

An Ethical Analysis of the Barriers to Effective Pain Management

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Introduction

Among the most significant findings of SUPPORT was that 50% of ICU patients suffered from moderate to severe pain during the last days of life.¹ At the time of its publication late in 1995, SUPPORT was merely the latest in a long series of articles in the medical literature documenting the widespread and significant undertreatment of pain, beginning with a 1973 study of hospital inpatients.² Much has been written about the phenomenon of undertreated pain and inadequate care of patients at the end of life, and many positive suggestions for reform of clinical education and clinical practice have been iterated and reiterated in the two decades separating the studies. Proposals for modifying clinician behaviors in this aspect of patient care have tended to focus on particular barriers to effective pain management and palliative care.³ The barriers considered in this article are the following:

- The failure of clinicians to identify pain relief as a priority in patient care
- Insufficient knowledge among clinicians about the assessment and management of pain
- Fear of regulatory scrutiny of prescribing practices for opioid analgesics
- The failure of the healthcare system to hold clinicians accountable for pain relief
- The persistence of irrational beliefs and unsubstantiated fears about addiction, tolerance, dependence, and adverse side effects of opioid analgesics

Clearly this is not an exhaustive list. Two other barriers are the resistance of patients and/or their family members to the use of opioid analgesics in the management of pain and cost constraints and their negative impact on the use of the latest and most effective opioid analgesics. Those listed are the primary subject of scrutiny because they are the most frequently mentioned, and because they place the emphasis where it belongs—with the physician.

The criticism of the “barriers” literature that is the focus of this article is its consistent failure to analyze these barriers from an ethical perspective. Indeed, some discussions of the barriers treat them as though they were artifacts of nature, as formidable and immutable as mountain ranges, the succession of the seasons, and the ebb and flow of the tides. But more importantly, to the extent that they are criticized at all in the context of advocating changes in clinician practice patterns, the barriers, and the unnecessary pain and suffering that they engender, are treated as merely clinical failures, free of any significant moral

Barriers to Effective Pain Management

implications. There are a few notable exceptions, and they will be mentioned in the course of the discussion. However, by virtue of the fact that they are exceptions, they further highlight the generally amoral discussion of these barriers in the literature. But the practice of medicine, or more broadly, health-care, is fundamentally a moral enterprise. Hence it cannot be practiced in a moral vacuum. No discussion of the goals and core values of medicine, from Hippocrates⁴ to the most recent pronouncements of the American Medical Association,⁵ has ever failed to emphasize the relief of pain and suffering as a pre-eminent responsibility of the physician. Consequently, the widespread failure of physicians to make effective pain management and palliative medicine a priority in patient care denotes an alarming departure of the profession from its deepest ethical roots, and the collective failure of the profession to recognize the ethical implications of undertreated pain and the unnecessary suffering that it engenders calls into question whether a majority of its practitioners continue to acknowledge that healthcare is a moral enterprise. A remarkable illustration of this concern, to which we shall return toward the conclusion of this article, is provided by Eric Cassell as he chronicles his early inquiries into what had become both the title and the central focus of his important work in the philosophy of medicine, i.e., the nature of suffering and the goals of medicine. Cassell observed, to his surprise and consternation, that while patients and lay persons considered the relief of suffering to be one of the primary ends of medicine, medical students could not see its relevance to their work, and professional colleagues had given its role in patient care little thought.⁶

Analyzing the Barriers from an Ethical Perspective

Applying ethical analysis to the barriers constitutes a legitimate and long overdue challenge to the conditions under which these barriers have been erected, preserved if not strengthened over a period of at least a quarter century, and discussed at great length and with distressing consistency as though they had no normative features whatsoever. The barriers are not listed in any particular order of origin or priority. Indeed, it is difficult to proceed with such an analytic process in a linear fashion because, as we shall see as we work through the list, there are strong and clear interrelationships between and among the barriers. Furthermore, it can reasonably be argued that the persistence of myths and misinformation about addiction, tolerance, and related issues ought not to be treated as a distinct barrier, but merely an aspect of insufficient knowledge. I consider it separately only because it has frequently been listed separately. It is also important to note that the myths and misinformation that constitute this barrier are also widespread among lay persons. While only some of the responsibility for this can be attributed to healthcare professionals, there is little question that a public educational initiative spearheaded by health professionals would be likely to significantly diminish their prevalence. Furthermore, as we shall see, the barriers are not simply artifacts of our healthcare system, they relate directly and immediately to aspects of our American culture and society.

Failure to Identify Pain Relief as a Priority

The results of SUPPORT vividly illustrate the hegemony of the curative model of medicine in America's most distinguished healthcare institutions.⁷ Anecdotal

evidence abounds of statements by clinicians that if there are no more therapeutic interventions available for a patient, there is nothing more to offer the patient, thereby legitimizing their withdrawal from active involvement in the case.

The curative model of medicine has been the subject of much recent critique precisely because it appears, in practice if not in theory, to create a hostile environment for good care of gravely ill and dying patients.⁸ Indeed, Cassell's critique of modern medicine is directed at precisely those aspects that are the essence of the curative model: "The test of a system of medicine should be its adequacy in the face of suffering; this book starts from the premise that modern medicine fails that test. In fact, the central assumptions on which twentieth-century medicine is founded provide no basis for an understanding of suffering."⁹ Among those central assumptions is a remnant of Cartesian dualism that dichotomizes the physical and the mental (as in psychological and emotional) and privileges the physical. This dualism undermines the alleviation of suffering because, in the words of Cassell, "bodies do not suffer, persons suffer." Similarly, bodies are the site of disease, but *persons* undergo the experience of illness. If medicine can delineate the physical and the biological as its domain and responsibility, and leave the rest to other professionals, then medicine can insulate itself from the responsibility to acknowledge and respond to the pain and suffering that result from a patient's (*qua* person) response to the experience of illness. It is from this perspective that the curious failure of medicine to identify pain relief as a priority begins to become intelligible, though far from acceptable.

We can gain further insight into the relationship between the dominance of the curative model in modern medical education and practice and the under-treatment of pain by noting what is too often viewed as the "competing" model—palliative medicine. In many significant respects the most essential characteristics of the curative and the palliative models do seem to place them in two completely separate and distinct realms and not just at the opposite ends of a continuum. For example, curative medicine, as exemplified by the care provided to the patients in SUPPORT, is analytic and rationalistic, whereas palliative medicine is humanistic and personal.¹⁰ Similarly, the curative model considers the process of making the diagnosis and effecting a cure to be the solving of an elaborate puzzle, or as surgeon Sherwin Nuland characterizes it, the pursuit of "The Riddle."¹¹ Indeed Nuland, in his description of his efforts to save the life of an elderly and recalcitrant but indubitably competent patient named Hazel Welch, acknowledges that a physician's single-minded determination to solve the riddle of the patient's disease may sometimes mean that the patient's best interests (as person) will not be served.¹² The idea that a good physician, even a good surgeon, might be expected to be able to discern when pursuit of the riddle is not in the patient's best interests or is inconsistent with the patient's wishes and respond accordingly does not seem to be something that Nuland has seriously considered.¹³ So zealous is Nuland's defense of the pursuit of "The Riddle" of disease in isolation from any consideration of the patient's best interests as perceived by the patient that one might not unreasonably conclude that the pursuit of the riddle has its own *raison d'être* separate and apart from beneficence toward patients. Nuland argues, for example:

Every medical specialist must admit that he has at times convinced patients to undergo diagnostic or therapeutic measures at a point in

illness so far beyond reason that The Riddle might better have remained unsolved. Too often near the end, were the doctor able to see deeply within himself, he might recognize that his decisions and advice are motivated by his inability to give up The Riddle and admit defeat as long as there is any chance of solving it. Though he be kind and considerate of the patient he treats, he allows himself to push his kindness aside because the seduction of The Riddle is so strong and the failure to solve it renders him so weak.¹⁴

Another characteristic of the curative model and point of contrast with the palliative model is the privileging of scientific objectivity and the devaluing of the patient's subjective experience. By cloaking oneself with the mantle of objectivity as the stance most conducive to good medical practice, the modern clinician liberates herself from any need or responsibility for delving into the interstices and idiosyncrasies of the patient as person, for whom disease is inseparable from the personal experience of illness as pain, dysfunction, anxiety, and other forms of emotional distress. From the objective view, the details of an individual patient's experience are anecdotal and essentially devoid of material significance insofar as either making the diagnosis or effecting the cure are concerned. According to the palliative model, the objective determination that a patient carries a particular terminal diagnosis is the beginning of the challenge of good patient care, not the end of it. Helping the patient to understand the nature of the illness, and fashioning an appropriate and genuine response to it, which will include but not be limited to palliative measures of a clinical nature, demands relating to the patient as person.

Finally, the curative model makes death the enemy, always to be resisted until resistance has become demonstrably futile. However, in the intensive care unit futility is in the eye of the few beholders who see patient care according to the curative mode. There is almost always another diagnostic procedure to try, or dysfunctional organ on which to apply an innovative therapy or intervention. Surely one of the reasons too few dying patients find their way into hospice care, and usually too late in the progression of their terminal condition, is because "dying" is a word that is no longer in the lexicon of curative medicine. It has been supplanted by "multi-organ system failure," a term that does not suggest, either to lay persons or healthcare professionals, that the patient is approaching the end of life, but only that the patient is seriously ill and that there is much that might be done. We have almost arrived at the point at which a determination that a patient is actively dying can only be made *ex post facto*, i.e., after the patient has died despite the many life-sustaining interventions that have been undertaken to cope with the multi-organ system failure. If all of those interventions fail, including repeated and extensive cardiopulmonary resuscitation, then and only then might one reasonably conclude that at some time in the hours or days or weeks immediately prior thereto, the patient must have been dying.¹⁵

The curative model of medicine is limited by certain conceptual infirmities. One is the view that pain is a symptom to be observed and explored in pursuit of a correct diagnosis or an accurate prognosis. Since information about disease and its progression is the goal of the clinician, efforts to provide palliation are perceived as undermining the pursuit of that goal. It has been suggested that medical education and training is premised on a clinical concept of pain, characterized by detachment and objectivity, that is radically different from the lay

person's concept of pain.¹⁶ When the process of enculturation as a physician is complete, the lay concept of pain has been forgotten in a way that makes even more relevant today the ancient Prayer of Maimonides "never to forget that the patient is a fellow creature in pain, not a mere vessel of disease."¹⁷

Another conceptual infirmity of the curative model is its failure to impart to healthcare professionals any basis upon which to formulate a concept of a medical fate worse than death. One can unreflectively fight on against death if there is no perceivable opportunity cost to the patient. The practitioners of and the advocates for palliative medicine, on the contrary, recognize that most patients do have a concept of a medical fate worse than death, such as existence in a persistent vegetative state, or enduring significant pain while undergoing therapeutic interventions that have little likelihood of success. The greatest failure as a clinician, from the palliative medicine perspective, is the failure to respect the patient's sincere and informed efforts to avoid or escape that fate. In Nuland's persistent efforts to persuade his 92-year-old patient Hazel Welch to consent to surgery for a ruptured duodenum, he told her that the procedure had a one-in-three chance of success, and minimized the distress she would experience in the postoperative period. A one-in-three chance of success was excellent, he argued, or at least good enough when the alternative was certain death. Mrs. Welch's initial response was that at 92 years of age she had lived quite long enough, and death was something that she welcomed, or at least did not fear.¹⁸

Nuland's chapter entitled "Lessons Learned," showcasing his care and treatment and the ultimate death of Hazel Welch, brings into stark relief the tension between the predominantly curative model of modern medicine, and the emerging demands for better care of the dying and an acknowledgment on the part of clinical specialties that caring is as important as curing. Inasmuch as Nuland ultimately declares that if he encountered Hazel Welch or someone similarly situated again he would not do anything differently, it is not at all clear what lessons are supposed to have been learned. Perhaps the lessons are to be learned by the readers, who now can more fully appreciate how difficult is the task of seeking parity between the curative and the palliative models of medicine.

Insufficient Knowledge among Clinicians

An interesting question with which to begin is whether the failure to make pain management a priority in patient care results from the fact that it has no place of significance in undergraduate and graduate medical education, or whether it has no place of significance in medical education because it is not deemed to be a priority by physicians. An analysis of the interrelationship between the medical school curriculum and the content of the national boards is beyond the scope of this article. What is clear, however, is that when surveyed, practicing physicians readily acknowledge that their knowledge in the area of pain management is inadequate.¹⁹ One reason, of course, is that medical schools have scrupulously avoided developing a pain curriculum.²⁰ When pain is addressed, too often it is by faculty whose knowledge and skills in assessment and management are woefully outdated, so that myths and misinformation are passed from one generation of physicians to another virtually untouched by the remarkable advances of the last quarter century.²¹

Barriers to Effective Pain Management

What we find then, is a phenomenon that might fairly be described as the cultivation and propagation of ignorance. The question that the phenomenon raises is whether it presents any ethical issues. Given the absence of discussion of the question in the clinical and bioethics literature, one might come to the conclusion that it does not. That would, I suggest, be a premature and ultimately erroneous conclusion. As one of the few ethicists to consider the question observed:

[T]here is a broadly based humanistic ethics which applies to the domain of medical care which gives patients a strong *prima facie* right to freedom from unnecessary pain and which places upon medical professionals two concomitant moral obligations to patients. First, there is a duty not to inflict additional pain and suffering beyond that which is absolutely necessary. . . . Next, there is the duty to do all that can be done *within the limits of current medical knowledge* and available resources to relieve all the pain and suffering which can be alleviated (emphasis added).²²

Pain management presents the most glaring example of a disparity between the current state of medical knowledge and the prevailing custom of medical practice. This disparity also signals the awesome justificatory force that the barriers which we are considering carry. It is hard to imagine another aspect of medicine in which such a profound failure to incorporate current knowledge into medical education and medical practice would evoke such an underwhelming response both from within and outside the profession. This lack of response most likely is symptomatic of the singular ambivalence toward pain and suffering that characterizes the larger society. This ambivalence tolerates the coexistence of such religious attitudes as the redemptive power of suffering and such secular views as the physician-assisted suicide movement, as well as notions, inconsistent on their face, that the virtuous physician (at least in the classical sense) has a duty to relieve the pain and suffering of patients but that the *sine qua non* of the “good patient” is the willingness and ability to endure pain without complaint.

The medical profession’s most recent response to the manifest incompetence of many of its members in providing appropriate care to patients suffering from terminal conditions is an interesting one. Rather than expressing any moral outrage about a system of medical education that routinely produces practitioners who are not competent to provide minimally sufficient care to a large population of patients, or exerting political pressure to promptly address the deficits in undergraduate and graduate medical education, the American Medical Association (AMA) has instead secured a \$1.54 million grant from the Robert Wood Johnson Foundation to undertake a project known as Education for Physicians on End-of-Life Care (EPEC) under the aegis of the AMA’s recently established Institute of Ethics. According to the pamphlet describing the EPEC project, its purpose is “to educate physicians in the *essential clinical competencies* in end-of-life care that every physician should have.” The curriculum is said to teach “*fundamental skills* in communication, ethical decision making, palliative care, psychosocial considerations, and symptom management” (emphasis added).²³ The underlying question that remains unasked, or at least unanswered, is why there should have to be a major national postgraduate, post-licensure educational initiative in order to provide practicing physicians with “fundamental

skills” and “the essential clinical competencies . . . every physician should have.”²⁴ We deserve, but have not received, some justification for why medical schools and residency programs continue to graduate students who lack these “fundamental skills” and “essential clinical competencies.” The possible reply that the critical mass of medical science and technology has simply become too large for the medical curriculum to contain all that a physician needs to know will not suffice. If there were a restoration within the curriculum of a proper balance between the essential knowledge and skills of the curative model and those of the palliative model, it is hard to believe that there would not be time enough at least to dispel the myths about pain management and the care of dying patients.

Fear of Regulatory Scrutiny of Prescribing Practices for Opioid Analgesics

Let us readily acknowledge at the outset of the discussion of this particular barrier that protestations by state medical licensing boards and the federal Drug Enforcement Administration to the contrary notwithstanding, these fears are pervasive and not without foundation in fact. Indeed, one can make the argument that by the nature and frequency of their disciplinary actions against physicians who treat significant numbers of patients with pain, state medical licensing boards have allowed themselves to be conscripted into the federal government’s war on drugs. The best evidence of such conscription is the fact that while the medical literature over the last quarter century is replete with studies demonstrating widespread and significant underuse of opioid analgesics by physicians in their treatment of patients with pain, there is only a single instance in which a state board has disciplined a physician for unprofessional practice for failure to provide appropriate pain management in their care of such patients.²⁵ However, there are many cases in which the courts have criticized the efforts of state boards to discipline physicians on the grounds that they inappropriately prescribe (i.e., overprescribe) opioid analgesics for patients with pain.²⁶

The message that has been sent and clearly received by physicians is that their primary responsibility is to help regulators prevent drug diversion and the excessive prescribing of opioid analgesics, not to effectively manage the pain of their patients.²⁷ There is an ethical issue presented when the political agenda of a declared war on drugs coerces physicians into providing inadequate pain relief for their patients who require sustained administration of opioid analgesics to avoid intolerable pain. Recent surveys of physicians indicate an appreciation on their part that they do in fact underprescribe for their pain patients in an effort to avoid regulatory scrutiny.²⁸ The first ethical question is why the medical boards, which after all are composed of physicians, fail to “just say no” to any efforts to persuade them to regulate the prescribing practices of their licensees in such a manner that the war on drugs is fought on the backs of patients with severe and persistent pain. It is difficult to imagine that any such effort at federal coercion could succeed in the face of a strong stand on the part of organized medicine. The fact that the taking of such a stand has never been seriously considered by national medical organizations suggests that the profession shares, at least to some significant degree, the missionary zeal that motivates the war.²⁹ How else can we explain their willing-

Barriers to Effective Pain Management

ness to allow one of the fundamental and most time-honored goals of medicine to be seriously compromised by a political agenda to fight illicit drug trafficking?

But there is also an ethical issue on the level of each individual physician who undertakes to treat patients with pain while at the same time seeking to minimize regulatory scrutiny. The ethical issue arises out of the nature of the professional relationship and the duty of the professional as fiduciary. No one has written more extensively or more thoughtfully about the moral authority and the moral responsibility of the physician than Edmund Pellegrino, often in collaboration with David Thomasma. Among the obligations that they maintain arise from the special nature of the patient-physician relationship is technical competence: “the act of medical profession is inauthentic and a lie unless it fulfills the expectation of technical competence.”³⁰

Beyond this, whenever a physician presents herself to a patient who seeks care there is an implicit act of profession. This act gives rise to a reasonable expectation by the ill person that the physician will deal honestly and fairly with her, that care will be provided with the requisite professional knowledge and skill, and that the professional’s overriding concern will be the patient’s welfare.³¹ When one of the patient’s primary afflictions is pain, a physician who purports to manage that pain but does so ineffectively because of inadequate knowledge or skill violates a fundamental ethic of the profession of medicine. Similarly, when a physician deliberately prescribes lower doses or less effective analgesics than the patient’s condition indicates solely to avoid closer scrutiny of her prescribing practices, she violates another fundamental ethic of the profession. The professional’s interest in not being the subject of burdensome regulatory inquiry is inappropriately privileged over the well-being of the patient, whose interest is in securing the most effective pain relief available.

The professional responsibility always to act in the best interests of the patient will from time to time require that a physician engage in acts of moral courage. When caring for patients with severe and persistent pain by prescribing necessarily large doses of opioid analgesics, a regulatory environment that may be hostile to good pain management does not confer on the physician the moral authority to undertreat pain. Rather, it creates an ethical duty to challenge the conditions that render the environment hostile to good patient care.

Failure of the Healthcare System to Hold Physicians Accountable for Pain Management

By healthcare system I mean healthcare institutions and the entities or organizations that review or regulate the patient care they provide, as well as the entities or organizations that perform the same function with regard to healthcare professionals. The initial case in point for this particular discussion will be the hospital. SUPPORT shows us that effective pain management for critically ill patients in major academic medical centers is not an institutional priority.³² Indeed, the remarkable inattention to the pain and suffering of dying patients in the ICUs of these elite medical centers appears to fulfill a prophetic statement made in a much earlier study of pain management in the hospital setting: “medical innovation may simply exacerbate or cause new problems of pain management.”³³ By far the most compelling conclusion of the earlier study is the following: “Chief among the difficulties facing anyone who would reform current practices of pain management in our hospitals is the far from obvious

fact that most aspects of pain work are peripheral to the attention and the responsibilities of the staff . . . in other words, . . . *the staff is not genuinely accountable for much of its interaction with or behavior toward patients in pain.*"³⁴

A simple policy that might demonstrate the intent of a healthcare institution to establish and maintain physician and nursing staff accountability for good pain management is exemplified by one that is made applicable to researchers at the Massachusetts General Hospital who use white rats for medical research. As part of the requisition request, the researcher must complete a detailed form. Among the questions on the form are those that ask whether the animal will experience any pain, and if so the procedures that will be followed to minimize the animal's suffering, as well as the identity of the person who will be responsible for managing the animal's pain. No similar institutional form exists with regard to patients.³⁵ What will not suffice as an explanation for the absence of such policies in American hospitals is that we may safely assume that good pain management is a priority in the care and treatment of every patient.

The culture of the modern hospital has actually caused the institution to be a hostile environment for prompt and effective pain assessment and pain management. Among other barriers not infrequently mentioned is the reluctance of patients to accurately report the nature, severity, and duration of their pain. The reasons cited by patients for underreporting pain include the fear that they will be viewed as weak, unappreciative, and uncooperative, and as a result will receive less attentive care from hospital staff than they otherwise would.³⁶ An antidote to the "don't ask, don't tell" approach to pain in healthcare institutions is the regular charting of patient pain as the "fifth vital sign." If accurate charting for patients requires inquiry into a patient's pain levels, the message can be conveyed to patients that they should report the nature and extent of their pain and should expect prompt and effective responses to complaints of significant pain.

There is another plausible reason why patients have demonstrated such a remarkable capacity to tolerate and endure undertreated pain that has not been adequately addressed in the literature but that goes to the heart of the ethics of the healthcare professional. Patients are largely ignorant of the fact that their pain is being undertreated for reasons that have nothing to do with the limitations of palliative medicine or their well-being as patients. In other words, patients have not been provided the opportunity to give an informed consent to the undertreatment of their pain. Patients, perhaps not unreasonably, assume that all of the pain relief that can be safely and effectively administered has in fact been provided. Hence their continued suffering must be a result of the inherent limitations of medical science and technology. They have, misguidedly it would seem, trusted that the physicians and nurses responsible for their care would not allow them to suffer unnecessarily. While it is true that some patients endure unnecessary levels of pain because they harbor the same myths and phobias as healthcare professionals regarding addiction and side effects, it is not clear with what skill and persistence those patients have been counseled about the realities of safe and effective pain management practices. It is fair to assume that most patients are educable on these issues, and unrelenting pain should be an effective motivational tool.

Long-term care facilities perform no better, but as the stepchild of the healthcare "system" their performance has come under less scrutiny. We are just now

beginning to take note of the magnitude of the problem of undertreated pain in these facilities.³⁷ This is ironic, of course, given the extent of nursing home reform legislation that has shifted the focus of review of these entities to the quality of life they provide to their residents. Certainly undertreated pain destroys quality of life as much, if not more than any other factor. In an effort to improve the quality of pain relief provided to all elderly patients, the American Geriatrics Society recently published clinical practice guidelines for the management of chronic pain in older persons.³⁸

The economics of managed care further exacerbates the inattention to pain assessment and management. With lower staffing levels, fewer nurses are responsible for larger numbers of patients, decreasing the likelihood that even a more demonstrative and persistent patient will succeed in securing the relief required. The reluctance of physicians to prescribe and of nurses to administer opioid analgesics, which will be examined below, will be further reinforced if staffing levels make it more difficult to provide the necessary monitoring of patients for potential adverse side effects. The existing guidelines, while urging the use of opioid analgesics whenever indicated, also emphasize the need for careful and consistent monitoring of patients who are receiving them.

While hospitals have, for reasons that are not within the scope of this article, become the primary locus for the accountability of clinicians for quality patient care, we must look elsewhere for the primary locus of accountability for unethical medical practice. While the American Medical Association (AMA) promulgates a Code of Medical Ethics, which is updated and expanded through pronouncements of its Council for Ethical and Judicial Affairs, and the current code does in fact address the responsibility of the physician "to relieve the pain and suffering and to promote the dignity and autonomy of dying patients in their care,"³⁹ the AMA is a voluntary professional association that cannot in any meaningful way sanction physicians for unethical practice. That task falls to state medical licensing boards. As noted earlier, systematically undertreating the pain of patients has yet to be deemed the basis of incompetent, unprofessional, or unethical medical practice by more than one state board.⁴⁰ Indeed, in 1998, the medical licensing board for the state of California received a complaint by the daughter of a patient who died of cancer. Her complaint alleged that the treating physician had allowed the patient to suffer unnecessarily by underprescribing opioid analgesics. The board investigated the complaint and issued a statement that while it was indeed the case the patient had received inadequate pain relief, it declined to take any action against the responsible physician. Two articles in prominent medical journals in the last 10 years, articles that are exceptions to the ethical silence that has characterized discussions of the barriers to good pain management, would certainly seem not simply to support such a rule, but to require it.

What distinguishes "The Physician's Responsibility to Hopelessly Ill Patients—A Second Look" from the many other articles discussing the need to improve care of gravely ill or dying patients is not merely the large number (12) of distinguished physicians who wrote it, but more importantly their recognition and clear statement of the moral implications of this widespread failure to meet an acceptable standard of clinical practice: "To allow a patient to experience unbearable pain or suffering is unethical medical practice."⁴¹ Not quite 10 years later, Edmund Pellegrino, one of the most respected figures in the field of clinical bioethics, writes: "Not to relieve pain optimally is tantamount to moral and

legal malpractice.”⁴² Perhaps the only example of a more strongly worded condemnation of such behavior on the part of physicians is that of David Morris: “Not relieving pain brushes dangerously close to the act of willfully inflicting it.”⁴³

Unless medical licensing boards take seriously the duty of physicians to provide appropriate care to their patients with severe pain, such stern language will remain nothing more than rhetoric, to which significant numbers of the profession will continue, as they have in the past, to turn a deaf ear. Rhetoric without reform changes nothing. Improvements in the overall quality of care provided to patients with pain requires organizational changes.⁴⁴ The organizations where such changes must be brought about are the hospital, the nursing home, and the state medical licensing board.

Irrational Beliefs about Addiction, Dependence, Tolerance, and Adverse Side Effects

Remarkably and lamentably, we continue to graduate from the medical and nursing schools of this country significant numbers of young professionals who are unable or unwilling to meaningfully distinguish between addiction to narcotics and physiological dependence on opioid analgesics for the relief of severe and persistent pain. According to a former director of the National Institute on Drug Abuse, “the confusion between the use of narcotics by street addicts influences the attitudes and behavior of dispensing practitioners, patients, and their families, as well as government policymakers who regulate the availability of these drugs.”⁴⁵ Similarly, David Morris observes:

Unbelievably, American doctors regularly refuse to prescribe effective doses of narcotic pain killers to dying patients on the grounds that the patients might become addicted. The treatment of cancer pain, clearly, is still not based solely on scientific fact but draws on ignorance, fear, prejudice, and on an invisible, unacknowledged moral code expressing half-baked notions about the evil of drugs and the duty to bear affliction.⁴⁶

The sense of outrage in Morris’s statement is defensible. The medical literature confirms that patients who receive large and extended doses of opioid analgesics for the management of pain are not and rarely become addicts.⁴⁷ Similarly, there is a wealth of information that emphasizes the important difference between the natural, physiological dependence that develops to opioid analgesics and the pathological psychological dependence that characterizes addiction. The persistence of these strands of myth and misinformation suggests too that medical and nursing students are not being exposed to this important literature, but that to the contrary they are continuing to be exposed to instructors and mentors who themselves have not learned to make these critical distinctions.

Concerns over the development of patient tolerance to opioid analgesics—necessitating an increase over time in the dosage required to maintain analgesia—can also be shown to be the product of persistent myth and misinformation. The need for higher doses is almost invariably related to a progression of underlying disease producing the pain. Patients whose disease is stable do not customarily require increasing doses once an effective level of analgesic is achieved and maintained.⁴⁸ The myth of tolerance has been one of the bases for undermedicating patients with pain caused by a chronic or progressive disease.

Finally, the side effects of the sustained use of opioid analgesics have been greatly exaggerated. The most common side effects of the drugs recommended for moderate to severe pain that persists are constipation, sedation, and respiratory depression. Prevailing clinical practice guidelines offer a range of effective means of managing these side effects without compromising the goal of pain relief.⁴⁹ Under the rubric of *primum non nocere* (nonmaleficence), many patients are undermedicated on the theory that a dosage high enough to produce analgesia will either produce discomfort from side effects that exceeds the discomfort of unrelieved pain, sedation that will undermine quality of life, or respiratory depression that may be life-threatening. It is only when these myths are dispelled that the ethical implications of their persistence can be appreciated.

Toward a Duty to Relieve Suffering

There is both a theoretical and a practical level on which to consider ethical discourse on the phenomenon of undertreated pain. On the theoretical level, however, there does not appear to be any legitimate grounds for debate. There is not even a distinct and insular minority of healthcare professionals challenging the existence of such a duty. As Morris observes, the patient's "duty to bear affliction" is at most a part of "an invisible, unacknowledged moral code." You will find in the common listing of the rights of hospital patients an expectation of competent and compassionate care. You will not find in the common listing of the responsibilities of hospital patients a duty to accept with grace and equanimity such unnecessary suffering as may be deemed appropriate by caregivers.

Thus far in the discussion and analysis of the pervasive problem of undertreated pain, there have been only a very few who have recognized and had the temerity to comment in writing on its ethical implications. But in American society in particular there is another source for moral judgment—the courts. On one occasion in the last decade the issue of undertreated pain was considered in that venue. Henry James, an elderly patient in a long-term care facility was dying of metastatic prostate cancer. He had been provided by a physician with a prescription for opioid analgesics to manage his pain. However, a nurse-employee of the facility who was in a position of responsibility for the care that Mr. James received refused to allow the pain relief to be provided, on the grounds that such a large, sustained dose would addict the patient. Without the necessary pain relief, Mr. James suffered unnecessarily in the last months of his illness.

Following his death, the family of Henry James brought suit against the nurse and the corporate parent of the facility that employed her, alleging professional negligence. Expert witnesses testified for the plaintiff as to the standard of care for patients like Mr. James, which in their opinions had been violated by the defendants. The defendants did not take this unprecedented claim seriously. After all, asked defense counsel, in terms of monetary damages, what could a few months of pain be worth? The rural, northeastern North Carolina jury answered that because the suffering was entirely unnecessary, those months of agony were worth \$7.5 million in compensatory damages. But that is not the end of the story. The law of every jurisdiction recognizes that in a civil action based on tortious wrongdoing, there will be occasions in which the conduct (act or omission) of the tortfeasor is, in the eyes of the community

as represented by the jury, especially blameworthy because it involves recklessness, malice, fraud, or similarly egregious elements. When confronted with such conduct, a jury may express the moral outrage of the community through the assessment of punitive damages, which are designed both to punish the defendant(s) in the case and to discourage others similarly situated from behaving in a like manner. Unnecessary suffering tolerated by a supposedly beneficent and compassionate caregiver so shocked the conscience of this community that the jury assessed an additional \$7.5 million in punitive damages.⁵⁰

The case of Henry James should give the healthcare professions and the bioethics community cause for concern and further reflection and introspection. Why, as Cassell asked almost 20 years ago, is the collective view of healthcare professionals about the ethical implications of undertreated pain so different from that of laypersons? Why should a rural North Carolina jury, comprised of individuals unaccustomed to seven-figure transactions, view the opiophobic behavior of a nurse to be the proper subject of significant moral outrage, while the majority of healthcare professionals and bioethicists have never even been capable of acknowledging the ethical implications of the undertreated pain of millions of Americans? Perhaps those within the healthcare system—and that includes bioethicists—simply find it incomprehensible that those whom we presume to be motivated primarily by compassion and beneficence could actually be so estranged from a fundamental goal of the profession and act unethically.

The barriers on which we have focused are not theoretical, but real. What I have undertaken to demonstrate is that neither their existence nor the significant influence that healthcare professionals allow them to have on patient care will withstand close ethical scrutiny—inside or outside of a jury room. The failure of clinicians to identify pain relief as a priority in patient care is antithetical to the most ancient and honored goals of medicine and duties of the physician. Insufficient knowledge among clinicians about effective pain assessment and management techniques is at the very least an indictment of the institutions that train healthcare professionals. But I would argue it is more than this. The problem of undertreated pain has been the subject of articles published in virtually every major medical and nursing journal read by such professionals. These articles constitute more than adequate notice that baseline knowledge and skills are *prima facie* inadequate, and that these inadequacies, if allowed to continue, will result in the unnecessary suffering of many patients.

Fear of regulatory scrutiny might explain why clinicians are uneasy as they prescribe and administer appropriate levels of opioid analgesics to their patients with pain, but it has no moral force with which to justify them in refusing to provide their patients with the pain relief they require. This particular fear, in fact, rather than being offered as an excuse for inaction, should motivate truly caring clinicians to organize and challenge regulatory scrutiny that has a chilling effect on good patient care. The failure of the healthcare system to hold clinicians accountable is, in the final analysis, a failure of clinicians to hold themselves accountable. That is because ultimately it is the organized medical staff through which hospitals monitor and regulate the quality of care provided. Similarly, licensing boards are professionals regulating themselves. This fundamental fact renders the disparity between the goals of a profession and the custom and practice of the profession all the more distressing. No small portion of that distress should be the ethical anomaly of beneficent professions

that tolerate and contribute to an epidemic of unrelieved pain and unaddressed suffering among the most vulnerable patients they exist only to serve.

Finally, for the most scientifically oriented of the learned professions to be extensively disempowered from providing good patient care because of the persistence of myths, irrational beliefs, and outdated information—their own and their patients’—is more than a matter of excusable ignorance. Ignorance is not a defense to many crimes for which society presumes personal responsibility to acquire important information. Similarly, ignorance of what constitutes good clinical practice is not a defense to a professional liability claim. For this reason, the AMA Code of Medical Ethics calls on physicians to identify those professional colleagues who demonstrate by their conduct that they are deficient in either knowledge and skill or integrity, so that those persons can be either educated or rehabilitated (depending on the nature of their deficiency) or removed from the profession.⁵¹

Conclusion

The profound reluctance to consider the ethical dimensions and implications of undertreated pain in the clinical setting may be more understandable than defensible. If a foundational principle of the healthcare professions is beneficence, and allowing unnecessary pain to persist when one has a fiduciary duty to act in the best interests of the sufferer is the antithesis of “doing good,” then a widespread custom and practice of tolerating unnecessary pain is an indictment of professionals that a cautious person might prefer not to make. The more pragmatically minded might argue that questioning the ethical integrity of many clinicians is not the most effective way to improve the quality of pain management. What is needed, on this view, are incentives for clinicians to acquire and apply state-of-the-art pain management skills. Bludgeoning them with an ethical club or raising the specter of punitive malpractice judgments will merely engender professional retrenchment and continued defensive denial. Challenges to professional “self-esteem, sense of competence, or autonomy” may well be met with staunch opposition.⁵² Nevertheless, as this ethical analysis of the barriers to good pain management has, hopefully, demonstrated, when left unexamined, reasons have a pernicious tendency to become excuses. An important role of the bioethicist, as Leon Kass reminds us, is to vitally concern ourselves with “what is praised and blamed, honored and held shameful, in medical training and medical practice.”⁵³ In so doing, we may not always win friends among our colleagues, but perhaps it is enough if we are able to influence them by motivating change in this most important sphere of clinical practice.

Notes

1. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. *JAMA* 1995;274:1591-8.
2. Marks RM, Sachar EJ. Undertreatment of medical inpatients with narcotic analgesics. *Annals of Internal Medicine* 1973;78:173-81.
3. There are many articles and reports that allude to such barriers, and there is remarkable consistency among them. Those considered in this article are taken from one of the more recent

- sources, New York State Public Health Council. *Breaking Down the Barriers to Effective Pain Management*. Albany, N.Y., 1998.
4. Hippocrates. The art. Reprinted in Reiser SJ, Dyck AJ, Curran WJ, eds. *Ethics in Medicine*. Cambridge, Mass.: MIT Press, 1977.
 5. American Medical Association. *Code of Medical Ethics*. Chicago: American Medical Association, 1997:2.20.
 6. Cassell E. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 1982;306:639-45.
 7. See note 1, SUPPORT Principal Investigators 1995.
 8. For extended discussions of the deficiencies in the care of dying patients, see American Board of Internal Medicine. *Caring for the Dying: Identification and Promotion of Physician Competency*. Institute of Medicine. *Approaching Death: Improving Care at the End of Life*. Washington, D.C.: National Academy Press, 1997.
 9. Cassell E. *The Nature of Suffering*. New York: Oxford University Press, 1991:viii.
 10. For many of these distinctions, I draw heavily upon the discussion in Fox E. Predominance of the curative model of medical care—a residual problem. *JAMA* 1997;278:761-3.
 11. Nuland S. *How We Die*. New York: Alfred A. Knopf, 1994.
 12. See note 11, Nuland 1994. Nuland is remarkably candid about the ambivalence he feels toward his treatment of Hazel Welch. While he acknowledges that respecting her competent refusal of consent to surgery and compassionately caring for what would then be her imminent death might have been the most beneficent response, he also asserts with great conviction that a doggedly persistent pursuit of the riddle is what we train and enculturate our physicians to do and we ought not to criticize them when they approach patient care consistently in that fashion.
 13. Perhaps because this is so, George Annas, one of the few commentators to take Nuland to task for his treatment of Hazel Welch and his subsequent assertion that he would do the same thing again in a similar situation, admonishes patients that if they wish to maintain control in the face of grave or terminal illness, they need to get out and stay out of acute care facilities. See Annas GJ. How we lie. *Hastings Center Report* 1995;25(6):S12-S14.
 14. See note 11, Nuland 1994:249.
 15. Recent studies in the literature lend a certain surface plausibility to this phenomenon. However, the conclusion drawn by those conducting the studies is not that disavowing the “d” word (“dying”) is reasonable and appropriate, but rather that curative and palliative measures must often be undertaken in tandem, because the fact that a patient is indeed dying is not always discernable. See Lynn J, Teno J, Harrell, Jr. F. Accurate prognostications of death—opportunities and challenges for clinicians. *Western Journal of Medicine* 1995;163:250-257.
 16. Ruddick W. Do doctors undertreat pain? *Bioethics* 1997;11:248-55.
 17. See note 16, Ruddick 1997:246-247.
 18. See note 11, Nuland 1994:250-4.
 19. For example, a recent survey of oncologists, one of the clinical specialties most likely to encounter patients with significant pain problems, revealed that 76% considered poor pain assessment to be a major barrier to effective pain management. Fifty-two percent of the same group rated their training in pain management to be poor, and another 39% rated it as only fair. Von Roenn JH, et al. Physician attitudes and practice in cancer pain management. *Annals of Internal Medicine* 1993;119:121-6, 124.
 20. Weiner RS. An interview with John J. Bonica M.D. *Pain Practitioner* 1989;1:2.
 21. Hill CS. When will adequate pain treatment be the norm? *JAMA* 1995;274:1881-2.
 22. Edwards RB. Pain and the ethics of pain management. *Social Sciences and Medicine* 1984;18:515-523. In August 1999 the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) adopted standards that recognize the right of all patients to effective pain relief.
 23. The pursuit of major external funding for this educational initiative by the AMA’s Institute for Ethics suggests a subtle (exceedingly so) interrelationship between professional ethics and major deficits in professional competence. So too does the language of the AMA’s “Principles of Medical Ethics,” the first of which provides that “A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity,” and the second of which provides in pertinent part that “A physician . . . shall strive to expose those physicians deficient in character or competence . . .” (emphasis added). See note 5, American Medical Association 1997:xiv.
 24. The AMA has good grounds for the basic presupposition that medical schools continue, as they

Barriers to Effective Pain Management

- have in the past, to graduate students who are generally lacking in the fundamental skills and essential clinical competences for the care of dying patients. The Institute of Medicine recently reported that a review of a number of recent studies clearly indicates that optimal care for those who are dying, which of course includes effective pain management strategies, “was not an educational priority and was, in fact, hardly perceptible as an issue.” See note 8, Institute of Medicine 1997:8–9.
25. Foubister V. Oregon doctor cited for negligence for undertreating pain. *American Medical News* 1999;Sept. 27:7,9.
 26. A case in point is *Hoover v. Agency for Health Care Administration*, 676 So. 2d 1380 (Fla. Dist. Ct. App. 1996), in which the state regulatory agency sought to discipline a physician who prescribed opioid analgesics for a group of patients with severe chronic nonmalignant pain. The court of appeals affirmed a hearing officer’s findings in favor of Dr. Hoover and chastised the board for “once again . . . overzealously supplanting a hearing officer’s valid findings of fact regarding a doctor’s prescribing practices with its own opinion in a case founded on a woefully inadequate quantum of evidence.”
 27. One study of knowledge and attitudes of state medical licensing board members with regard to pain management partially explains this phenomenon. The study revealed an appalling level of ignorance on the part of board members about state-of-the-art pain management practice. See Joranson DF, et al. Opioids for chronic cancer and non-cancer pain: a survey of state medical board members. *Federation Bulletin: Journal of Medical Licensure Discipline* 1992;79: 15–49.
 28. Skelly FJ. Fear of sanctions limits prescribing pain drugs. *American Medical News* 1994;Aug. 15:19.
 29. What we have instead are a few outspoken pain specialists who perennially remain voices crying in the wilderness. Prime examples are Foley KM. The decriminalization of cancer pain. *Advances in Pain Research and Therapy* 1985;11:5–18; Hill CS, Jr. Government regulatory influences on opioid prescribing and their impact on the treatment of pain of nonmalignant origin. *Journal of Pain and Symptom Management* 1996;11:287–8.
 30. Pellegrino ED, Thomasma DC. *A Philosophical Basis of Medical Practice*. New York: Oxford University Press, 1981:213.
 31. See note 30, Pellegrino, Thomasma 1981:210.
 32. See note 1, SUPPORT Principal Investigators 1995.
 33. Fagerhaugh SY, Strauss A. *Politics of Pain Management: Staff-Patient Interaction*. Menlo Park, Calif.: Addison-Wesley, 1977:7.
 34. See note 33, Fagerhaugh, Strauss 1977:26. The new JCAHO pain standards (see note 22) should have the salutary effect of reversing this nonaccountability.
 35. Ferrell B. State of the art—the who, what and why of pain. Keynote address, “Must Patients Suffer? Ethical, Legal and Clinical Concerns about Pain and Its Alleviation,” USC Pacific Center for Health Policy and Ethics Conference, Santa Monica, California, 17–18 March 1995.
 36. Cleeland CS. Barriers to the management of pain. *Oncology* 1987;1:19.
 37. Bernabei R, et al. Management of pain in elderly patients with cancer. *JAMA* 1998;279:1877–82.
 38. American Geriatrics Society. *Management of Chronic Pain in Older Persons*. New York: American Geriatrics Society, 1998.
 39. See note 5, American Medical Association 1997:2.20.
 40. In April 1999 the Nevada Board of Medical Examiners adopted regulations intended to create duty “to adequately prescribe controlled substances for pain control in accordance with accepted prevailing standards for the practice of medicine as contained in these regulations.” Failure to fulfill the duty may result in disciplinary action. Nevada Administrative Code 630.230, 1999.
 41. Wanzer SH, et al. The physician’s responsibility towards hopelessly ill patients—a second look. *New England Journal of Medicine* 1989;320:844–9.
 42. Pellegrino ED. Emerging ethical issues in palliative care. *JAMA* 1998;279:1521–2, 1521.
 43. Morris DB. *The Culture of Pain*. Berkeley: University of California Press, 1991:191.
 44. This was the judgment expressed in the editorial that appeared in the same issue as the results of SUPPORT. Lo B. Improving care near the end of life—why is it so hard? *JAMA* 1995;274:1634–6.
 45. Schuster CR. Does treatment of cancer pain with narcotics produce junkies? In: Hill CS, Jr., Fields WS, eds. *Advances in Pain Research and Therapy*. New York: Raven Press, Ltd., 1989:1.
 46. See note 43, Morris 1991:192.
 47. Porter J, Jick H. Addiction rare in patients treated with narcotics. *New England Journal of Medicine* 1980;320:123.

48. Foley KM. Changing concepts of tolerance to opioids: what the cancer patient has taught us. In: Chapman CR, Foley KM, eds. *Current and Emerging Issues in Cancer Pain: Research and Practice*. New York: Raven Press, Ltd., 1993:331-50.
49. Agency for Health Care Policy and Research. *Management of Cancer Pain*. Washington, D.C.: Agency for Health Care Policy and Research, 1994:61-5.
50. Estate of Henry James v. Hillhaven Corp., 89 CVS 64 (S.C. Hertford Co., N.C., 1991). While the defendants' posttrial motions were still under advisement by the trial court, the defendants' professional liability insurance carrier settled the case for an undisclosed amount rather than await the ruling on the motions or test the legitimacy of the judgment in the appellate courts.
51. See note 5, American Medical Association 1997:xiv, II.
52. Greco PJ, Eisenberg JM. Changing physicians' practices. *New England Journal of Medicine* 1993;329:1271-4.
53. Kass LR. Practicing ethics: where's the action? *Hastings Center Report* 1990;20(1):5-12, 11.