Pain Management

Historically, physicians have sought to alleviate pain and suffering. With the scientific and technological advances that have occurred in recent decades, clinicians have increasingly focused on the control or cure of disease. As a result, the traditional compassion of medical care has often been diluted or neglected.

This attitude of compassion was taught by Jesus in the parable of the Good Samaritan and was demonstrated in His ministry to those who were ill. As Christian physicians and dentists, we are compelled by love for our Lord Jesus Christ and love for our neighbor to include effective pain management in our ministry to our patients.

Pain management is important for all patients, but is especially important in patients with chronic or terminal illnesses. The total management of pain involves four areas: physical, emotional, social, and spiritual pain.

Physical pain should be treated by using all effective modalities. However, we understand pain to be an important symptom alerting the patient to a need or a potential problem. Therefore it may not always be appropriate to remove this symptom completely.

When pain cannot be completely eliminated, it is the clinician's responsibility to help the patient cope with the residual pain and to live as fully as possible. In patients who are imminently dying, it is acceptable to use increasing doses of analgesics to the level necessary to control severe pain without the intent of shortening life, but with the realization that in some instances control of pain might hasten death.

Emotional pain may include fear of pain, disability or death; frustration; worries of what will happen to those left behind; and feelings of being a burden on loved ones. Social pain may include a feeling of abandonment by loved ones or caregivers, and a fear of lack of access to medical resources. These aspects of pain can be addressed by a compassionate and supportive presence.

Spiritual pain may include a sense of isolation from God, fear of death, and feelings of guilt and anger. Management should include an affirmation of God's enduring love for us and an opportunity for repentance, reconciliation, and acceptance of His offer of eternal life.

As Christian physicians and dentists, we desire to address the physical, emotional, social and spiritual pain of our patients in order to more fully reflect the love and compassion of our Lord.

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Explanation

The Problem

There are many legitimate goals for the practicing clinician including patient education, disease prevention, diagnosis of illness, restoration of health, relief of symptoms, preservation or restoration of function, and postponement of death. Physicians and dentists are taught that the relief of symptoms should be a secondary goal; the primary goals should be diagnosis and cure. It is better to treat the disease process directly so that the symptoms will abate than it is to only treat the symptoms, especially pain, thereby masking the illness. This is one reason that the treatment of pain is sometimes inadequate. Sometimes, however, a chronic condition has been diagnosed and it cannot be reversed, so treatment of the symptoms, especially the pain, may become the primary goal. Other times, diagnosis of an acute problem is clear and treatment is underway, but the pain is overwhelming, so that its relief should then become the primary goal.

Another reason that pain relief may be inadequate is that it is difficult for the clinician to assess the severity of a patient's pain. Pain is subjective; there is no way to directly measure its intensity. Clinicians are concerned about the overuse or inappropriate use of narcotic analgesics for fear of chemical dependence. All practicing physicians can remember being tricked into writing a narcotic prescription for a patient who claimed to have a migraine headache or some other painful condition and who was later found to be a substance abuser. Sometimes our rationality gets in the way of our compassion.

For these and perhaps other reasons, pain management has not been a priority in medical and dental education. As a result, clinicians are often not prepared to give expert pain relief in those situations where it is indicated.

The hospice movement in Europe and North America has emphasized the relief of symptoms, including pain, in patients who are terminally ill. Dedicated physicians in this discipline have greatly enhanced our understanding of the mechanisms of and management of chronic pain. They have also learned that chemical dependence on narcotics is a rare occurrence in patients with chronic pain. Experts in pain management state that in only a very small percentage of patients is it not possible to give adequate pain control without danger of addiction. Even though this expertise has developed and is available in most settings, some clinicians are still reluctant to use sufficient medication for the above reasons. Inadequate pain relief is often cited as a reason that physician-assisted suicide or euthanasia should be made legally available.

A Christian Response

Clinicians who model themselves after Jesus should be dedicated to clinical competence, and they should also have an extra dose of compassion. They should ensure that their patients receive the best pain management available either by becoming experts in pain management themselves or referring patients to an expert when needed.

Christians have an additional issue which sometimes interferes with adequate treatment of pain. We recognize that we live in a fallen world, and one of the results of "the fall" is "the curse" of pain (Gen. 3:16). In the past, some Christians were vocal in their opposition to the use of analgesia or anesthesia to relieve the pain of childbirth. Some Christians believe that we must tolerate some pain. Since scripture indicates that sometimes pain is allowed in our lives as a means of instruction or correction, some believe that we should not be too vigorous in our attempts to eliminate pain. Most Christian clinicians, however, have responded to a call of ministry through medicine; a call which includes the compassionate treatment of all conditions. God has called us to relieve suffering and has allowed us to develop the means to do it, and we must therefore be good stewards of those abilities and resources.

The Principle of Double Effect

We owe a debt to Roman Catholic moral thought for the principle of double effect which is often invoked in discussions about pain relief. This principle deals with both the intentions and the results of actions.

If one action can have both good and bad effects, it is ethically permissible to do the act with good intention (e.g. use of morphine for pain relief), even if the bad effect (potential for respiratory depression

leading to earlier death) can be anticipated. The act must be done with good intentions. The bad effect must not be intended, but is merely tolerable. In addition, there must be a reasonable proportion between the good and the bad effects; e.g. this potentially lethal use of morphine would be tolerable for pain relief in a person who is dying, but would not be acceptable for pain relief in an otherwise healthy person who is passing a kidney stone.

This principle is felt by many to justify the liberal, but judicious, use of narcotics in terminally ill patients, but does not justifying intentional mercy killing.

Abstracts

Bernabei R, et al. Management of Pain in Elderly Patients With Cancer. JAMA 1998;279(23): 1877-82.

This retrospective study evaluated the use and adequacy of pain management in elderly and minority cancer patients admitted to nursing homes in 5 states using data from the Systematic Assessment of Geriatric Drug Use via Epidemiology (SAGE) database. “Pain assessment was based on patients’ report and was completed by a multidisciplinary team of nursing home personnel that observed, over a 7 day period, whether each resident complained or showed evidence of pain daily.” This study showed a total of 4003 patients reported daily pain, with the greatest percentage of those being in the age category of 65-74 years. Of patients with daily pain, more than a quarter did not receive any analgesic agent and patients older than 85 years were also more likely to receive no analgesia. This study also noted “other independent predictors of failing to receive any analgesic agent were minority race, low cognitive performance and the number of other medications received.” The authors concludes, “Daily pain is prevalent among nursing home residents with cancer and is often untreated, particularly among older and minority patients.”

Weissman DE. Consultation in Palliative Medicine. Archives of Internal Medicine 1997;157(7):733-737.

“Palliative medicine is an emerging medical discipline in the United States, modeled after similar efforts in Great Britain, Australia, and Canada. Increasingly, academic medical centers are starting clinical programs in palliative medicine including inpatient consultation services. A description of the essential components of a palliative medicine consultation is presented, based on the author’s experience of more than 600 patients encounters at the Medical College of Wisconsin in Milwaukee. A palliative medicine consultation consists of 6 features: assessment and management of physical symptoms; assisting patients to identify personal goals for the end-of-life care; assessment and management of psychological and spiritual needs; assessment of the patient’s support system; assessment and communication of estimated prognosis; and assessment of discharge planning issues.”

American Pain Society Task Force on Pain, Symptoms and End of Life Care (M Max, MD, Chair). Treatment of Pain at the End of Life: A Position Statement from the American Pain Society. APS Bulletin 1997;7(1):11.

The American Pain Society is the U.S. Chapter of the International Association for the Study of Pain. Its position statement recognizes the following six points:

1. The fierce debate over euthanasia and physician-assisted suicide illuminates a broad public concern that “terminal illness is often accompanied by severe pain and other symptoms that make death seem preferable."

2. Clinicians, with the proper training, can provide adequate pain relief for more than 90% of dying cancer patients. However, current treatment often falls short. Studies show that a substantial portion of patients, particularly those in minority groups, receive inadequate analgesic treatment and suicidal wishes correlate to unrelieved pain or untreated mood symptoms (such as anxiety and depression), both of which are readily respond to clinical treatment

3. Despite the best intentions of clinicians, pain and symptom control is often suboptimal because the entire healthcare system has been designed around cure of disease rather than palliation.” Programs designed to teach and improve palliative care must contain several essential

components such as clinician education, accountability of all professionals of the organization to the treatment of pain to all ages, and improved pain visibility for prompt attention, among other things.

4. Efforts to ensure pain management is available to all who need it must take priority over legalization of physician-assisted suicide. “Experience in The Netherlands, where there has been relatively little effort to improve pain and symptoms treatment, suggests that legalization of physician assisted suicide might weaken society’s resolve to expand services and resources aimed at caring for the dying patient.

5. Health care providers who aggressively treat pain with analgesic drugs and when needed, terminal sedation, must be protected even if death is the unintentional consequence. Regulation and appropriate documentation together can justify the use of treatments that when administered, knowingly depress respiration and hasten death in some way. Such treatment is based on ethical principle should not be considered as euthanasia or physician assisted suicide.

6. More research needs to be done within the scope of symptom treatment in addition to the current focus on finding cures.

American Pain Society Quality of Care Committee. Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain. JAMA 1995;274(23):1874-80.

Using articles found on MEDLINE from 1980 to 1995 dealing with pain assessment and treatment and quality improvement and education, the APS's Quality of Care Committee developed the following guidelines that are necessary components of any quality improvement program.

1. Recognize and treat pain promptly

2. Make information about analgesics readily available

3. Promise patients attentive analgesic care

4. Define explicit policies for use of advanced analgesic technologies

5. Examine the process and outcomes of pain management with the goal of continuous improvement

The authors included three articles and one study describing the results of comprehensive implementation of the above guidelines in a large cancer hospital. They showed improved pain relief and increased patient satisfaction.

Orr RD. Pain management rather than assisted suicide: The ethical high ground. Pain Medicine 2001;2(2):131-7

"Physician-assisted suicide and euthanasia (PAS/E) have been outside the bounds of acceptable behavior for physicians for hundreds of years and remain illegal in all jurisdictions except Oregon and The Netherlands. The morally, legally and professionally acceptable alternative is excellent end-of-life care. In this article, the arguments in favor of PAS/E are discussed briefly and rebutted. The arguments against this practice are outlined and supported. Because pain (and fear of pain) at the end of life is one of the driving forces behind the recurrent debate about legalization of PAS/E, the medical professional as a whole, and pain specialists in particular, have an obligation to use all available means to relieve pain."

Angell M. The quality of mercy. New England Journal of Medicine 1982; 306(2):98-99

"Few things a doctor does are more important than relieving pain. Yet the treatment of severe pain in hospitalized patients is regularly and systematically inadequate.....It is generally agreed that most pain, no matter how severe, can be effectively relieved by narcotic analgesics. Why this inconsistency between what is practiced and what is possible?" After this introduction, the author goes on to discuss the issues of side effects and irrational fear of addiction. She documents the low incidence of addiction and other serious side effects in the management of chronic pain.

She discusses "prn" dosing and the alternative of regular dosing for the management of chronic pain, including the advantages and disadvantages of each. She proposes an intermediate, a prn order for a range of doses, with the patient asked at specific intervals if he or she needs medication, and whether a small or large dose.

She concludes by saying "Pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained."

Hill CS. When will adequate pain treatment be the norm? JAMA 1995; 274(23):1881-1882

After noting the concerted efforts to improve pain control made by major organizations such as the World Health Organization the Agency for Health Care Policy and Research (USPHS), the author wonders why there have been only limited results. He believes that past educational efforts have been insufficient. He endorses a practice guideline for quality improvement developed by the American Pain Society to monitor results of pain control. If this does not prove adequate, he believes that patients must be empowered to demand adequate pain relief, regardless of the cause or the methods required to achieve relief. He concludes, "In all situations, relief of pain, either acute or chronic, must be the standard of success."

American Pain Society Quality of Care Committee. Quality improvement guidelines for the treatment of acute pain and cancer pain. JAMA 1995;274(23):1874-1880

After extensive study, a working group concluded that QI programs to improve pain management should include 5 key elements: (1) assuring that a report of unrelieved pain raises a "red flag" that attracts clinicians attention; (2) making information about analgesics convenient where orders are written; (3) promising patients responsive analgesic care and urging them to communicate pain; (4) implementing policies and safeguards for the use of modern analgesic technologies; and (5) coordinating and assessing implementation of these measures.

Bibliography

Ferrell, Betty, R. “Pain Management: A Moral Imperative.” American Nurses Association Center for Ethics and Human Rights Communique Winter 1996-1997; 5 (2): 4-5.

Dugan, Daniel C. “Pain and the Ethics of Pain Management.” HEC (Healthcare Ethics Committee) Forum Dec, 1996; 8 (6): 330-339.

Henry, H. Andrews and Murrell, K. J. “Psychospiritual Care of the Dying Patient: the Impact of Being a Christian.” Linacre Quarterly Aug, 1996; 63 (3): 81-94.

World Health Organization. Cancer Pain Relief. Geneva, Switzerland: WHO, 1986

In an effort to improve cancer pain relief in developing countries, the WHO proposed in 1986 a 3-step analgesic ladder using inexpensive drugs.

Foley KM. The treatment of pain in the patient with cancer. Ca - A Cancer Journal for Clinicians 1986;36(4):194-215

A good review of analgesic procedures, plus tables of comparative doses of non-narcotic and narcotic analgesics along with recommendations for their use. Behavioral approaches and supportive care are also discussed.

Portenoy RK. Practical aspects of pain control in the patient with cancer. Ca - A Cancer Journal for Clinicians 1988;38(6):327-352

After discussing the multi-factorial aspect of pain, the author gives an update on analgesics, routes of administration, and other procedures including neuroaugmentation, phsyiatric approaches, neurosurgery, and psychological approaches.

Ferrell BR, Rhiner M. High-tech comfort: ethical issues in cancer pain management for the 1990's. Journal of Clinical Ethics 1991;2(2):108-112

The authors look at how pain impacts the physical, psychological, social, and spiritual well-being of patients. They then apply the four primary ethical principles to pain management, and conclude with 10 practical implications.

Walco GA, Cassidy RC, Schechter NL. Pain, hurt, and harm: The ethics of pain control in infants and children. New England Journal of Medicine 1994;331(8):541-544

The authors cite several published guidelines for the management of pain in children, but lament that they are inadequately utilized. They recommend administrative interventions such as standards for pain assessment and management in hospital quality-assurance programs.

Agency for Health Care Policy and Research (USPHS). Clinical Practice Guideline on Acute Pain Management: Operative or Medical Procedures and Trauma. Washington DC: U.S. Department of Health and Human Services, 1992; AHCPR Pub. No. 92-0032

Agency for Health Care Policy and Research (USPHS). Clinical Practice Guideline number 9 on Management of Cancer Pain. Washington DC: U.S. Department of Health and Human Services, 1994; AHCPR Pub. No. 94-0592

These comprehensive 140 page (acute) and 250 page (cancer) state-of-the-art guides to the management of pain are available at no charge from AHCPR, Executive Office Center, Suite 501; 2101 East Jefferson Street; Rockville, MD 20852

Twaddle ML. Hospice care. In Dignity and Dying: A Christian Appraisal. Grand Rapids, MI: Eerdmans, 1996:183-190

Recognizing that the suffering of extreme pain may cause seriously ill patients to request assisted suicide or euthanasia, the author asserts that Hospice presents such patients with a better, alternative option. Such a program seeks to acknowledge and relieve patients physical, psychological, spiritual, and social pain, thereby allowing them "the freedom to see death and dying in the context of a complete life experience [by being] freed from the physical symptoms that bind them to the present."

Ferrell BR, Dean G. The meaning of cancer pain. Seminars in Oncology Nursing 1995;11)1):17-22

Pain is a common symptom in cancer and one experienced by patients and family caregivers. A neglected area of pain management is enhancing the individual's ability to derive meaning from pain and suffering associated with illness. Because pain is often a metaphor for impending death, the meaning derived from pain may contribute to the ultimate meaning of death for the individual. This article provides case examples and analysis of the search for meaning in cancer pain.