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EDs taking on the issue of chronic pain.
Healthcare benchmarks and quality improvement 2011 Sep; 18(9): 105-7
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Nestor, Elizabeth
The challenges of treating pain in the emergency department.
Medicine and health, Rhode Island 2011 Aug; 94(8): 243-4
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Christopher, Myra J
It's time for bioethics to see chronic pain as an ethical issue.
The American journal of bioethics : AJOB 2011 Jun; 11(6): 3-4
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Gamboa Antiñolo, Fernando Miguel
[Medical ethics and pain]. = Ética médica y dolor.
Medicina clínica 2011 May 28; 136(15): 671-3
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Document 5
Bellieni, Carlo; Buonocore, Giuseppe
Improve the struggle against babies' pain.
Lancet 2011 Apr 16; 377(9774): 1315-6; author reply 1316
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Document 6
Meghani, Salimah H
Corporatization of pain medicine: implications for widening pain care disparities.
Pain medicine (Malden, Mass.) 2011 Apr; 12(4): 634-44
Abstract: The current health care system in the United States is structured in a way that ensures that more opportunity and resources flow to the wealthy and socially advantaged. The values intrinsic to the current profit-oriented culture are directly antithetical to the idea of equitable access. A large body of literature points to disparities in pain treatment and pain outcomes among vulnerable groups. These disparities range from the presence of disproportionately higher numbers and magnitude of risk factors for developing disabling pain, lack of access to primary care providers, analgesics and interventions, lack of referral to pain specialists, longer wait times to receive care, receipt of poor quality of pain care, and lack of geographical access to pharmacies that carry opioids. This article examines the manner in which the profit-oriented culture in medicine has directly and indirectly structured access to pain care, thereby widening pain treatment disparities among vulnerable groups. Specifically, the author argues that the corporatization of pain medicine amplifies disparities in pain outcomes in two ways: 1) directly through driving up the cost of pain care, rendering it inaccessible to the financially vulnerable; and 2) indirectly through an interface with corporate loss-aversion/risk management culture that draws upon irrelevant social characteristics, thus worsening disparities for certain populations. Thus, while financial vulnerability is the core reason for lack of access, it does not fully explain the implications of corporate microculture regarding access. The effect of corporatization on pain medicine must be conceptualized in terms of overt access to facilities, providers, pharmaceuticals, specialty services, and interventions, but also in terms of the indirect or covert effect of corporate culture in shaping clinical interactions and outcomes.
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Document 7
Schatman, Michael E
Pain and corporatization: more special interests, more disparities, more vulnerability.
Pain medicine (Malden, Mass.) 2011 Apr; 12(4): 632-3
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Document 8
Giordano, James; Benedikter, Roland
The shifting architectonics of pain medicine: toward ethical realignment of scientific, medical and market values for the emerging global community--groundwork for policy.
Pain medicine (Malden, Mass.) 2011 Mar; 12(3): 406-14
Abstract: Following the Second Industrial Revolution, Western medicine has become an interwoven enterprise of humanitarian and technologic values. In this essay, we posited that rather than being seen as a means toward achieving the ends of providing technically right and morally sound pain care, the resources and goods of pain medicine have been subordinated to a market-based values system that regards these tools as ends unto themselves. We argued that this approach is 1) pragmatically inapt, in that it fails to acknowledge and provide those tools as rightly necessary for the "good" of pain medicine to be enacted; and is therefore 2) morally unsound, in that the good, while recognized, is not afforded, thereby disserving the fiduciary of science/technology, medicine, and economics. We framed these issues within 1) the context(s) and effects of postmodernism and 2) the increasing call for a globally relevant and applicable system of pain care. Toward this latter end, we addressed how policies can be created that accommodate differing social values, and still enable the execution of care in ways that are morally sound, yet economically viable. We posited that such policies need to be finely grained so as to 1) sustain research in pain diagnosis, assessment, treatment, and management; 2) translate research efforts into clinically relevant resources; 3) enable availability and just distribution of both low- and high-tech resources; and 4) prompt fiscal programs that support, allow, and reinforce responsible choice (of such resources) as socioculturally required, valued, and valid.

Document 9
Schatman, Michael E; Lebovits, Allen H
On the transformation of the "profession" of pain medicine to the "business" of pain medicine: an introduction to a special series.
Pain medicine (Malden, Mass.) 2011 Mar; 12(3): 403-5

Document 10
Schatman, Michael E
The role of the health insurance industry in perpetuating suboptimal pain management.
Pain medicine (Malden, Mass.) 2011 Mar; 12(3): 415-26
Abstract: BACKGROUND: Unlike pain practitioners, health care insurers in the United States are not expected to function according to a system of medical ethics. Rather, they are permitted to function under the business "ethic" of cost-containment and profitability. Despite calls for balancing the disparate agendas of stakeholders in pain management in a pluralistic system, the health insurance industry has continued to fail to take the needs of suffering chronic pain patients into consideration in developing and enacting their policies that ultimately dictate the quality and quantity of pain management services available to enrollees. This essay examined these self-serving strategies, which include failure to reimburse services and certain medications irrespective of their evidence-bases for clinical efficacy and cost-efficiency; "carving out" specific services from interdisciplinary treatment programs; and delaying and/or interrupting the provision of medically necessary treatment. Blatant and more subtle strategies utilized by insurers to achieve these ethically questionable goals are examined. Additionally, this essay addressed some of the insurance industry's efforts to delegitimize chronic pain and its treatment as a whole. CONCLUSION: The author concludes that the outlook for chronic pain sufferers is not particularly bright, until such time that a not-for-profit single-payer system replaces the current treatment/reimbursement paradigm.

Document 11
Zenz, M
[The right to pain treatment--obligatory continuing education]. = Recht auf Schmerzbehandlung--Pflicht zur Fortbildung.
Schmerz (Berlin, Germany) 2011 Feb; 25(1): 7-9

Document 12
Collen, Mark
Pain contracts/agreements for people with chronic pain.
The American journal of bioethics : AJOB 2011 Feb; 11(2): 48

Document 13
International Pain Summit Of The International Association For The Study Of Pain,
Declaration of Montréal: declaration that access to pain management is a fundamental human right.
Journal of pain & palliative care pharmacotherapy 2011; 25(1): 29-31
Abstract: At the conclusion of the 13th World Congress on Pain in Montreal, Quebec, Canada, the International Association for the Study of Pain (IASP) hosted an International Pain Summit on September 3, 2010, to address the tragedy of unrelieved pain in the world. At the conclusion of the Summit, the delegates adopted a Declaration that Access to Pain Management is a Fundamental Human Right. That Declaration is presented.

Document 14
Thomas, L; Lohman, D; Amon, J
Doctors take on the state: championing patients' right to pain treatment.
International journal of clinical practice 2010 Nov; 64(12): 1599-600

Document 15
Olmstead, Deborah L; Scott, Shannon D; Austin, Wendy J
Unresolved pain in children: a relational ethics perspective.
Nursing ethics 2010 Nov; 17(6): 695-704
Abstract: It is considered the right of children to have their pain managed effectively. Yet, despite extensive research findings, policy guidelines and practice standard recommendations for the optimal management of paediatric pain, clinical practices remain inadequate. Empirical evidence definitively shows that unrelieved pain in children has only harmful consequences, with no benefits. Contributing factors identified in this undermanaged pain include the significant role of nurses. Nursing attitudes and beliefs about children's pain experiences, the relationships nurses share with children who are suffering, and knowledge deficits in pain management practices are all shown to impact unresolved pain in children. In this article, a relational ethics perspective is used to explore the need for nurses to engage in authentic relationships with children who are experiencing pain, and to use evidence-based practices to manage that pain in order for this indefensible suffering of children to end.

Document 16
Zeiler, Kristin
A phenomenological analysis of bodily self-awareness in the experience of pain and pleasure: on dys-appearance and eu-appearance.
Medicine, health care, and philosophy 2010 Nov; 13(4): 333-42
Abstract: The aim of this article is to explore nuances within the field of bodily self-awareness. My starting-point is phenomenological. I focus on how the subject experiences her or his body, i.e. how the body stands forth to the subject. I build on the phenomenologist Drew Leder's distinction between bodily dis-appearance and dys-appearance. In bodily dis-appearance, I am only prereflectively aware of my body. My body is not a thematic object of my experience. Bodily dys-appearance takes place when the body appears to me as "ill" or "bad." This is often the case when I experience pain or illness. Here, I will examine three versions of bodily dys-appearance. Whereas many phenomenological studies have explored cases of bodily dys-appearance, few studies have focused on the opposite of bodily dys-appearance, i.e. on bodily modes of being where the body appears to the subject as something good, easy or well. This is done in this article. When the body stands forth as good, easy or well to the subject, I suggest that the body eu-appears to this person. The analysis of eu-appearance shows that the subject can attend to her or his body as something positive and that this attention need not result in discomfort or alienation. Eu-appearance can take place in physical exercise, in sexual pleasure and in some cases of wanted pregnancies. I also discuss, briefly, the case of masochism.

Document 17
Rowe, Will
Pain treatment agreements.
The American journal of bioethics : AJOB 2010 Nov; 10(11): 3-4

Document 18
Payne, Richard; Anderson, Evan; Arnold, Robert; Duensing, Lennie; Gilson, Aaron; Green, Carmen; Haywood, Carlton Jr.; Passik, Steve; Rich, Ben; Robin, Lisa; Shuler, Nick; Christopher, Myra
A rose by any other name: pain contracts/agreements.
The American journal of bioethics : AJOB 2010 Nov; 10(11): 5-12

Document 19
Goldberg, Daniel S
On the erroneous conflation of opiophobia and the undertreatment of pain.
The American journal of bioethics : AJOB 2010 Nov; 10(11): 20-2

Document 20
Fine, Robert L
The physician's covenant with patients in pain.
The American journal of bioethics : AJOB 2010 Nov; 10(11): 23-4

Document 21
Derbyshire, Stuart W G
Foetal pain?
Best practice & research. Clinical obstetrics & gynaecology 2010 Oct; 24(5): 647-55
Abstract: The majority of commentary on foetal pain has looked at the maturation of neural pathways to decide a lower age limit for foetal pain. This approach is sensible because there must be a minimal necessary neural development that makes pain possible. Very broadly, it is generally agreed that the minimal necessary neural pathways for pain are in place by 24 weeks gestation. Arguments remain, however, as to the possibility of foetal pain before or after 24 weeks. Some argue that the foetus can feel pain earlier than 24 weeks because pain can be supported by subcortical structures. Others argue that the foetus cannot feel pain at any stage because it is maintained in a state of sedation in the womb and lacks further neural and conceptual development necessary for pain. Much of this argument rests on the definition of terms such as 'wakefulness' and 'pain'. If a behavioural and neural reaction to a noxious stimulus is considered sufficient for pain, then pain is possible from 24 weeks and probably much earlier. If a conceptual subjectivity is considered necessary for pain, however, then pain is not possible at any gestational age. Regardless of how pain is defined, it is clear that pain for conceptual beings is qualitatively different than pain for non-conceptual beings. It is therefore a mistake to draw an equivalence between foetal pain and pain in the older infant or adult.

Document 22
Best, Mark; Neuhauser, Duncan
Henry K Beecher: Pain, belief and truth at the bedside. The powerful placebo, ethical research and anaesthesia safety.
Quality & safety in health care 2010 Oct; 19(5): 466-8
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Document 23
Giordano, James; Abramson, Kim; Boswell, Mark V
Pain assessment: subjectivity, objectivity, and the use of neurotechnology.
Pain physician 2010 Jul; 13(4): 305-15
Abstract: The pain clinician is confronted with the formidable task of objectifying the subjective phenomenon of pain so as to determine the right treatments for both the pain syndrome and the patient in whom the pathology is expressed. However, the experience of pain - and its expression - remains enigmatic. Can currently available evaluative tools, questionnaires, and scales actually provide adequately objective information about the experiential dimensions of pain? Can, or will, current and future iterations of biotechnology - whether used singularly or in combination (with other technologies as well as observational-behavioral methods) - afford objective validation of pain? And what of the clinical, ethical, legal and social issues that arise in and from the use - and potential misuse - of these approaches? Subsequent trajectories of clinical care depend upon the findings gained through the use of these techniques and their inappropriate employment - or misinterpretation of the results they provide - can lead to misdiagnoses and incorrect treatment. This essay is the first of a two-part series that explicates how the intellectual tasks of knowing about pain and the assessment of its experience and expression in the pain patient are constituent to the moral responsibility of pain medicine. Herein, we discuss the problem of pain and its expression, and those methods, techniques, and technologies available to bridge the gap between subjective experience and objective evaluation. We address how these assessment approaches are fundamental to apprehend both pain as an objective, neurological event, and its impact upon the subjective experience, existence, and expectations of the person in pain. In this way, we argue that the right use of technology - together with inter-subjectivity, compassion, and insight - can sustain the good of pain care as both a therapeutic and moral enterprise.
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American Society of Interventional Pain Physicians
Guidelines for testimony for the speciality of interventional pain management.
Pain physician 2010 Jul; 13(4): 317-8
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American Society of Interventional Pain Physicians
Guidelines for the speciality of interventional pain management.
Pain physician 2010 Jul; 13(4): 319-20
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Document 26
Eun Yang, Sung
Models of knowledge in the assessment of postoperative pain.
British journal of nursing (Mark Allen Publishing) 2010 Apr 22-May 13; 19(8): 511-4
Abstract: This article illustrates a process of knowledge development and the interrelationship between knowledge and practice using Carper's fundamental patterns of knowing. It explores two kinds of knowledge, theoretical knowledge and practical knowledge, using postoperative pain assessment as an illustration. By using their theoretical knowledge and their practical experience, nurses can maintain and develop their professional knowledge and competence.
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Document 27
Benyamin, Ramsin M; Datta, Sukdeb; Falco, Frank J E
A perfect storm in interventional pain management: regulated, but unbalanced.
Pain physician 2010 Mar ; 13(2): 109-16
Abstract: Interventional pain management now stands at the crossroads at what is described as "the perfect storm." The confluence of several factors has led to devastating results for interventional pain management. This article seeks to provide a perspective to various issues producing conditions conducive to creating a "perfect storm" such as use and abuse of interventional pain management techniques, and in the same context, use and abuse of various non-interventional techniques. The rapid increase in opioid drug prescribing, costs to health care, large increases in death rates, and random and rampant drug testing, can also lead to increases in health care utilization. Other important aspects that are seldom discussed include medico-legal and ethical perspectives of individual and professional societal opinions and the interpretation of diagnostic accuracy of controlled diagnostic blocks. The aim of this article is to discuss the impact of several factors on interventional pain management and overuse, abuse, waste, and fraud; inappropriate application without evidence-based literature support (sometimes leading to selective use or non-use of randomized or observational studies for proving biased viewpoints - post priori rather than a priori), and issues related to multiple professional societies having their own agendas to push rather than promulgating the science of interventional pain management. This perspective is based on a review of articles published in this issue of Pain Physician, information in the public domain, and other relevant articles. Based on the results of this review, various issues of relevance to modern interventional pain management are discussed and the viewpoints of several experts debated. In conclusion, supporters of interventional pain management disagree on multiple aspects for various reasons while detractors claim that interventional pain management should not exist as a speciality. Issues to be addressed include appropriate use of evidence-based medicine (EBM), overuse, overutilization, and abuse.
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Document 28
Ballantyne, Jane C.; Fleisher, Lee A.
Ethical issues in opioid prescribing for chronic pain.
Pain 2010 March; 148(3): 365-367

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* Book Document 29

Dimond, Bridgit

LEGAL ASPECTS OF PAIN MANAGEMENT

London: Quay Books, 2010. 185 p.

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Article Document 30

Lohman, Diederik; Schleifer, Rebecca; Amon, Joseph J.

Access to pain treatment as a human right.

BMC Medicine 2010; 8: 8

Abstract: BACKGROUND: Almost five decades ago, governments around the world adopted the 1961 Single Convention on Narcotic Drugs which, in addition to addressing the control of illicit narcotics, obligated countries to work towards universal access to the narcotic drugs necessary to alleviate pain and suffering. Yet, despite the existence of inexpensive and effective pain relief medicines, tens of millions of people around the world continue to suffer from moderate to severe pain each year without treatment. DISCUSSION: Significant barriers to effective pain treatment include: the failure of many governments to put in place functioning drug supply systems; the failure to enact policies on pain treatment and palliative care; poor training of healthcare workers; the existence of unnecessarily restrictive drug control regulations and practices; fear among healthcare workers of legal sanctions for legitimate medical practice; and the inflated cost of pain treatment. These barriers can be understood not only as a failure to provide essential medicines and relieve suffering but also as human rights abuses. SUMMARY: According to international human rights law, countries have to provide pain treatment medications as part of their core obligations under the right to health; failure to take reasonable steps to ensure that people who suffer pain have access to adequate pain treatment may result in the violation of the obligation to protect against cruel, inhuman and degrading treatment.

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http://www.biomedcentral.com/1741-7015/8/8 (link may be outdated)

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Worth, Tammy

Assessing nursing home residents' pain

AJN: American Journal of Nursing 2009 December; 109(12): 22

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* Article Document 32

Macpherson, Cheryl; Aarons, Derrick

Overcoming barriers to pain relief in the Caribbean.

Developing World Bioethics 2009 December; 9(3): 99-104

Abstract: This paper examines pain and pain relief in the Caribbean, where pain is widely perceived as an unavoidable part of life, and where unnecessary suffering results from untreated and under treated pain. Barriers to pain relief in the Caribbean include patient and family attitudes, inadequate knowledge among health professionals and unduly restrictive regulations on the medical use of opioids. Similar barriers exist all over the world. This paper urges medical, nursing and public health professionals, and educators to examine attitudes towards pain and pain relief and to work towards making effective pain relief and palliation more accessible. It recommends that i) health professionals and officials be better educated about pain, palliation and opioids, ii) regulatory restrictions be updated in light of clinical and scientific evidence, iii) opioid procurement policies be adjusted to facilitate increased medical use, iv) medical charts and records be modified to routinely elicit and document patients levels of pain, and v) educational campaigns be developed to inform the public that moderate and severe pain can be safely relieved at the end of life and other stages of life. The professional, respectful, and beneficent response to patients in pain is to provide rapid and aggressive pain relief or to urgently consult a pain or palliative specialist. When a health system hinders such efforts the ethical response is to identify, facilitate and advocate for overcoming barriers to improvement.

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http://www3.interscience.wiley.com/journal/117981440/home (link may be outdated)

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* Article Document 33

Macpherson, Cheryl

Undertreating pain violates ethical principles.

Journal of Medical Ethics 2009 October; 35(10): 603-606

Abstract: Disabling pain or symptoms can occur at any age from many different causes. Pain and palliative specialists are able to relieve most pain and symptoms, although repeated adjustments to modalities, medications and doses may be needed. Because pain and palliative specialists comprise only a small percentage of physicians, many patients find it difficult to access them or obtain pain relief. Globally, there are too few such specialists to meet existing needs. Most are affiliated with hospice and palliative units, so their accessibility to patients without terminal conditions is negligible. Doctors outside pain and palliative specialties are often unfamiliar with pain guidelines and sceptical about patient reports of unrelieved pain. They are therefore likely to undertreat it. Undertreating pain, however, violates respect for persons and beneficence. This paper reviews literature supporting these claims and offers a narrative description of the author's attempts to find relief from shingles and postherpetic neuralgia. It argues that physicians in most specialties are not, but should be, familiar with palliative evidence and guidelines so that they are equipped to relieve pain and symptoms quickly and effectively. Such information should be routinely introduced in medical curricula to encourage the mastery of knowledge, attitudes and skills necessary to upholding ethical principles and to ensure that more doctors in any discipline are willing to believe and be compassionate to patients whose pain is unresponsive to initial treatments. Routinely exposing students to such information would better prepare them to fulfil their professional duties to patients and society.

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http://jme.bmj.com/content/35/10.toc (link may be outdated)

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Raz, Mical

The painless brain: lobotomy, psychiatry, and the treatment of chronic pain and terminal illness.

Perspectives in Biology and Medicine 2009 Autumn; 52(4): 555-565

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http://muse.jhu.edu/journals/pbm/ (link may be outdated)

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McGrew, Megan; Giordano, James

Whence tendance? Accepting the responsibility of care for the chronic pain patient.

Pain Physician 2009 May-June; 12(3): 483-485

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Charon, Rita

Meditations on pain [review of Pain and its Transformations: The Interface of Biology and Culture, edited by Sarah Coakley and Kay Kaufman Shelemay]

Lancet 2009 April 4; 373(9670): 1163-1164

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http://www.thelancet.com/journals/lancet/issue/current (link may be outdated)

Article Document 37

Novy, Diane M; Ritter, Laura M; McNeill, Jeanette

A primer of ethical issues involving opioid therapy for chronic nonmalignant pain in a multidisciplinary setting.

Pain medicine (Malden, Mass.) 2009 Mar; 10(2): 356-63

Abstract: OBJECTIVE: This forum presents a clinical vignette of orofacial pain and expounds on ethical issues related to opioid therapy in the context of multidisciplinary treatment. The purpose of this forum is to assist health care providers from different disciplines in identifying ethical issues and conflicts regarding opioid therapy encountered in multidisciplinary clinical pain practices. DESIGN: We use the case vignette and opioid therapy as a backdrop for a discussion of 1) an overview of ethics terminology; 2) a presentation of key ethics principles; 3) our conceptualization of ethical obligations of patients regarding opioid therapy; and 4) the process of developing an appropriate treatment plan within the context of the discussed ethical principles.

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* Article Document 38

Nathan, Jonathan I.

Chronic pain treatment: a high moral imperative with offsetting personal risks for the physician -- a medical student's perspective.

Pain Practice 2009 March-April; 9(2): 155-163

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* Article Document 39

Rejeh, Nahid; Ahmadi, Fazlollah; Mohamadi, Eesa; Anoosheh, Moniereh; Kazemnejad, Anooshirvan

Ethical challenges in pain management post-surgery.

Nursing Ethics 2009 March; 16(2): 161-172

Abstract: This qualitative study describes ethical challenges faced by Iranian nurses in the process of pain management in surgical units. To address this issue, semistructured interviews were conducted with 26 nurses working in surgery units in three large university hospitals in Tehran. An analysis of the transcripts revealed three main categories: institutional limitations; nurses' proximity to and involvement with pain and suffering; and nurses' fallibility. Specific themes identified within the categories were: insufficient resources, medical hierarchy; difficulties with believing patients' complaints regarding pain and suffering; and experiencing the consequences of poor judgments. Our findings lead us to conclude that, as nurses are much closer to patients' pain and suffering than other health professionals, being aware of their ethical problems, and being able to reflect on them and discuss and learn from them, will reduce the burden of the ethical challenges faced. The findings will help nurses in other countries to devise suitable ways to reduce the ethical burdens they bear in their daily practice.

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* Article Document 40

Giordano, James; Engebretson, Joan C.; Benedikter, Roland

Culture, subjectivity, and the ethics of patient-centered pain care

CQ: Cambridge Quarterly of Healthcare Ethics 2009 January; 18(1): 47-56

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Article Document 41

Wall, Illan rua

On pain and the sense of human rights

Australian Feminist Law Journal 2008 December; 29: 53-76

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Burgess, Diana Jill; Crowley-Matoka, Megan; Phelan, Sean; Dovidio, John F.; Kerns, Robert; Roth, Craig; Saha, Somnath; van Ryn, Michelle
Patient race and physicians' decisions to prescribe opioids for chronic low back pain.
Social Science and Medicine 2008 December; 67(11): 1852-1860
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Giordano, James; Schatman, Michael E.
A crisis in chronic pain care: an ethical analysis. Part three: toward an integrative, multi-disciplinary pain medicine built around the needs of the patient.
Pain Physician 2008 November-December; 11(6): 775-784
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* Article Document 44
Diesfeld, Kate
Interpersonal issues between pain physician and patient: strategies to reduce conflict.
Pain Medicine 2008 November; 9(8): 1118-1124
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Article Document 45
Giordano, James
Maldynia: chronic pain as illness, and the need for complementarity in pain care.
Forschende Komplementärmedizin 2008 October; 15(5): 277-281
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Giordano, James; Schatman, Michael E.
A crisis in chronic pain care: an ethical analysis. Part two: proposed structure and function of an ethics of pain medicine.
Pain Physician 2008 September-October; 11(5): 589-595
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Gligorov, Nada
Unconscious pain.
American Journal of Bioethics 2008 September; 8(9): 27-28
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Article Document 48
Martorella, Géraldine; Côté, José; Choinière, Manon
Pain catastrophizing: a dimensional concept analysis
Journal of Advanced Nursing 2008 August; 63(4): 417-426
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* Article Document 49
Giordano, James
Ethics of, and in, pain medicine: constructs, content, and contexts of application
Pain Physician 2008 July-August; 11(4): 391-392
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Giordano, James; Schatman, Michael E.
An ethical analysis of crisis in chronic pain care: facts, issues and problems in pain medicine; Part I
Pain physician 2008 July-August; 11(4): 483-490
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Krueger, Alan B.; Stone, Arthur A.
Assessment of pain: a community-based diary survey in the USA
Lancet 2008 May 3-9; 371(9623): 1519-1525

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Document 52

Coulehan, Jack

In the Land of Pain, by Alphonse Daudet [book review]

Medical Ethics Newsletter [Lahey Clinic] 2008 Winter; 15(1): 5

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Niebr j, Leslaw T.; Jadamus-Niebr j, Danuta; Giordano, James

Toward a moral grounding of pain medicine: consideration of neuroscience, reverence, beneficence, and autonomy [commentary]

Pain Physician 2008 January; 11(1): 7-12

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http://www.painphysicianjournal.com/2008/january/2008;11;7-12.pdf?PHPSESSID=0b4f316f6e6ab7dd469571e755c59001 (link may be outdated)

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Pesut, Barbara; McDonald, Heather

Connecting philosophy and practice: implications of two philosophic approaches to pain for nurses' expert clinical decision making

Nursing Philosophy 2007 October; 8(4): 256-263

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Document 55

Praill, David

The price of pain

Bioethics Forum: Diverse Commentary on Issues in Bioethics [electronic] 2007 September 28; 2p.

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http://www.bioethicsforum.org (link may be outdated)

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beautiful. Appropriate "suffering with" another can help to maintain and restore the dignity of the relationships involved, even as it preserves and enhances the dignity of patient and caregiver alike.
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