

PCA: patient-controlled analgesia or politically correct analgesia?

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Patient control: distinguishing reality from rhetoric

Politicians, managers, and clinicians have written and spoken a great deal in recent years about patient involvement and choice in health care. The word 'patient' has even given way in some contexts to 'user' or 'customer', as consumer-orientation has displaced the traditional view of the patient as a passive recipient of experts' care. Although it is the rhetoric of health care that has changed most obviously, there have been some tangible changes in patient management that emphasize patients' active role. The rapid and widespread adoption of patient-controlled analgesia (PCA) as a method of acute pain management should be understood in this context.

For PCA to be accurately described as patient-controlled analgesia, both patients and staff have to change their attitudes and behaviour. Patients, instead of relying on anaesthetists to prescribe analgesia and on nurses to administer it, have to feel able to take control of their analgesia and then to exercise control. We have examined in detail patients' perspective on PCA to find out whether they adopt this role.¹⁻⁴ Unfortunately, concerns about overdosing and side effects, mistrust of technology, and ambivalent attitudes to the need to feel, or avoid, pain all restricted patients' freedom to control pain by using PCA. Even patients who said that they had 'complete control' over their pain still had side effects, felt that PCA was unsafe or that the machine did not always work correctly.³ Although PCA is popular with patients,^{1 5} this cannot be attributed to improved pain relief, because there is little advantage over nurse-administered analgesia,^{5 6} and the evidence of patients' perspective has failed to support the notion that PCA is popular because it affords patients control. On the contrary, we found that patients liked PCA because it freed them from the need to exercise control by 'bothering' nurses with their requests for analgesia.

The results of intensive investigation of the patients' perspective are, therefore, inconsistent with the rhetoric surrounding PCA. Patients do not, in general, embrace the opportunity for control over their pain relief. Their stance is probably not specific to PCA, or to technological approaches to empowerment: surgical patients also rejected a purely psychological attempt to encourage them to feel in control of their postoperative care and recovery.⁷

A new role for staff?

Just as PCA presents patients with a new role, it necessitates a corresponding change in the attitudes and behaviour of nurses and anaesthetists who have to accept that they are no longer in charge of pain relief and must devolve this to the patient. As a general statement this appears straightforward. However, when resolved into the specific changes that are needed, the enormity of the required reversal in the staff role becomes clearer. Most obviously, PCA requires staff to trust patients to make their own decisions about when they need analgesia and how much they need. It follows that staff will have to tolerate patients who seem to under-medicate themselves. For instance, they should respect the decisions of patients who prioritize avoiding side effects over gaining pain relief. Conversely, they should not harass patients who inject more analgesic than staff think that they need. Staff should trust patients to treat themselves wisely, reassured by the knowledge that PCA machines observe lock-out periods and maximum dosages. Staff should also respect patients' decisions to inject morphine to help them sleep, or to provide reassurance.

A further change in the staff role must follow from devolving pain-control to the patient.

Staff—who remain responsible for other aspects of care—will have to negotiate with patients where their different responsibilities meet or potentially conflict. In this respect, the patient should be treated as another member of the clinical team—a difficult concept for many staff. The role for staff that we have outlined contradicts the self-image of medical and nursing staff as the experts and it is incompatible with the entrenched paternalistic attitudes and behaviour of staff to patients. However, it is implausible to suppose that previous attitudes that 'staff know best' and that 'patients can't be trusted' have been reversed so effectively, particularly

in the absence of any commensurate change in staff training and in the face of patients' continued deference to staff authority. Professions do not give up their power so easily. Why, therefore, is PCA so popular with staff, judged by their attitudes to it,⁸ and by the extent of its use? Certainly, it fits the rhetoric of patient empowerment, but this is hardly likely to matter to staff on the ward. A clue to a more likely explanation is the finding that *patients* value PCA because it avoids having to disclose their pain to staff or to 'bother' them.² The implication is that patients fear disapproval for doing either. There is, indeed, evidence that nurses at least, dislike or disapprove of patients who show that they are distressed or in pain.⁹ Therefore, they distance themselves psychologically from them—for example, by regarding patients as complaining rather than suffering.¹⁰ PCA might be valued by staff because it provides a novel way to distance themselves psychologically from patients in pain. PCA achieves distancing because, whereas the rhetoric is about giving patients *control* of pain management, the reality is that it makes patients *responsible* for pain management. There is nothing novel in the suggestion that clinicians devise procedures for shifting responsibility from themselves to patients. In chronic pain management, this manoeuvre is well understood. Pain management programmes use cognitive-behavioural techniques to emphasize the patients' own role in modulating their pain and managing its effect on their lives. The function of these programmes is to transfer responsibility from staff to patients for a problem that staff are no longer willing, or able, to resolve.

The need for research into the staff perspective

Whereas our description of the patient perspective is based on published evidence, there is virtually no work on staff attitudes and behaviour. Our account of patients' perspective does, however, contain a clue that staff find it difficult to cede control: almost half of a sample of 200 patients reported that they pressed the PCA button when told to by nurses or others.³ Systematic research into the staff perspective is now needed. Evidence that would test our argument would be whether or not, upon careful and detailed observation, staff routinely disapprove of patients' decisions about the use of PCA or try to influence them. It will not be difficult to gather the relevant evidence. Indeed, we can illustrate the kinds of evidence that would support our case from observations that we made in the course of a recent study of the management of postoperative pain in paediatric patients.¹⁰ Reports by parents provided observations that, if replicated systematically, would indicate that staff control PCA. For instance, one mother explained that her daughter '*had been taken off her morphine because she has been pressing it too much. .. The nurses said she's overdosed*'. Another complained that '*the doctor came and told us that [child] was pressing the button too much before. .. She'll be taking too much*'. The same child also found that '*the night nurse told me off for pressing the button too much, but I wanted to press it because I was in pain, but she said I couldn't press it any more at all*'. Other descriptions of meddling by staff showed that patients experience contradictory attempts to control PCA. A father whose child was nauseated explained that '*the nurses thought it was the morphine so she stopped pressing the button. She was in really extreme pain for about 6 h*', but that later '*the anaesthetist came up and said it wasn't the morphine so she began pressing it again. She feels really sick all the time now though*.' Interestingly, nurses reported that some patients used PCA 'sensibly', but this meant sparingly; for example '*she's being much more sensible with her PCA. She's not pressing it as much as she was before*'. A critical difficulty with nursing and medical staff's concept of 'over-use' is that patients are unable to monitor their drug administration in the way that an objective professional could. As one parent explained, '*It must be really difficult for [child] to know how many times she has pressed it and everything. I mean she keeps falling asleep and waking up. How would she know?*'

It will also be possible to gather evidence to show whether staff respect the patient's right to negotiate with them as members of the care team. An observation from our study of paediatric pain management¹⁰ illustrates the kind of finding that, if replicated systematically, would indicate that staff do not accept this right (we did not observe any evidence of patients successfully negotiating with staff):

Nurse. *Shall we turn you?*

Patient. *Please come back in a few minutes, and then you can.*

Nurse. *That won't make any difference. .. come on, let's turn you over.*

Patient. *Please don't touch my scar. Please, please, why can't you come back in two minutes when the morphine has worked. Oh mum, mum.*

Towards a realistic understanding of PCA

The observations provided above only illustrate our argument, and they emerged in the course of research in which PCA was peripheral. Moreover, the patients were children, so adult–child power relationships might have contributed to staff reluctance to cede control or negotiate. Nevertheless the observations are consistent with our previous report that patients sometimes pressed the PCA button when instructed.³ Unfortunately, we did not think to ask in that study whether patients sometimes *refrained* from pressing when told *not* to. Until the necessary studies are undertaken, there remains no evidence that traditional attitudes of staff surrounding pain-control have changed to accommodate the autonomous patient, and PCA cannot be regarded as patient-controlled.

The evidence that is already available suggests that patient control is a political and professional construction rather than a product of patients' own aspirations.^{2 3 7} If research into the staff perspective mirrors what we know from the patient perspective—that control is neither devolved by staff nor embraced by patients—research should, therefore, go on to examine what drives the construction of patient empowerment of which PCA is an exemplar. We have proposed that the answer does not lie entirely in political correctness. The search should examine the influence of emotional factors that have long been known to degrade clinicians' relationships with patients, by helping them to distance themselves psychologically from patients and to evade feelings of responsibility for patients' pain and suffering. Clearly, in some situations, such as chronic intractable pain, it may be appropriate to transfer responsibility to patients whereas, in others, clinicians must retain responsibility. There is a need for a more realistic debate about the functions and effects of techniques such as PCA, that seek to empower patients, and for careful analysis to show when these techniques are genuinely in patients' interests. This debate must be grounded in empirical research into what staff and patients do, rather than in assumptions that merely recycle the tired rhetoric of patient empowerment.

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