually do good and prevent pain or harm.[5] Therefore, a close examination of the problem of pain undertreatment as well as strategies for improvement is warranted.

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In addition, this article explores how nurses can meet their ethical duty to relieve pain through the application of Beauchamp and Childress' three principles of beneficence.

The right of older patients to pain relief

Extreme cases involving nurses who have neglected to treat pain in older patients have resulted in serious legal consequences. The existence of statutes of limitations and award caps for medical malpractice has contributed to recent charges against nurses for elder abuse in cases of pain undertreatment in older patients.[6] Each individual state has a statute that specifies what elder abuse entails for that specific state. There are several types of elder abuse: physical abuse, neglect, or a deprivation of care that results in physical harm, pain, or mental suffering of an elder.[7] Some authors have even claimed that the failure to treat pain or reckless undertreatment of pain in older patients can be legally characterized as elder abuse.[6,8,9]

Previous regulatory efforts to improve pain management include the enactment of laws to permit the therapeutic use of opioids for chronic pain treatment, the incorporation of relief of pain into professional codes of ethics and standards of practice, and the addition of the requirement for pain-management standards in health-care systems.[10] As of 2001, the Joint Commission has had standards for health-care agencies that validate a patient's right to have pain assessed and treated.[11] Therefore, effective pain management could be considered a patient's legal right.

The undertreatment of pain in older adults

Although prevalent in patients of all ages and across all settings, being older than 70 years is the number one risk factor for pain undertreatment.[2] According to the American Pain Foundation (2008), the reasons that may contribute to the undertreatment of pain in older people include misconceptions regarding the aging process, difficulty accessing care, and the stigma associated with admission of pain.[2]

Although research has given little attention specifically to the inequities in pain care,[2] three categories of barriers to effective treatment of pain in older adults have been identified and include patient, health-care provider, and health-care system barriers. Elderly patients traditionally underreport pain, believing it is a part of normal aging.[12] Also, older people may have a fear of addiction, tolerance, hyperanalgesia, and side effects such as constipation or sedation.[13] Many older adults have coexisting conditions that can make pain difficult to manage.[13] The idea that opioids adversely impact the quality of life is also a common misconception.[14] Older patients may think that it is virtuous to hurt or that they should be stoic when in pain.[15] Some older adults may also be subject to delays in mail order deliveries, increased costs due to limited formularies, and high co-pays.[16] Patient barriers often require nurses to negotiate with older patients to overcome patient barriers to establish mutually acceptable goals.

However, nurse barriers interfere with the provision of pain relief in older patients. A significant nurse barrier is the tendency to underestimate a patient's pain and disregard the patient's self-report. This pattern of doubting patient self-reports of pain persists despite improvements in nurse education regarding pain assessment, improved documentation of frequent pain assessments,[3] and decisive directives to improve pain outcomes.[2,14,17] Also, nurses may fear that patients may become addicted or fear the adverse effects of analgesics in older patients.[13] Instead, nurses need to adopt a bias-free approach to pain management that is consistent with the ethical responsibility to seek and trust the patient's self-report of pain.[12] Not surprisingly, undertreated pain continues to be a common concern in the literature.[18]

In addition to patient and nurse barriers, the health-care system presents impediments to the relief of pain. The health-care industry has focused heavily on cure of diseases. A cure-focus may contribute to a minimization of symptom management.[13] However, national efforts are being implemented to encourage health-care workers to provide more patient-centered care to include an attention to patient priorities, such

as the effective management of their pain.[19] As a persistent and resistant problem, a transformational change in the way in which pain relief is provided is needed.[20]

Managing pain in older adults is complex and requires nurses to possess knowledge and skills to assess and manage pain through pharmacological and nonpharmacological means. Older adults are more susceptible to the side effects of many medications used to control pain (i.e. opioids and nonsteroidal anti-inflammatory medications). Therefore, knowledge of current multimodal approaches that incorporate pharmacological and nonpharmacological approaches is needed.[2]

Pharmacologically, a multimodal approach to pain treatment is recommended to minimize these adverse effects in older adults.[2] Opioids and many other classes of medications may be used in the treatment of pain in elder patients. When treating pain, nurses need to be knowledgeable regarding recommended medications for pain as well as dosages for older adults because they differ from recommendations for younger patients. Recently, biologics have emerged as novel analgesics for those with chronic pain. Biologics are believed to have fewer side effects because they are able to act more specifically than other approaches to relieving pain.[21]

Nurses play a primary role in the incorporation of nonpharmacological interventions in a patient's treatment plan. Nonpharmacological interventions for pain are particularly important for older patients because they are more susceptible to adverse effects of pain medications, such as opioids and nonsteroidal anti-inflammatory medications. Nonpharmacological treatments may include physical modalities, such as the application of ice, or interventions to ease psychosocial components of pain, such as music therapy and spiritual care.

Older adults benefit from the creativity that stems from the incorporation of an individualized multimodal approach to pain management. The adverse impact of undertreated pain can be prevented if effective pain relief is provided by nurses. Execution of this individualized approach relies on nurse knowledge regarding the appropriate pain-assessment and pain-management methods. Knowledge and skills for effective delivery of pain-management methods will equip nurses to confidently administer pain treatments.

Empower nurses to provide pain relief to older adults

One of the roles of nurses is the role of nurse advocate. Acting as a nurse advocate involves beneficent actions taken on behalf of patients in order to achieve mutually determined goals. One strategy to begin closing the gap between the knowledge that pain can be effectively relieved and the actual provision of pain relief in nursing practice may be to enable nurses to provide adequate pain relief through the role of a patient advocate. Nurse advocacy is an essential ingredient in quality health-care delivery to older patients.[22] For improvement in the provision of pain relief, nurses need to assume a greater role in pain-care decisions. However, they may lack the knowledge and skills to do so.[22] Empowering nurses to feel confident that they have the knowledge and authority to make pain-management decisions will require appropriate education and administrative support.

Advocacy for the patient is addressed by the nursing profession in codes of ethics. The third provision of the American Nurses Association's *Code of Ethics for Nurses with Interpretative Statements* states that "the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient" (p. 4).[23] Therefore, advocacy is an integral part of the nurse's role for any patient. However, advocacy is often essential for effective pain treatment in older adults. The presence of advanced age, sensory impairment, and illness can serve to increase the vulnerability of older adults to pain undertreatment.[19]

The role of nurse advocate requires astute communication skills. Nurses must investigate and analyze patients and their physical and psychosocial situations to provide effective pain management.[24] This involves the nurse listening and questioning the patient regarding their pain-management goals and

expectation of treatment. Oftentimes, this discussion with the patient involves negotiation and the correction of misconceptions or unrealistic expectations that results in shared decision making.

Incorporation of advocacy training into nursing education curriculum, continuing education, and continuing orientation programs could facilitate better pain management for older adults. As improved pain-management practices are incorporated by bedside nurses, nursing administration can empower nurses to advocate by promoting an atmosphere of collaboration.[25]

Regardless of its etiology, pain is highly subjective. Despite the availability of and utilization of pain-assessment tools, pain continues to be undertreated. Nurses are often reluctant to rely on patient self-report.[26] However, self-report of pain using a validated pain scale is the most reliable indicator of pain and the need for pain relief.[18,26] In addition, pain-assessment tools are widely available for assessing pain in patients not able to provide self-report. These behavioral tools focus on patient behaviors that indicate the presence of pain rather than the incremental ratings of pain.

There is a significant amount of research done in the area of the nurse's role in pain management.[3,25,27–29] A research study that surveyed nurses found that there may be a persistent tendency to inadequately treat pain.[3] The study findings suggested that nurses allow their individual assessment of patient behavior to determine medication intervention decisions rather than the pain rating provided by the patient 40%–50% of the time.[3] This study points to the frequency and prevalence of a central contributor to the problem of unrelieved pain, that of not accepting the self-report of patients. It is clear that significant change is needed at the practice level, but this will only occur with the support of nursing administration.

A second research study surveyed six administrators of health-care institutions in order to understand the complexity of pain-management barriers from their point of view.[27] The researchers identified seven barriers, including the lack of knowledge, nonfacilitative attitudes, inconsistent leadership, poor working relationships, cultural and religious biases, physicians' fear of repercussions, and a lack of resources.[27] Although a small study, these findings suggested that unrelieved pain in older adults is a multifaceted problem.

In long-term care settings, research regarding pain administration has shown an extension of the disturbing trend of unrelieved pain in older adults. Approximately, one-quarter of older adults who reside in long-term care facilities do not receive pain relief.[2] For example, a study of 45 residents and 16 nursing assistants in a single facility found that nursing assistant evaluation of resident pain was inconsistent with resident report over 60% of the time.[28]

Research into nurse advocacy for older adults in the area of pain management is limited with most studies focusing on end-of-life care. However, the limited research thus far points to the nurses' role of patient advocate as closely related to pain-management decisions. A large cross-sectional study that examined the content of nurse advocacy from the nurse and the patient perspective suggested that it is important for nurses to identify their role as the primary decision maker in the actual delivery of pain care.[25] The researchers noted that the nurse's pain-management skills and power over pain-care plans were significant factors impacting the decision to advocate or not. The findings point to the benefit of empowering nurses to make pain-management decisions and the need for the support of the nurse advocacy role.

Nurses are the health-care professionals who are primarily responsible for the management of their patients' pain.[17] For those patients under their care, it is within the nurse's expertise and moral responsibility to alleviate pain.[30] Therefore, the right of patients to adequate assessment and treatment of pain, as promoted by the Joint Commission,[11] has a corresponding ethical responsibility for nurses to provide this to their patients. Knowledge and skills are required to effectively manage pain of their older patients who may require dosage adjustments to avoid undesirable side effects.[32] Lack of pain-management competence may contribute to frustration and a tendency toward undertreatment or nontreatment of pain in the older patients.

Historically, a disparity in pain assessment and treatment has existed between the pain management provided to older adults when compared to that provided to younger patients.[2] Pain treatment disparity may be due to numerous barriers to effectively treat pain in older adults as previously discussed. Although

research has illuminated the problem, undertreated pain in elder patients is a problem that has persisted for decades.[2,3]

Nurses often have traditionally relied on a combination of their impressions and what the patient told them. Beliefs about pain and patients with pain vary among nurses, and impressions patients make on nurses are unreliable because every patient is different. Also, limited nurse knowledge of the effectiveness of multimodal approaches has traditionally contributed to ineffective pain treatment. More recently, noteworthy efforts have been made to improve pain management, including requirements by professional organizations and accreditation agencies.[12] Also, the development of effective pain-assessment tools, increased knowledge regarding appropriate dosages of pharmacological approaches to pain in older adults, and the increased use of nonpharmacological approaches to complement pharmacological pain treatment have enabled health-care professionals to effectively and safely manage pain in older adults.

Nurses may receive some pain-management training in their undergraduate nursing education. However, continuing education on topics related to pain management may be less common. Some nurses may feel that they must learn to effectively manage pain on their own through trial and error. This uncertainty may contribute to ineffective pain treatment by nurses who lack the knowledge and skills to make informed pain-management decisions. The principles of pain management include the individual nurse's responsibility to be knowledgeable regarding pain management, the patient's right to pain relief, and the nurse's obligation to provide for the relief of pain as well as advocate for it.[32]

Not only is the alleviation of suffering one of the roles of nursing, it is one of the major goals of the health-care system.[33] It is clear that patients with pain desire relief. Nurses who provide pain relief promote the good (beneficence) of the patient. Unrelieved pain can potentially contribute to a negative impact on the well-being of older adults. Adverse effects may include a decreased level of mobility and independence, an increased susceptibility to infection, a negative impact on social support and relationships, and an increased economic burden.[2,32] Furthermore, when pain is undertreated and medication is underprescribed, some suggest that it is the moral equivalent of inflicting pain.[12] Undertreating pain in older adults is not ethically defensible.[12]

Three principles of beneficence as a framework for pain management

The ethical principle of beneficence is integral to the nursing profession's mission to alleviate pain and suffering. According to Beauchamp and Childress, beneficence can be conceptualized as three principles: one ought to prevent harm or pain, one ought to remove harm or pain, and one ought to do or promote good or pain relief.[5] The three principles of beneficence can further illuminate nursing decisions regarding the management of pain, especially for older adults who are vulnerable to undertreated pain. Consistent with the nature of pain management, the principle of beneficence does not tell us how to apply pain-management methods, but it does tell us how to provide pain relief and prevent evil or harm.[4] Harm through the adverse effects of undertreated pain is the evil that can be prevented through effective pain assessment and management. Pain relief is the good that is provided through effective pain assessment and management.

When the three principles of beneficence are applied to pain management, the nurse's role to alleviate pain becomes even more apparent and serves as an ethical lens for practical pain-management guidance. The structure is simple, concise, and understandable (see Table 1). The three principles of beneficence provide a lens through which the nurse role in the relief of pain can be considered.

First, nurses ought to anticipate and treat pain effectively. Older adults are often hesitant to complain of pain or feel that pain is a normal part of aging. Nurses, therefore, need to anticipate an older patient's pain if the patient has a pain-generating condition, such as arthritis or postsurgical pain.[19] Anticipation of patient need for pain management is consistent with a patient-centered approach to care and may require educating patients to correct any misconceptions of pain and to explain pharmacological and nonpharmacological methods of pain management.

Table 1. Three principles of beneficence in pain management

Principles of beneficence	Patterns
Nurses ought to prevent pain It is the nurse's responsibility to anticipate pain when a patient has a pain-generating condition or treatment. Patient education is often needed to help patients understand that pain relief is possible. Self-report of pain should be attempted in cognitively impaired adults. If self-report of pain is not possible, validated pain-behavioral tools can help detect the presence of pain.	*Beneficence* mandates that nurses assess pain at regular intervals in older adult patients and offer treatments for self-reports of pain or evidence of pain, if self-report is not possible.
Nurses ought to remove pain Nurses ought to utilize a combination of pharmacological approaches and nonpharmacological interventions to facilitate pain relief.	*Beneficence* (and nonmaleficence) mandates that nurses provide pain relief through either pharmacological or nonpharmacological means or a combination of both.
Nurses ought to promote pain relief Nurses have an ethical responsibility to advocate for the provision of pain relief. Using their knowledge of pain-management principles, nurses can positively influence change within the multidisciplinary health-care team, in the community, and throughout society.	*Beneficence* mandates that nurses promote pain relief for the good of patients

The Institute of Medicine of the National Academies (USA) defined patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions"[19] (p. 3). Patients in pain need a response from their nurse that is empathic and aimed at alleviating their pain while respecting them as individuals.

Consistent and appropriate use of validated pain-assessment tools provides the essential data on which pain-management decisions can be based. Validated pain rating scales allow nurses to assess and evaluate the subjective pain experience of the patient in a way that provides a foundation for pain-management decisions.[2] Both patients and nurses benefit from consistent use of pain rating scales in combination with nursing knowledge and judgment to gauge the effectiveness of pain-management interventions.

Second, nurses ought to provide relief of pain. Nurses actively participate in assessing and providing quality pain management to minimize patient suffering through advocacy.[24] Older patients may need pain-management coaching by nurses in order to make appropriate pain-management decisions. Mutual decisions regarding pain relief can be reached between the nurse and patient through collaboration consistent with the patient's priorities and goals as well as the reality of the pain-generating condition or illness. Older patients may state, "I can stand the pain, it's not that bad" when asked about the need for pain medications. The use of a pain rating scale for all pain assessments helps to establish consistency between the nurse's perception of the pain goal and the patient's perception. Appropriate timing for nursing pain assessments is essential for making accurate determination of the effectiveness of pain interventions performed as well as for the evaluation of the need for additional interventions. For example, in acute-care settings, nursing pain assessments may be completed every 4 hours and as needed to assess the effectiveness of pain interventions, such as 1 hour following oral medications. The goal of a patient's pain-management plan can then be negotiated through mutual decision making in which the patient identifies a pain rating using a

validated pain rating scale that will be used as the goal of the pain-management plan. The goal of the pain-management plan should represent the patient's goal for pain relief.

Third, nurses ought to promote good. Active involvement in the development of policies and pain-management evaluation mechanisms helps to reduce patient risk.[8] Acceptance of the inherent good of the relief of pain is almost universal. Nurses can help promote effective pain management in their work setting by raising the awareness of the problem of undertreated pain.

Although challenged by the complexities of managing pain in older patients with chronic conditions and increased vulnerability to medications, nurses must resolve to improve pain management in order to promote the effective pain relief of patients. A question posed by the third principle of beneficence is ''What is the good, and how do we achieve (create, protect, and cultivate) it?''[31] (p. 251). In the management of pain, the good of pain management begins with appropriate pain assessment followed by effective pain treatment to meet goals based on mutual decision making between a patient and that patient's nurse. Reassessment then follows pain treatment promptly at an interval appropriate to evaluate the effectiveness of the intervention.

Practical and simple guidance to pain-management decisions is often missing in the clinical setting. Although it is beyond the scope of this article, it is pertinent to note that a multidisciplinary approach is needed to address the multifaceted problem of the undertreatment of pain.[2,20]

In consideration of the documented failure of past efforts to correct this issue, health-care institutions need to put forth a concentrated effort to reverse this pattern of inadequate pain management. Education alone has proven to be ineffective for the lasting change. Increased awareness of the principles of good pain management (assessment and treatment) in the community, in health-care settings, in nursing education, and in policy is the first step toward change to eradicate inadequate pain management.

Recommendations to improve pain management for older adults

Implementation of the following recommendations may assist others in moving the nursing profession closer to eradicating the problem of unrelieved pain in older adults:

Nursing practice

- Evaluate current pain-management policies for needed changes that will facilitate frequent nursing pain assessment and appropriate management and the role of the nurse as patient advocate. Staff nurse involvement in pain-management policy reviews can facilitate open dialogue and initiate problem solving regarding the challenges faced.
- Support nurse advocacy role in health-care institutions by empowering nurses to make decisions in the area of pain management. The provision of relevant pain-management educational opportunities on an annual basis may help to empower and equip staff nurses to better advocate for their patients in this area.
- Recognize nurses who act as pain-management advocates for their patients. Incorporate pain-management skills into yearly performance evaluation criteria.

Nursing education

- Teach nursing students to apply the professional code of ethics as it relates to the nurse's professional responsibility to relieve pain through the use of case study evaluations and discussions of diverse nurse and patient situations that require conflict resolution and advocacy. Incorporate the principles of pain management into nursing curricula as an important content.

- Provide opportunities for nursing students to explore the ethical implications of situations in nursing practice that may require the nurse to advocate for the relief of patient's pain.
- Incorporate ethical discussions of the nurse responsibility to provide pain relief into nursing education content focusing on pain-generating conditions in older adults.

Policy-level changes

- Advocate for designated funding for mandatory, annual education offerings for nurses who focus on the ethical challenges and implications of pain management and the nurse advocate role.
- Advocate for dedicated funding for research involving the effectiveness of strategies that may improve pain management for older patients.
- Incorporate the role of nurse advocate for pain management into annual nurse evaluations.

Patient education

- Teach patients about methods for pain assessment and management that can be applied at home, such as the use of a pain journal and a validated pain rating scale, to facilitate improved self-management of pain.
- Teach patients about nonpharmacological options to help them manage their pain. Include both pharmacological and nonpharmacological interventions in pain treatment plans for older adults.
- Provide patient education offerings and materials that discuss a patient's right to effective pain management, multimodal approaches to pain management, and management of side effects of pain medications.

Strong administrative support is needed for nurses as they advocate for patients in the area of pain management. Leaders of health-care institutions need to be united regarding ensuring that pain management is a high priority. This is consistent with the professional goals of the nursing profession. Attention to the importance of nurse advocacy within pain management could begin by incorporating a discussion of pain management into yearly performance evaluations. Health-care facilities should foster growth by encouraging nurse leaders to be supportive of the role of nurse advocate in pain-management decisions. Incorporation of organizational ethics committee members into educational offerings for nurses can serve to increase familiarity with ethical theory.

Nursing education should include opportunities for the development of negotiation skills and assertiveness to enable nurses to act as advocates for patients in pain.[22] Education in the various nursing roles is integral to nursing education curricula. However, within such discussions of the nurse advocacy role, pain management should be emphasized and explored. Incorporation of the ethical aspects of pain management in nursing education programs may assist to improve pain management for student nurses' future patients.

Older patients may need education regarding their right to pain management, available options to include pharmacological and nonpharmacological methods, the negative consequences of uncontrolled pain, and the management of side effects of treatments. Patient education regarding the availability and importance of effective pain management could include educational offerings or materials in hospitals, senior centers, physician offices, and through other media, such as a web site. Education alone will not remove barriers to pain management but may help to remove some patient barriers to effective pain management, such as opioid taboos.

Blacksher[34] argued that ethics underlie the reformation efforts focused on unrelieved pain. Nurses need to ensure they have a clear understanding of their role as patient advocate in pain management. In addition, nurses are advised to consider their ethical obligation to relieve pain. Older adults are the most vulnerable group to having their pain undertreated. Bedside nurses and nursing administrators must join

together in a unified effort to find solutions to help eradicate the persistent problem of undertreated pain in older patients and in so doing provide patient-centered care to their patients. Consideration of the three principles of beneficence suggested by Beauchamp and Childress[5] may be helpful to promote improved pain management for older adults.

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Conflict of interest

This is an original manuscript that has not been submitted to any other publication. The manuscript does not include any case studies.

References

1. Ferrell BR. Ethical and professional issues in pain technology: a challenge to supportive care. *Support Care Cancer* 1994; 2: 21–26.
2. American Pain Foundation. A reporter's guide: covering pain and its management, http://www.painfoundation.org/learn/publications/files/reporters-guide.pdf (2008, accessed 13 July 2009).
3. McCaffery M, Pasero C, and Ferrell BR. Nurses' decisions about opioid dose. *Am J Nurs* 2007; 107: 35–37.
4. Erlen JA. Concerns related to vulnerable populations. In: Pinch W and Haddad AM (eds) *Nursing and health care ethics: a legacy and a vision*. Silver Spring, MD: Oxford University Press, 2008, pp. 172–181.
5. Beauchamp TL and Childress J. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press, 1994.
6. Tucker KL. The debate on elder abuse for undertreated pain. *Pain Med* 2004; 5: 214–228.
7. Online Legal Media. Elder abuse and neglect, http://www.lawyersandsettlements.com/elder_care.html (2010, accessed 6 September 2010).
8. Jaffe-Gill E, De Benedictis T, and Segal J. Elder abuse: types, signs, symptoms, and prevention, http://www.helpguide.org/mental/elder_abuse_physical_emotional_sexual_neglect.htm (2008, accessed 23 March 2009).
9. Kirk TW. Managing pain, managing ethics. *Pain Manag Nurs* 2007; 8: 25–34.
10. Imhof S and Kaskie B. How can we make the pain go away? Public policies to manage pain at the end of life. *Gerontologist* 2008; 48: 423–431.
11. Joint Commission. Health care issues, http://www.jointcommission.org/NewsRoom/health_care_issues.htm (2010, accessed 6 September 2010)
12. O'Malley P. The undertreatment of pain: ethical and legal implications for the clinical nurse specialist. *Clin Nurse Spec* 2005; 19: 236–237.
13. Frank-Stromborg M and Christiansen A. The undertreatment of pain: a liability risk for nurses. *Clin J Oncol Nurs* 2000; 4: 41–44.
14. Brennan F, Carr DB and Cousins M. Pain medicine: a fundamental human right. *Pain Med* 2007; 105: 205–221.
15. Resnik DB, Rehm M and Minard RB. The undertreatment of pain: scientific, clinical, cultural, and philosophical factors. *Med Health Care Philos* 2001; 4: 277–288.
16. American Geriatrics Society. The management of chronic pain in older persons. *J Am Geriatr Soc* 1998; 46: 635–651.
17. Bell L and Duffy A. Pain assessment and management in surgical nursing: a literature review. *Br J Nurs* 2009; 18: 153–156.
18. Hunter S. Determination of moral negligence in the context of the undermedication of pain by nurses. *Nurs Ethics* 2000; 7: 379–391.

19. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century report brief, http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx22 (2001, accessed 13 May 2012).
20. Institute of Medicine. Relieving pain in America: a blueprint for transforming prevention, care, education, and research, http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research/Press-Release.aspx (2011, accessed 15 December 2011).
21. Hatcher JP, Chessell IP, and Hughes JP. Biologics: the next-generation therapeutics of analgesia? *Expert Rev Neurother* 2011; 11: 1653–1658.
22. Rees J, King L, and Schmitz K. Nurses' perceptions of ethical issues in the care of older people. *Nurs Ethics* 2009; 16: 436–452.
23. American Nurses Association. *Code of ethics for nurses with interpretive statements*. Silver Springs, MD: American Nurses Association, 2001.
24. Vaartio H, Leino-Kilpi H, Salanterä S, et al. Nurse advocacy: how it is defined by patients and nurses, what does it involve and how is it experienced? *Scand J Caring Sci* 2006; 20: 282–292.
25. Vaartio H, Leino-Kilpi H, Suominen T, et al. The content of advocacy in procedural pain care – patients' and nurses' perspectives. *J Adv Nurs* 2008; 64: 504–513.
26. Horgas AL and Elliott AF. Pain assessment and management in persons with dementia. *Nurs Clin North Am* 2004; 39: 593–606.
27. Brockopp DW, Brockopp G, Warden S, et al. Barriers to change: a pain management project. *Int J Nurs Stud* 1998; 35: 226–232.
28. Horgas AL and Dunn K. Pain in nursing home residents. Comparison of residents' self-report and nursing assistants' perceptions. Incongruencies exist in resident and caregiver reports of pain; therefore, pain management education is needed to prevent suffering. *J Gerontol Nurs* 2001; 27: 44–53.
29. Horgas AL, Elliott AF and Marsiske M. Pain management in persons with dementia: relationship between self-report and behavioral observation. *J Adv Nurs* 2009; 57: 126–132.
30. Pierce SF, Dalton JA and Duffey M. The nurse's ethical obligation to relieve pain: actualizing the moral mandate. *J Nurs Law* 2001; 7: 19–29.
31. Kenny N and Giacomini M. Wanted: a new ethics field for health care policy. *Health Care Anal* 2005; 13: 247–259.
32. Zalon ML, Constantino RE, and Andrews KL. The right to pain treatment: a reminder for nurses. *Dimens Crit Care Nurs* 2008; 27: 93–101.
33. Danis M, Clancy C and Churchill LR. *Ethical dimensions of health policy*. New York: Oxford University Press, 2002.
34. Blacksher E. Hearing from pain: using ethics to reframe, prevent, and resolve the problem of unrelieved pain. *Pain Med* 2001; 2: 169–175.