Reviewer's report

Title: Paramedic assessment of pain in the cognitively impaired adult patient

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Reviewer: Kenneth D Craig

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The paper has great merit in bringing to our attention the importance of systematic, validated assessment of pain in emergency situations, both prior to and within hospitals. An important background literature is covered. The systematic review conducted highlighted the needs and challenges of pursuing this objective. The perspective brought to bear on the issues has both breadth and depth. The systematic review underlined the deficits in this area. Perhaps problematic is the relatively arbitrary use of the literature not included in the systematic review to generate and bolster arguments. This will be a recurring theme in the following commentary. While the paper generally has considerable merit, it raises an number of issues that should be addressed.

It is incorrect to assert that pain is not experienced vicariously by others. There is a very considerable literature addressing the vicarious experience of pain, dating back to the 1960s, with current social neuroscience investigation of pain empathy burgeoning. Recent summaries, papers by Ochsner and Decety and others come to mind. Perhaps what needs to be emphasized is the discontinuity between the experience of the person in pain and the perception of the observer, at least as inferable from brain imaging data.

The assertion that pain cannot be validated by objective means is not clear. Current definitions of pain emphasize its nature as a subjective experience. It is not equivalent to pathophysiological states. Self-report and nonverbal measures of pain are objective. They do require validation. Perhaps the authors could be clear about what they mean by ‘objective’.

It is reasonable to assert that self-report of pain should be sought whenever possible, but it is incumbent upon authors to also note the limitations of this approach. While the paper acknowledges that self-report requires considerable cognitive, linguistic, and social competence, it does not make the important point that self-report is vulnerable to personal and situational bias. Particularly important is the notorious reluctance of seniors to report pain. This should be at least acknowledged.

Related to this would be the importance of recognizing confounds between fear and pain in self-report assessment.

It is suggested that accurate assessment is needed to guide pain management decisions, but this is to “mitigate the cause” and dictate the “type and initial dose of any analgesic administered”. Is there no room for psychological, social or environmental intervention?
Throughout the paper it is recognized that ‘reliable’ scales are needed. This term has specific psychometric meaning. Sometimes it seems to appear when the word ‘valid’ was probably intended.

Can the assertion that dementia “does not involve impaired consciousness” needs to be defended.

On p.11, clinical practice for UK paramedics is said to advise “that the use of pain scales in assessing patients with cognitive impairment may not be possible”. Are behaviourally-oriented measures not scales?

The injunction to “Identify possible causes of pain” may be misleading because it ignores the large number of patients, cognitively impaired or not, for whom a pathophysiological basis of their complaints, or pain disability, cannot be identified. While all of us welcome evidence consistent with a disease or injury explanation, it should be clear that this confirmation is not needed.

Parenthetically, in the paragraph discussing the foregoing, it is observed “there is no strong evidence that patients with dementia suffer less pain.” It should be noted that work by Hadjistavropoulos et al., and Kunz et al., would lead one to believe they suffer more pain than cognitively intact people, if nonverbal measures are to be taken seriously.

The discussion of nonverbal measures focuses upon the need to conduct observations over time, i.e., to have base rate data available. It is noteworthy that facial expression does make as substantial a demand. As well, there is data contradicting the conclusion based on the Kappesser et al study to the effect that the facial display of pain does differ from expression of other negative emotional states and that people routinely make the distinction.

Some criticism of the Abbey Pain Scale would be appropriate. For example, the account of facial expression could come closer to the empirically described facial display of pain. Frowning and looking frightened are non-noxious aversive states differentiable from pain. The behavioural change item implies a need for long-term observation. The physical changes examples mostly do not describe the current situation.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.