

Patient Attitudes and Beliefs Regarding Pain Medication after Cardiac Surgery: Barriers to Adequate Pain Management

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■ ABSTRACT:

Several studies have outlined the impact of patient's beliefs on their level of pain relief after surgery and have underlined that misconceptions are barriers to effective pain relief. The aim of this survey was to evaluate the beliefs of the patients to help create a specifically adapted pain education program. After ethics approval, all patients scheduled to undergo cardiac surgery of any kind were approached and asked to complete a voluntary, non-nominative questionnaire that included the Barriers Questionnaire and the Screening Tool for Addiction Risk (STAR) Questionnaire. All completed questionnaires were collected from the charts every evening or the morning before surgery. Of 564 patients scheduled for surgery, 379 patients (67.5%) returned questionnaires. The average age was 60.3 years, and 66.0% were male. Results of the Barriers Questionnaire showed that 31% of patients were in strong agreement that "it is easy to become addicted to pain medication," 20% agreed that "good patients do not speak of their pain," and 36% believe that "pain medication should be saved in case pain worsens." Little or no gains have been made in decreasing misconceptions related to the treatment of pain. This study underlines the considerable need for and absolute necessity to provide pain education to patients undergoing cardiac surgery.

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Patients experience pain after cardiac surgery to varying degrees (Diby, Romand, Frick, Heidegger & Walder, 2008) and between 30 to 50% of patients experience moderate to severe pain for an average of 5 to 12 days after sternotomy (Polomano, Dunwoody, Krenzischek & Rathmell, 2008). Unfortunately, patients do not want to complain about their painful experience, many do not want to use pain

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medication, and they often wait until pain is unbearable to do so (Leegaard, Naden, & Fagermoen, 2008).

The mainstay of postsurgical pain treatment is the systematic application of a multimodal regimen consisting of opioids, acetaminophen, and nonsteroidal anti-inflammatory drugs when applicable. Other adjuvants such as ketamine are added when necessary (Cogan, 2010). Although the use of opioids is both well established and supported by the World Health Organization pain ladder for the control of moderate to severe pain after surgery (Vargas-Schaffer, 2010), their use is fraught with obstacles, not the least of which are the patient's beliefs and attitudes towards the consumption of opioids and their fear of possible addiction. Murnion, Gnjidic, and Hilmer (2010) have described several patient factors that may contribute to the under treatment of pain, such as inappropriate expectations, deficient knowledge of pain and its treatment, underreporting of pain, and inadequate patient information. Lin, Chou, Wu, Chang, and Lai (2006) have shown that patient beliefs and attitudes regarding pain medication and patient education programs can have an impact on pain levels.

Before launching an Acute Pain Service for a unique group of patients who were to undergo cardiac surgery in a specialized institution, medical and nursing personnel wished to prepare an exclusively adapted patient information booklet. The first step undertaken in this process was an evaluation of patients' attitudes and beliefs regarding the use of opioids as well as the likelihood of addiction in this population. The hypothesis retained was that patients would have significant barriers to, or misconceptions regarding, taking opioids for pain after surgery. The purpose of this article is to describe the beliefs of the cardiac surgery patient population, to describe how they differ from those of the general surgical population, if at all, and to acquire knowledge that will enable the creation of appropriately tailored learning material.

METHODS

After obtaining institutional ethics approval, a research assistant identified all patients scheduled for elective surgery between August 6, 2009 and January 13, 2010. Inclusion dates reflect the availability of the research personnel and the desire to obtain a sample size of at least one-fourth of the annual surgical population. Inclusion criteria included all patients 18 to 90 years of age, all patients undergoing cardiac surgery, an ability to understand and speak French, and a willingness to participate in study. Exclusion criteria were inappropriate age, non-cardiac surgery, difficulties with French, and a lack of willingness to participate.

All eligible patients were met briefly, the non-nominative voluntary survey was explained, and the questionnaire was left with the patient to be completed. Questionnaires were collected directly from the patient every evening or from the chart the next day. Patients arriving for emergency surgery, those transferred late in the day from another hospital, or those arriving on weekends were not usually contacted for logistic reasons.

Questionnaires

The questionnaire contained four sections: (1) demographic information, (2) the Barriers Questionnaire II, (3) the STAR questionnaire, and (4) a section for comments. Demographic data included information on age, sex, first time cardiac surgery, civil status, occupation, and level of education.

Barriers Questionnaire

The Barriers Questionnaire is a segment of the Patient Outcome Questionnaire and is used to evaluate how reticent a patient is to express his/her pain or to use pain medications. This is measured on a Likert scale from 0 to 5, where 0 is "completely disagree" and 5 is "completely agree." The items measure two domains: (1) fears related to analgesic use (addiction, side effects, fear of injections, and tolerance) and (2) beliefs that hinder communication (disease progression, distract the doctor, being a good patient, and fatalism). Both internal validity and reliability have been shown in previous studies (Gunnarsdottir, Serlin, & Ward, 2005; Potter, Wiseman, Dunn, & Boyle, 2003). Specifically, content validity, internal consistency, and test-retest reliability ($r = .90$ over a one-week interval) have been cited (Ward & Gatwood, 1994). We used the French version of the Barriers Questionnaire first used by Beauregard, Pomp, and Choinière (1998).

STAR Questionnaire

This questionnaire is a screening tool for addiction risk (STAR) consisting of 14 true or false questions, developed for use in chronic pain patients who attend a pain clinic (Friedman, Li, & Mehrotra, 2003). It was chosen for use in this study because it is one of four questionnaires that are self administered, has been used with adults with nonmalignant pain, and has shown good reliability and validity (Wallace, Keenum, & Roskos, 2007). Results of the study by Wallace, Keenum, and Roskos (2007) also noted that the STAR questionnaire had the fewest number of questions and the fewest number of linguistic problems per statement or question, compared with the other three questionnaires. Furthermore, it was designed for use before initiating opioid therapy. The answers for the STAR are

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