THE ETHICS OF PAIN MANAGEMENT
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The Ethics of Pain Management

• OBJECTIVES:
  • Provide a definition of pain and distinguish from suffering
  • Discuss ethical principles and their applications in pain management.
  • Identify barriers and their ethical implications in pain management.
  • Discuss how pain should be treated.

Definitions of Pain

• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”
  Merskey

• “Pain is what the experiencing person says it is, existing whenever he or she says it does”
  McCaffery

Definition of Suffering

• “State of severe distress associated with events that threaten the intactness of person”
  Eric J. Cassell

Pain and Suffering

• Pain and suffering are related when:
  – The pain is overwhelming
  – The patient does not believe the pain can be controlled
  – The source of the pain is unknown
  – The pain is apparently without end
  E. Cassell

End-of-Life Care

• Treating “total pain” is relieving the four dimensions of suffering:
  – Physical
  – Psychological
  – Social
  – Spiritual
  – Addressing total pain-C. Saunders
Suffering

• The treatment of suffering involves addressing:
  – Distressing symptoms, such as pain of dyspnea
  – Fears for physical safety, of dying or abandonment
  – Affection, love and acceptance in the face of devastating illness
  – Esteem, respect and appreciation for the person
  – Self-actualization and transcendence

Quality End-of-Life Care:
Patients’ Perspectives

• Receiving adequate pain management
• Avoiding inappropriate prolongation of dying
• Relieving burden
• Achieving a sense of control
• Strengthening relationships

Patients at Risk for Pain

• I. Cancer
• II. Non-cancer illness:
  – Dementia
  – Cardiovascular disease
  – Pulmonary disease
  – Neurological disease: stroke, ALS, MS, Muscular Dystrophy, mentally impaired
  – End Stage Organ Disease: Renal, Liver
  – AIDS

The Imperative

• There is a moral imperative for relieving pain that transcends:
  – The expressed wish to be treated
  – The informed consent process

L. Farber et al

BIOETHICAL PRINCIPLES

• Beneficence - Do that which is good; that which most contributes to the patient’s well-being
• Non-maleficence - Do not harm; do not act so as to bring injury or harm to the patient, primum non nocere (first, do no harm)
• Autonomy: Respect the integrity of each individual as a decision maker; seek to enhance the capacity and opportunity for the individual to choose for himself or herself.

Application of bioethical principles:

• Paternalism: Places beneficence over autonomy when these principles appear in conflict. It chooses for another what is deemed to be for the other’s good, or in the other’s best interest.
• Non-paternalism: Places autonomy over beneficence when these principles appear in conflict. It stresses the individual’s ability and right to decide for himself or herself, even when those who care for the individual would have decided differently.
Ethics of Pain Management

Ethical Imperatives to adequate pain management

• MORAL ISSUES:
  – Patients have a strong prima facie right to freedom from unnecessary pain.
  – Pain is dehumanizing.
  – Pain destroys autonomy. The Ethical Principal of Autonomy allows self-determination by patients.
  – Pain is humiliating.
  – In its extreme, pain destroys the “soul” itself and all will to live.

Informed Consent

• Emphasis on patient autonomy risks abandonment because those in pain are denied relief because expressed consent is lacking
• In an incapacitated patient, either presumed consent (that expected by most people) or implied consent (inferred from a person’s behavior) is used as consent to the administration of analgesia

Rule of Double Effect

• Refers to an action with a good and bad outcome which is morally justified by:
  – The act itself must not be intrinsically wrong
  – The agent must intend only the good and not the bad effect (although bad effect may be foreseen)
  – The bad effect may not be the means by which to bring about the good effect
  – The good effect must outweigh the bad effect

Rule of Double Effect

• Used as justification for occasions when clinicians administer high doses of opiates or sedatives in amounts that may hasten a death
• Views the bad effects as foreseen but not intended

However.....

Schwarz

Rule of Double Effect

• There are challenges to this rule:
  – The data does not support the contention that opioids hasten death (Fohr, SA)
  – Opioids, when used appropriately, rarely cause respiratory depression
  – A patient’s death is generally related to progression of the disease, not the opioids (Manfredi, PL)

Supreme Court Decisions

• In Washington v. Glucksberg and Vacco v. Quill, the majority of justices suggested that the Constitution’s guarantee of individual liberty included the liberty to be free from unnecessary pain during the dying process.
• The court distinguished assisted suicide from palliative care by accepting the principle of double effect
Supreme Court Decisions

- In Quill, Justice O’Connor wrote favorably of “relieving pain even to the point of unconsciousness” and Justice Breyer noted the “need for sedation which can end in coma”

  Luce, et al.

Problems with Pain Management

- The patient is the passive “victim” of pain because control is given to the caregiver
- PRN regimen makes patients powerless over their pain (forces them to endure pain until next opportunity for medication)—this can also inhibit a request for medication because a patient may not want to be a “nuisance” to the staff

  Post et al.

Problems with Pain Management

- Women are given pain medication less often than male patients because they are seen as emotionally labile
- Elderly patients are less likely to receive pain medication as compared to younger patients

  Calderone

Problems with Pain Management

- Cultural aspects—Hispanics are twice as likely as non-Hispanic whites to receive no medication for pain
  – Culturally influenced expressions of pain
  – Failure of health professions to recognize the presence of pain in patients whose cultural backgrounds differ from their own

  Knox et al.

Problems with Pain Management

- Health professionals often do not validate the patient’s complaint of pain
  – They may suggest that the pain is “imagined”, “psychological” or that the patient is “faking”
  – Patients come to distrust the health professionals and their own perceptions, “am I crazy?”

  Cassell

Mayday Fund Study: Public Attitudes About Pain and Analgesics

- Americans would rather bear pain than take action to relieve it.
- Americans withstand pain because of fear that too much medication will cause them to become addicted or dependent.
- Americans avoid taking medications to alleviate pain and prefer alternatives to drugs

Barriers to End of Life Care

- Institutional - complex culture, structures and policies; slow to change
- Regulatory - national, state, local level
- Reimbursement - lack of understanding by CMS and Insurers as to what is needed

Barriers to Pain Management

- **PATIENT**
  - “Wimp”
  - Fear of adverse drug effects/events
  - Fear of addiction
  - Other illness or disease/pathology
  - Knowledge deficit

- **CAREGIVER**
  - Knowledge deficit
  - Fear of opioids
  - Legal pressure
  - Pain as a “symptom”
  - Fear of addiction
  - PRN

Barriers to Pain Management

- Normal/natural reluctance to discuss end of life issues, especially those related to pain
- Paucity of clinical education and training in pain and symptom management
- Limited exposure and knowledge of health care professionals on the signs and symptoms of impending death
- Paradigm shift from cure to comfort care

Barriers to Pain Management

- Myths of Western culture:
  - Enduring pain is a character-building, moral-enhancing endeavor
  - Patients who receive pain medication will become addicted to the drugs
  - Post et al

Chronic Pain Misconceptions in the Elderly

- Personal weakness to acknowledge pain and conversely, strength in character to bear pain.
- Chronic pain is part of aging.
- Chronic pain is a punishment for past actions.
- Chronic pain heralds a serious disease.
- Acknowledging pain will cause painful and invasive testing and loss of autonomy.
- Cognitively impaired elders have higher thresholds and cannot be assessed for pain.
- Elders in LTCF seek attention with pain symptoms and are likely to become addicted to pain medications.

What about Physician Assisted Suicide?

- Most patients requesting such assistance are really requesting assistance in relieving pain
- Patients fear life with unrelieved pain more than they fear death
  - Post et al
### What to do?

- Patients must be reassured early in the terminal disease process that they will not be allowed to suffer (Wanzer).
- It is a provider’s duty to relieve pain, suffering, fear, terror and fear of abandonment (Quill).

### The Ethics of Pain Management

- “*if we know that severe pain and suffering can be alleviated and we do nothing about it, then we ourselves become the tormentors*”
  
  – Primo Levi, Auschwitz survivor