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Culture's Effects

on Pain Assessment and Management

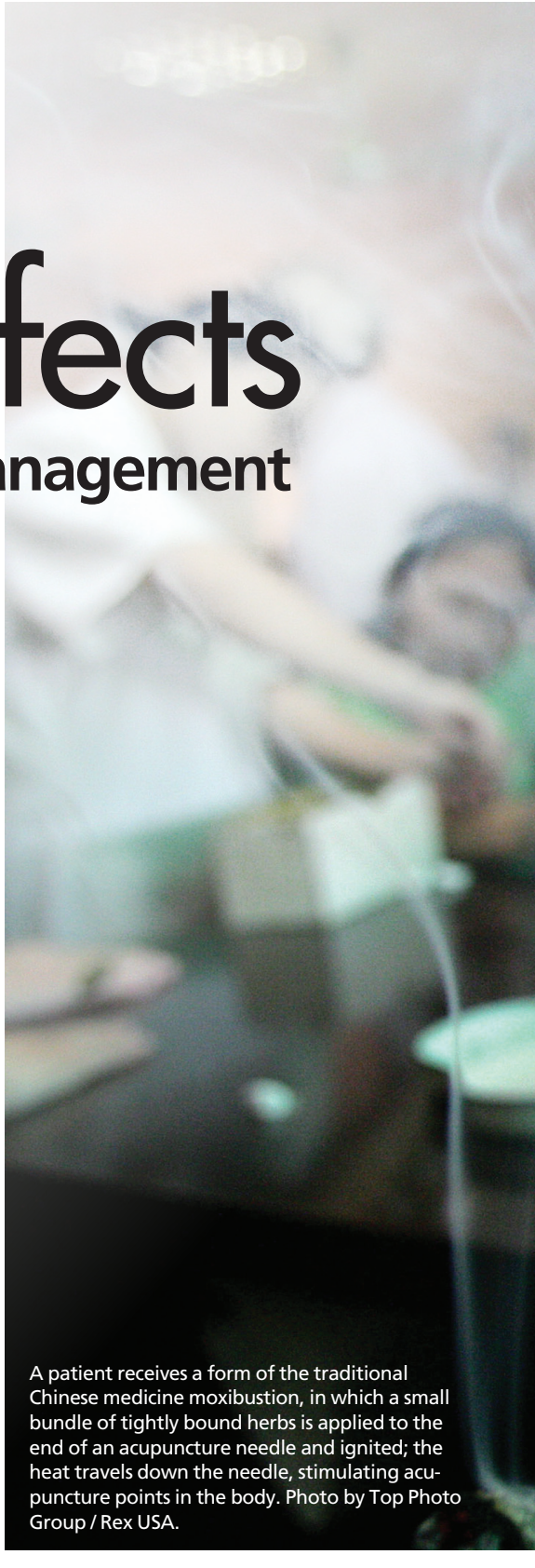
Cultural patterns influence nurses' and their patients' responses to pain.

OVERVIEW: Minority patients are at high risk for poor pain outcomes. When patients belong to a culture or speak a language that's different from that of their health care provider, the provider faces additional challenges in successfully assessing and managing the patients' pain. This article describes how and why culture affects both patients and nurses. It also discusses why members of cultural minority groups frequently receive suboptimal pain management and how nurses can improve patients' pain outcomes by using culturally sensitive assessments and providing culturally comfortable care.

Cultural diversity enriches America, yet it also poses many challenges for nurses. Currently, about 20% of people in the United States speak languages other than English at home.[1] The U.S. Census Bureau predicts that minority groups will increase from 30% of the U.S. population as reported in the 2000 census to 54% in 2050.[2] The purpose of this article is to help nurses learn to effectively assess and manage the pain of patients who come from diverse cultures and speak different languages.

CULTURAL CONCEPTS

People are cultural beings, and as such we are greatly influenced by each of the cultural groups we belong to—ethnic, religious, geographic, socioeconomic, and so on. Each of these groups influences the way we think and act by instilling in us both general and specific expectations of how the world works and how we should interact with it. Cultural paradigms map the "right" ways to think and act in all kinds of situations.[3]



A patient receives a form of the traditional Chinese medicine moxibustion, in which a small bundle of tightly bound herbs is applied to the end of an acupuncture needle and ignited; the heat travels down the needle, stimulating acupuncture points in the body. Photo by Top Photo Group / Rex USA.

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Culture also influences beliefs about how to prevent and treat illness and what constitutes good care.[3] More specifically, it influences how each person experiences and responds to pain, including when and how to ask for treatment.[4-6]

By virtue of belonging to multiple cultural groups, each of us has a unique cultural perspective. Nurses must embrace this crucial point in order to provide patients with culturally acceptable pain management. Nurses should also be aware of the cultural patterns (beliefs, values, and behaviors) that influence their own and their patients' responses to pain. At the same time, it's important not to stereotype patients by assuming that they'll adhere to a particular culture's typical pain patterns. Rather than attempting to catalog the pain beliefs and practices of particular cultural groups, this article considers the diverse ways in which culture influences how patients respond to and regard pain. Its intention is to help nurses understand patterns they might otherwise misinterpret. To determine how best to help a patient with pain, nurses must first discern how the patient thinks and feels about the pain experience.

HOW CULTURE AFFECTS THE PAIN EXPERIENCE

Stoicism versus expressivity. Although experimentally controlled pain studies generally show that the intensity at which most people perceive a sensation and the point at which it becomes painful are approximately the same, the members of some ethnic groups have a higher tolerance for pain than others and can endure increasing levels of a pain stimulus for longer periods.[7] Because pain has psychological, social, and spiritual as well as physical dimensions, it is greatly influenced by cultural factors.[8] Thus, people of different cultures respond differently to pain. People from cultures that value stoicism tend to avoid vocalizing with moans or screams when they are in pain. They may strive to keep their faces "masked," trying not to show their pain even by grimacing. They may feel that they'll be perceived as weak if they admit to or show pain, and they may deny having pain when asked. They may prefer to be left alone to bear their pain without bothering others and may have learned to cope without seeking attention or care.[9, 10] Although the wishes of patients with these beliefs must be respected, nurses still need to provide them with information that will allow them to choose whether or not to accept treatment for their pain.

Other cultural groups tend to be more expressive about pain. They learned from childhood that when one is in pain, the appropriate response is to moan or cry. Indeed, some cultural groups believe that one of the best ways to cope with and relieve pain is to groan or scream. Some groups encourage members in pain to seek attention and support and encourage caregivers to attend to them. Members of these groups may prefer not to be alone when they're in pain.[9, 10]

Although nurses may have deeply held beliefs about how best to respond to pain, they must be mindful that no response is inherently right or wrong. The responses may simply differ and may well be the products of cultural patterns and expectations.

Describing pain. People from different cultures conceptualize and describe pain using different cognitive

Self-Assessment Questions to Help Nurses Determine Their Cultural Norms Concerning Pain

When you were a child, how did those who cared for you react when you were in pain?
- How did they expect you to behave when you had a minor injury?
- How did they encourage you to cope when you had severe pain?
- How did they encourage you to behave during an injection or procedure?

When those who cared for you as a child were in pain, how did they react?
- What words did they use to describe the pain?
- How did they cope with their pain?
- Do you tend to follow their example?

Consider a painful experience you've had as an adult (for example, childbirth, a fracture, a procedure).
- How did you express (or not express) your pain?
- Did the pain cause you fear? What were you afraid of?
- How did you cope with the pain?
- How did you want others to react while you were in pain?

Have you ever felt "uncomfortable" with the way a patient was reacting (or not reacting) to pain?
- What did the patient do that concerned you?
- Why did you feel that way?

Do you have "feelings" (make value judgments) about patients in pain who
- behave more stoically or expressively than you would in a similar situation?
- ask for pain medicine frequently or not often enough?
- choose treatments you don't believe are effective or with which you are unfamiliar?
- belong to a cultural group (ethnic, linguistic, religious, socioeconomic) different from your own?

Do you tend to feel certain reactions to pain are "right" or "wrong"? Why? What about these reactions makes them seem right or wrong?
- Are some expressions or verbalizations of pain "right" or "wrong"?
- Some descriptions of pain?
- Some treatments for pain?

frameworks. Being asked to characterize pain using an unfamiliar descriptive context may result in inadequate pain control.[11] For example, when asked to rate their pain on a linear numeric scale, some Native American patients tended to choose a "favorite or sacred" number instead of the number that correctly indicated their level of pain.[12]

Another problem can arise when patients try to put their pain into words. Even when nurses and patients speak the same language, their different definitions of words may complicate communication.[13, 14] For instance, one patient denied having "pain" after an inherently painful procedure but on further questioning admitted to having an "almost intolerable ache." In this case, the word "pain" had a connotation the patient didn't associate with his experience.

Difficulties stemming from words' nuances are magnified when the patient's primary language is different from the nurse's. Even if an interpreter is available, many words in one language don't easily translate into another. And some languages have no equivalent for the English word "pain." Others have several equivalents for "pain," each with a different nuance.[11] Problems are apt to occur if the interpreter lacks proficiency in either or both languages or in interpretation skills.[15] For instance, a patient might describe his pain as "like electric shocks," which a family member serving as interpreter could translate as "twinges." To the nurse, this might indicate mild pain when in fact on a numeric pain scale the patient would rate his pain as high.

Decisions about managing pain. People's beliefs about the meaning of their pain influence what they feel should be done about the pain, if anything. Pain from the same source may be perceived by one person as an expected part of life, by another as a harbinger of a serious health problem, and by still others as deserved punishment, a character- or karma-building opportunity, or something else entirely.[16-18] For instance, a patient who believes that enduring pain courageously will help her gain merit for her life after death will find meaning in her pain and therefore may choose to tolerate it.

Some cultural groups tend to instill in their members self-efficacy—a sense of control over life, including how to respond to and manage pain.[19] Their members assume that their health and well-being are largely in their own hands. In contrast, other groups tend to be fatalistic and believe they can exert little influence over the future, including matters of health, illness, and pain.[20] Their members may feel helpless in the face of pain. Nurses may be puzzled by fatalistic attitudes about pain and consider patients who don't follow self-help recommendations to be noncompliant with the pain management plan. However, it's important to recognize that these beliefs and behaviors may arise from the social and cultural contexts in which the person lives rather than from a lack of willingness to confront pain.[21]

Cupping, which has been used for thousands of years in many cultures, is the application of heated glass cups to the skin to create suction and thereby increase blood flow.

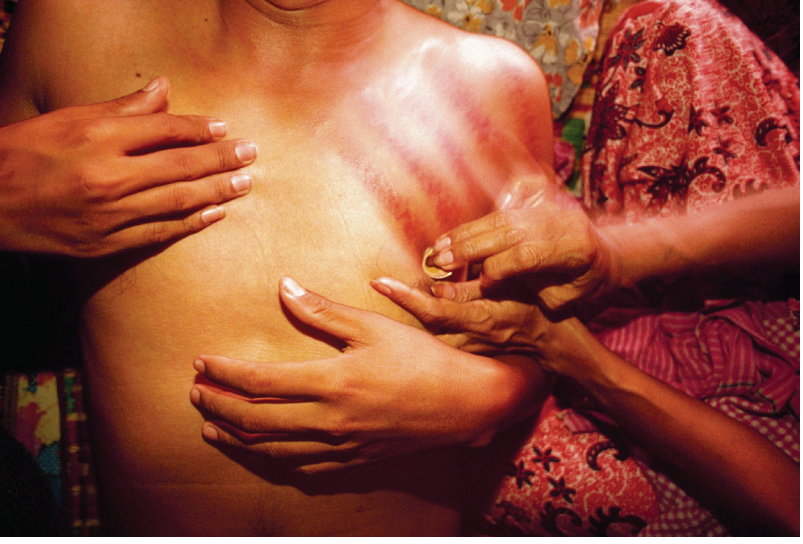
Some cultures teach that it's rude to tell health care practitioners about pain. Members of these groups assume that the nurse or physician will ask the right and important questions and that offering information about their pain without being asked is tantamount to questioning the clinician's judgment.[11] Furthermore, many people associate not complaining with being a good patient.[18]

Culture also influences beliefs about what pain treatments are appropriate. In the Western biomedical culture, medications are the first line of defense, whereas Eastern cultures tend to prefer medicinal herbs, touch, and energy therapies such as acupuncture and yoga.[22] Many people believe that the primary treatments for pain should be spiritual rituals or other acts that balance hot and cold or yin and yang.[23-25]

HOW CULTURE AFFECTS PAIN ASSESSMENT AND MANAGEMENT

Nurses, like their patients, learned about pain in childhood. As part of the socialization process, they learned the "normal" and "right" ways to respond to pain, which, in turn, taught them that other ways of responding were "abnormal" or "wrong."[26] Then, during the additional enculturation that occurred while they studied their vocation, nurses learned the "right" way to care for patients in pain. The result is a strong, though unconscious, sense of how "good" nurses think and practice.[18]

This tendency to feel that one's own cultural norms are correct and to evaluate others' beliefs in light of them is known as *ethnocentrism*. Most everyone is ethnocentric. Most of us tend to believe that attitudes and behaviors that match our own are correct and those that don't are abnormal, wrong, or inferior.[27] Thus, when a patient perceives, expresses, or reacts to pain in a way that doesn't conform to a nurse's



A Vietnamese folk healer scrapes a coin over a patient's oiled chest in the Southeast Asian practice of coining, which is believed to release "bad wind," the cause of the patient's illness, from the body. Photo by Michael S. Yamashita / Corbis.

beliefs or expectations, the nurse may consider the behavior inappropriate or frustrating.[26] Nurses need to remember that patients' diverse cultural patterns usually aren't right or wrong or normal or abnormal, just different.[28] Nurses need to first examine their own cultural beliefs about pain (for guidance, see *Self-Assessment Questions to Help Nurses Determine Their Cultural Norms Concerning Pain*) and then ask themselves which of their attitudes are cultural and which are proven by evidence to be superior.

PROBLEMS COMPLICATING PAIN MANAGEMENT

A growing body of research indicates that members of racial and ethnic minority groups are less likely than nonminorities to receive adequate pain management. The Institute of Medicine shocked the health care community with its report that, compared with whites, minority group members have poorer outcomes for a number of conditions, including pain.[29] Researchers from the American Pain Society concurred, reporting in a metaanalysis that disparities in pain management are evident over a wide variety of conditions and types of pain, including acute bone fractures, metastatic cancer, and postsurgical and chronic pain, and across multiple treatment settings (EDs, hospitals, long-term care facilities, home health care, palliative care, and others).[30]

How do culture, race, and ethnicity affect pain management? The following are some factors that lead to suboptimal pain outcomes.

Language and interpretation problems. Comprehensive pain assessment, which is essential for successful pain management and education, is contingent upon effective communication. Too often, clinicians don't use interpreters—let alone medical interpreters—when interviewing patients who lack proficiency in English. Without competent interpretation, it's impossible to adequately assess pain and teach pain management principles.[29, 31, 32] Using tools designed to assess pain in children or cognitively impaired patients, as is sometimes done, will very likely result in suboptimal pain outcomes.

Nonverbal communication problems. Nurses use many cues besides direct communication to assess a patient's pain, such as facial expression, body posture, and activity level.[33] However, nonverbal communication patterns are just as likely as is language to vary across cultures and therefore to be subject to misinterpretation.[34]

Culturally or linguistically inappropriate pain assessment tools. Types of pain assessment tools include numeric, visual analog, and verbal rating scales. Although many of these tools have been translated into different languages, the translations may convey different meanings that compromise their validity.[11, 31] For instance, if a numeric pain tool that's translated for a Chinese patient is presented horizontally instead of vertically, as Chinese is read, the patient could be confused about how to convey his level of pain.

Many assessment tools have been tested for validity in different languages. However, even when multiple cultural groups use a single language, the same words may have different nuances. For instance, many cultural groups speak Spanish, but within these groups are cultures, subcultures, and myriad dialects. Thus, even these tools may inadequately characterize the pain experience.[11, 14, 35]

Underreporting. Patients who believe that "good" patients don't complain or should face pain stoically may be less likely to admit to having pain.[36] Such patients may underreport their pain when nurses ask them to rate it.

Reluctance to use pain medications. Many people are reluctant to take opioid pain medications because of cultural taboos or fears about their use.[37] These patients may prefer to use familiar, culture-based remedies such as medicinal herbs or energy therapies.[23] Clinicians who are unfamiliar with these therapies may unintentionally disparage them or unnecessarily discourage patients from using them, in the process creating a barrier that hampers their ability to help patients. However, when an alternative therapy can interfere with medical therapy—as when a patient taking warfarin for anticoagulation wants to have coining therapy, in which a coin or other blunt object is used to abrade the skin—the patient may need to be taught why the practice could be harmful.

Some cultural groups' reluctance to use pain medications may be related to genetic differences that make them more likely to experience adverse effects. For instance, some patients don't produce certain enzymes and therefore metabolize drugs more slowly than is typical.[38, 39] Genetic factors can also affect the metabolizing of opioid medications. For example, many Chinese patients cannot convert codeine into the morphinelike metabolites that give the drug its analgesic property, making them less likely to receive adequate pain relief and more likely to have gastrointestinal problems.[17, 40]

Access to pain medications. Minority patients are less likely to have adequate health insurance, which may limit their access to medical care, pain management services, and medications.[41] In addition, many pharmacies located in poor or minority neighborhoods don't stock opioid medications.[42, 43]

Providers' fears of drug abuse. Many health care providers tend to associate certain minority groups with drug-seeking and drug-abusing behaviors.[44, 45] This fear that the medication may be used for illicit purposes can result in inadequate treatment.[45]

Prejudice and discrimination. According to the American Nurses Association, "Discrimination and racism continue to be a part of the fabric and tradition of American society and have adversely affected minority populations, the health care system in general, and the profession of nursing."[46] As distasteful as it is to consider, nurses must examine whether some patients receive less than optimal pain management because of prejudicial stereotypes or negative judgments based on race or ethnicity.

PROVIDING 'CULTURALLY COMFORTABLE' CARE

How can nurses prevent patients from different cultures and who speak different languages from suffering pain that can and should be better managed? Regulatory, accreditation, and professional organizations contend that providing culturally and linguistically appropriate care will resolve this problem.[32, 47-50] Nurses have been encouraged to provide "culturally competent" care for almost two decades.[28]

How to evaluate when cultural competence has been achieved is still being determined,[32, 51] but one way is to assess whether the patient is comfortable with the care provided. The principles of the patient-centered care movement provide a foundation for meeting patients' cultural needs and preferences.[52] These principles, as they relate to patients in pain, include the following.

- Understand the patient as a unique person.
- Explore the patient's experience of illness and pain.
- Perceive pain management from the patient's perspective.
- Promote shared decision making and adapt care to meet the patient's needs and expectations.

Nurses should also be aware of their culturally acquired attitudes about pain (to help you explore your beliefs, see *Self-Assessment Questions to Help Nurses Determine Their Cultural Norms Concerning Pain*).[53, 54] The next time you feel frustrated by the way a patient is reporting pain, you'll be better able to identify the beliefs and values that produced that feeling. Ask yourself which of your attitudes are culturally based and which are based on the evidence. Know your biases and prejudices so you can avoid letting them unconsciously guide your practice.

You can also be an advocate for patients from diverse ethnic and cultural groups. Identify at-risk patients and seek out ways to appropriately assess and manage their pain.[55] Take it upon yourself to pay particular attention to the needs of the minority patients in your care. Make time to explore the pain experiences of patients who aren't proficient in English by securing interpreters for them, and ask them about cultural therapies that might be helpful.

Seek out background material on how a patient's culture conceives of and portrays pain. Although no patient embodies a stereotype of her or his cultural group, knowing about the ways a patient's culture expresses and manages pain can help you identify patterns you might otherwise misunderstand or consider unimportant. Don't use this information to stereotype or make assumptions about patients. Rather, use it to broaden your perspective so you can more easily understand the patient's frame of reference and be more attentive to the patient's concerns and questions. (For more information on how to effectively care for patients of different cultures, see *Resources*.)

Vital to effective communication with patients whose language differs from your own are interpreter and translation services. Current accreditation and regulatory standards require health care providers to use competent medical interpreters.[32, 48-50, 56, 57] Medical interpretation is a complex skill, and using family members or other informal interpreters may compromise patients' abilities to understand and be understood.[15] Inadequate communication may result in inadequate pain assessment, which, in turn, may result in inadequate pain management.

CULTURALLY SENSITIVE PAIN ASSESSMENT

Several pain screening and assessment tools have been translated and tested for validity across cultural and linguistic groups, although questions persist about their validity.[14, 58, 59] The Pain Numeric Rating Scale is available in at least 19 languages.[60] The Brief Pain Inventory[61] and the McGill Pain Questionnaire[62,63] have been translated and validated in many languages and many cultures.[6, 64] These tools use the patient's own report to identify crucial aspects of pain, such as its location, quality, intensity, aggravating and alleviating

Explanatory Model Interview for Pain Assessment[5, 67]

- What do you think is causing your pain?
- When did it start? Why do you think it started when it did?
- What do you fear most about the pain?
- What problems does it cause you?
- What have you used to help you with the pain? How does it help?
- Who else have you consulted about the pain? Family members? A traditional healer?
- What treatments do you think might help you with the pain?
- Who helps you when you have pain? How do they help?

factors, associated symptoms, response to treatment, and the extent to which it interferes with activities.[65,66] Other elements of a comprehensive pain assessment that are uniquely affected by culture include what meaning the pain has for the patient and how she or he prefers to treat it (such as with herbs, home remedies, complementary therapies, or the services of alternative or cultural healers).

One pain assessment technique that can capture the effects of cultural norms on patients' pain experiences is the explanatory models approach.[67,68] Its open-ended questions can help nurses determine what patients believe is causing their pain and how it affects them. Nurses can also add questions to the interview that will help determine what patients' pain means to them, what their pain management goals are, and what they believe are the best ways to manage their pain. Using open-ended questions that solicit patients' understanding of and explanations for their pain will demonstrate to them that nurses want to understand them as unique beings with unique illnesses and pain experiences.[52] (For sample pain assessment questions, see the *Explanatory Model Interview for Pain Assessment*.[5,67]) This type of assessment is also appropriate for patients from cultures with which they're familiar.

Once nurses complete a comprehensive, culturally sensitive pain assessment and understand their patients' pain, they can help their patients communicate effectively with other health care providers. For instance, with the help of an interpreter, one night-shift nurse took the time to thoroughly assess a patient's pain by using a translated version of the Brief Pain Inventory and questions like those in the explanatory models approach. She then explained to the patient that many nurses and physicians use a numeric rating scale to help them manage their patients' pain. She explained how the patient could communicate his pain to other clinicians by equating it to the choices on a visual scale, such as the Wong–Baker FACES Pain Rating Scale. The next day the day-shift nurse reported that, although an interpreter hadn't been available, the patient's pain had finally been brought under control because he had successfully communicated using the FACES scale.

CULTURALLY COMFORTABLE PAIN MANAGEMENT

The information obtained from a culturally sensitive assessment will allow nurses to develop a pain management plan that meets the professional standard of care and is culturally acceptable to the patient. To do this, nurses can group what they've discovered about how the patient's culture influences her or his pain into three categories.

Cultural values and practices that are beneficial to the patient's health and well-being. Cultural patterns shown by research and evidence to promote health and well-being should be permitted and even encouraged.[69] Examples of beneficial cultural patterns include the involvement of large, supportive families and the use of complementary therapies such as acupuncture. Research indicates that family support improves patient outcomes[70] and that acupuncture can be effective in managing pain.[71]

Cultural practices that are neither helpful nor harmful to the patient's health and well-being. Cultural practices that are neutral from a Western medical perspective can and should be accommodated if possible.[69] Patients' cultural beliefs and practices provide stability and are sources of comfort during times of illness and pain. As long as they're not harmful, practices that aren't helpful from a scientific perspective are likely to be helpful from a patient's perspective because often what we *believe* helps does help.[72] Examples of such neutral practices include many religious and spiritual rituals.

Cultural practices that are harmful to the patient's health and well-being. These patterns should be

Resources

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Web sites

Culture Clues
http://depts.washington.edu/pfes/CultureClues.htm

Cultural Competence Resources for Healthcare Providers
www.hrsa.gov/culturalcompetence

Cultural Competency
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=3

EthnoMed
http://ethnomed.org

Transcultural C.A.R.E. Associates
www.transculturalcare.net

changed, if possible, through patient education that helps the patient adopt new patterns of thinking and acting.[69] Examples of harmful cultural patterns include taboos against using opioid medications even when they're necessary to control pain and the use of herbs that interfere with the pharmacologic effects of the patient's essential medications. Tact and diplomacy are needed to respectfully communicate why customary behaviors should be abandoned.

The next step is to *acknowledge* the similarities and differences between the patient's perspective and your own. The patient and nurse always have at least one area of agreement: both want the patient to achieve optimal comfort and well-being. Acknowledging this can show the patient that you want what's best for her or him. It's important to remember, however, that well-being consists not only of the patient's optimal physical condition (for example, ensuring that she or he has the least possible amount of pain), but also the patient's optimal psychological condition, which is influenced by culture. Both physical comfort and emotional well-being must be considered and balanced to achieve the best outcome.

Respecting cultural norms promotes a feeling of being valued.

Incorporating both beneficial and neutral cultural practices into patients' pain management plans will help nurses honor their patients' cultural needs and preferences. Because culture is such an important part of a person's identity, respecting cultural norms promotes a feeling of being valued. In turn, this improves communication, which will improve pain outcomes. However, if a patient's cultural beliefs or practices are counterproductive to pain management, it's the nurse's professional obligation to educate the patient in order to encourage change in her or his pain beliefs and practices. People can change their cultural norms, though they have the right not to. The nurse's role is to teach the patient so she or he can make an informed choice.[47]

One very effective way to educate the patient is through the classic LEARN model.[73] LEARN is a mnemonic for **L**isten, **E**xplain, **A**cknowledge, **R**ecommend, **N**egotiate. It's a communication and education model that can help nurses help their patients develop health-promoting beliefs and practices that take into account both the nurse's professional standards and the patient's cultural norms. (See the illustrative case below to learn how one nurse used this technique to help a Vietnamese patient achieve effective pain control.)

In the *listening* phase of LEARN, ask questions that will help you understand why a belief or practice that scientific evidence indicates may be harmful is meaningful or important to the patient. Ask nonjudgmental questions like those found in the *Explanatory Model Interview for Pain Assessment* and listen until you can understand the patient's perspective.

Once you understand the patient's perspective, use your professional knowledge to *explain* why the cultural belief or practice is harmful. Be careful not to disparage the patient's cultural norms, which can make rapport more difficult to achieve and sustain. Use layman's language to emphasize the science behind and advantages of your recommendation. If possible, use the patient's conceptual framework to explain your viewpoint. For instance, if the patient frames the problem using a yin–yang perspective, use the patient's terminology to explain how following your recommendations can counter the negative energy of pain.

The next step is to *recommend* a plan that meets both the patient's goals and your professional standards. Often by this stage an effective, mutually agreeable plan has become obvious. At other times you may need to draw on your creativity and problem-solving skills to devise a plan that helps the patient address the pain in culturally yet medically appropriate ways.

Finally, if by this time you haven't succeeded in finding a mutually agreeable pain management plan, you can *negotiate*. Don't give up too quickly on patients who seem reluctant to veer from their cultural norms. Although patients have the right to hold on to cultural beliefs and behaviors that you may consider counterproductive or even harmful, it's the nurse's obligation to adequately assess the patient's learning needs and to provide effective patient education.[47] The goal is to reach a mutually agreeable treatment plan that satisfies the patient's medical and cultural needs and the nurse's professional standards.

All patients have a right to effective pain management. Understanding the influences culture has on patients' pain experiences and attitudes regarding treatments will permit nurses to achieve better pain outcomes for all of them. The case report that follows illustrates how one patient's pain was handled in a culturally sensitive yet medically appropriate way.

ILLUSTRATIVE CASE

Mr. Nguyen, a 68-year-old Vietnamese man who immigrated to the United States in 1990, is brought to the ED by his daughter, who discovered that he'd been treating upper abdominal pain for several months with herbal tea. (This case is a composite based on the author's experience.) He's admitted after testing reveals stomach cancer. The nurse caring for Mr. Nguyen can see that he's a reserved man who tends to deny pain, and she's concerned that he may have a need for pain medication.

With the help of an interpreter, the nurse performs a comprehensive pain assessment. She discovers that Mr. Nguyen has a history of being quite stoic, having refused pain medication when he was recovering from wounds incurred during the Vietnam War. She also discovers that he doesn't like to take pills; he believes that teas made from medicinal herbs are more helpful and that opioids have the "wrong energy." He feels he should accept "what is"—what life hands him, including pain—without complaining. Mr. Nguyen reports that he is a Buddhist and that he frequently copes with pain by using a breathing meditation practice.

Mr. Nguyen's nurse is concerned that his pain may overwhelm his coping techniques. She explains that enduring too much pain has negative effects. Using his concept of promoting well-being by "balancing energy," she tells Mr. Nguyen how pain depletes the body's energy and how taking pain medication regularly can help keep this energy in balance.

She stresses to Mr. Nguyen that she wants what's best for him and acknowledges his preference for using his own coping methods. However, she says, if the pain gets bad, he may want to consider other options. She encourages Mr. Nguyen to practice meditation because it's an evidence-based pain management technique and asks him how the staff can help with this practice.

She also confers with the pharmacist about the herbal tea Mr. Nguyen had been drinking at home. The pharmacist says the herb has sedative and laxative effects and will have no adverse interactions with Mr. Nguyen's other medications. With the approval of his physician, the herb is included in the patient's medication profile. Mr. Nguyen's daughter prepares the tea for her father and the constipation Mr. Nguyen has had since being admitted resolves several hours later. He reports feeling much more comfortable.

Finally, the nurse tells Mr. Nguyen that pain medications are available in concentrated liquid form that could be added to his tea. Mr. Nguyen says he might try the drops if his pain becomes unmanageable. The nurse recommends to the physician that morphine drops be included with his discharge medications when he's transferred to a palliative care program. Several days later, he asks his daughter to prepare the tea and to add one-half the prescribed dose of morphine drops. With meditation, herbal tea, and morphine drops, Mr. Nguyen's last days are both physically and culturally comfortable. ▼

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