

**Table 1: Myths and facts about pain**

	<b>Myth</b>	<b>Fact</b>
<b>1.</b>	The nurse or the doctor is the best judge of whether a resident is in pain.	The resident knows best about her/his own pain. Self report is the most reliable indicator of location and intensity of pain.
<b>2.</b>	Pain is a natural part of ageing.	Pain is not a normal state, and is usually associated with pathology.
<b>3.</b>	Aggressive treatment is unwarranted in older people.	Older people are equally entitled to have pain relieved as their younger counterparts.
<b>4.</b>	People with dementia are unable to use assessment scales.	When an appropriate pain rating scale is used and the person is given adequate time to process and respond, many cognitively impaired people can use rating scales.
<b>5.</b>	Clinicians should rely on their own personal beliefs as to whether the resident is telling the truth about the status of her/his pain.	Pain is a subjective experience, different for each person. The resident's self report therefore is very important in establishing what the pain means to her/him.

	<b>Myth</b>	<b>Fact</b>
<b>6.</b>	When there is no physical cause identified there is no reason for a resident to have pain.	Pain is a multidimensional phenomenon which is little understood. It is better to accept that a resident has pain if that is what she/he says.
<b>7.</b>	Analgesia should only be given for pain that is currently present.	It is better to give analgesia prior to activities or movement in order to control incident pain. Maintaining a therapeutic dose in the blood stream avoids the peaks and troughs of sporadic analgesic administration.
<b>8.</b>	Use of opioids will cause addiction.	Opioids rarely cause addiction or other aberrant behaviours in older people.
<b>9.</b>	Older people complain more about pain.	Older people tend to <i>under-report</i> pain even though they have more pain related pathologies [13].