



ACCC and the National Cancer Pain Initiative: Where Do We Stand?

To cite this article: (1997) ACCC and the National Cancer Pain Initiative: Where Do We Stand?, *Oncology Issues*, 12:1, 5-5, DOI: [10.1080/10463356.1997.11904653](https://doi.org/10.1080/10463356.1997.11904653)

To link to this article: <https://doi.org/10.1080/10463356.1997.11904653>



Published online: 18 Oct 2017.



Submit your article to this journal [↗](#)



Article views: 6



View related articles [↗](#)



ACCC and the National Cancer Pain Initiative: Where Do We Stand?

Last September, Margaret A. Riley, M.N., R.N., C.N.A.A., of St. Joseph's Hospital of Atlanta in Atlanta, Ga., and I had the pleasure of representing ACCC at the National Summit on Cancer Pain Control in Reston, Va. This meeting was jointly sponsored by the American Cancer Society, the Oncology Nursing Society, and the American Allegiance of Cancer Pain Initiatives. The organizers of the summit selected forty-six organizations that they believed have an interest in pain management, either from the provider side or as patient representatives. The theme of the summit was simple—adequate pain control is something patients should expect, yet are not universally receiving. The challenge of the meeting was to develop working relationships among the participating organizations to begin addressing this enormous problem.

At the beginning of the meeting, we were polled about our expectations of success for an organized pain initiative. The nurses, social workers, and patient advocates tended to be very positive, while the physician members ranged from hopeful to frankly skeptical. (I must admit I was in the "hopeful" category.) As the meeting continued and the barriers to adequate pain management were discussed, I found it difficult not to drift toward the "skeptical" position. As many of you know, studies conducted with pain scales ("1" being no pain and "10" being worst pain imaginable) in hospitalized patients have shown that the average pain score is 3 to 4 and the worst pain in the last twenty-four hours is more than 7. Barriers to adequate pain control such as regulatory problems, fear of addiction in a "just say no" culture, communication problems between patient and provider, and lack of a visible method of displaying pain were all topics of discussion.

We next broke into focus groups to examine these problems in detail. It became immediately apparent that there had been little communication in the past among groups having an interest in pain management. I was impressed at the extensive resources available when all the participating organizations pooled their ideas. By the end of the day I had migrated back to the hopeful position.

In the end, summit attendees selected a few simple goals. These included:

- a letter to the Department of Health and Human Services asking that poorly controlled pain be declared a national health problem
- plans to endorse the American Cancer Society statement on pain management under development
- development of a simple, uniform pain scale for use in hospitals and clinics.

More importantly, a system of follow-up for these ideas was established, and future meetings were planned.

Margaret Riley and I went to the meeting without a definite idea of the role ACCC might play in a national pain initiative. As the meeting progressed, however, two points became clear. First, the matter of poorly controlled cancer pain is of great importance to patients and patient advocates. Second, few organizations in attendance could really effect any change in the system. If significant change is going to occur, ACCC will need to take a leading role in implementing the goals of the summit by circulating information to the community cancer centers (whether hospitals or freestanding centers) about these issues. In my opinion, this plan fits well with our mission to support all aspects of quality care in the community.

Dealing with the problem of poorly controlled cancer pain is obviously a daunting task. Nevertheless, it is likely that a pool of information about approaches to this problem is already available among our member institutions. Our next step should be tapping the membership for their ideas. I suggest we study the pain problem during the coming year through our new Ad Hoc Committee on Advocacy to see if we can generate an effective way to support the plans of the National Summit on Cancer Pain Control as well as work on specific ideas for our member institutions. ACCC's Standards Committee is adding a pain management section, not to require a formal pain program, but to emphasize the importance of pain control in a comprehensive cancer center. This is a good starting point.

In my view, the most important contribution that the National Summit on Cancer Pain Control can make is to promote networking among participating institutions. The summit can also serve as a clearinghouse for ideas and plans to avoid needless duplication of effort. Obviously it will be some time before we know how well the summit's planning committee can perform these tasks. Meanwhile, I believe we should become involved in this initiative as part of the ACCC mission. With our membership actively involved in providing care to a large segment of the cancer patient population, and with ACCC's experience in coordinating similar projects, we can definitely make a difference. It is a difference worth making, for many patients have no one to represent them in their efforts to seek better pain control. In a quote from Albert Camus, Dr. Kathleen Foley, professor of neurology at Memorial-Sloan Kettering Cancer Center in New York City, summed up the nature of this advocacy problem at the meeting when she said, "Those of us who can speak must speak for those who cannot."

E. E. E. E. E.