Responses and Dialogue

Responses to “An Ethical Analysis of the Barriers to Effective Pain Management” by Ben A. Rich (CQ Vol 9, No 1)

Challenges and Conflicts in Pain Management

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Ben Rich, J.D., Ph.D., presents a scholarly, passionate view of the ethics of the “barriers to effective pain management.” His manuscript is detailed, analytical, and compassionate. No reasonable sensitive person, especially a physician committed to caring for patients, can disagree with the proposal that human beings should have their physical, emotional, and spiritual pain tended to aggressively, meticulously, and compassionately. Similarly, the same individuals advocating for such pain management would agree that no one should go to jail unless he or she is guilty of a serious crime, that decent people should not be robbed or murdered, that children should not be hungry or homeless, and that all citizens of the United States deserve healthcare. Our society attempts to achieve these goals. Laws are written, discussed, and approved by state and federal congresses, voted on by citizens, and theoretically upheld by the courts, churches, and decent individuals. But, unless the world suddenly becomes inhabited by virtuous, ethical humans who can unfailingly differentiate “good” from “bad,” then, in spite of an abundance of laws and lawyers, doctors, and nurses, this world will continue to have pain and suffering. And, although we want to hold our doctors, politicians, educators, champion athletes, and others to “higher standards” than the average citizen, it is best to remind ourselves frequently that all humans can be weak and are bound to make imprecise judgments, that there is not a homogenous definition of “good,” that values and religious beliefs are variable. Religious and cultural attitudes permeate (consciously and unconsciously) the decisions made by doctors, lawyers, teachers, and patients. Also, in spite of more laws than anyone can remember or understand or interpret, we will never be able to dictate and enforce what a doctor does at the bedside of every sick, dying, or distressed patient. Passing more laws or adopting practice guidelines (e.g., Geriatrics Society) or a code of ethics (e.g., AMA) are noteworthy but may not be as effective as intended, because attitudes cannot be legislated and “good behavior” varies with the clinical scenario and who is the judge of the behavior. Certainly, establishing treatment of pain and suffering as a priority is critical. But, moving from this valued goal to the practical—the bedside—can be a gigantic extrapolation.

Pick your physician carefully. Ask the difficult questions before they are relevant. No medical school, state medical board, or hospital medical staff office will ever be able to guarantee that you and your doctor will agree on details of treatment of pain and suffering. At times, no one is “wrong”; at times, the conflicts relate to interpretation of prognosis (e.g., what are the...
chances that this bone marrow transplant is going to work?), differences in attitudes about what the options are for withdrawal of advanced technological interventions, or about hastening death with aggressive pain treatment. What appears to a patient as “treating pain” may appear to a physician as “euthanasia,” and vice versa. We should remember that “suffering is ultimately a personal matter.”

Physicians and other health professionals seldom disagree with the concept that pain and suffering should be treated. If I sent a survey to every physician in the United States with the question “Do you believe that a physician should alleviate a patient’s pain and suffering?” I doubt that I would receive anything short of a unanimous “Yes.” The next question is equally easy to handle. That is, “How do you treat pain and suffering?” Physicians will answer that their patients receive narcotics for pain, sedatives to provide sleep, antidepressants and psychotherapy to treat anxiety and depression. The challenges and conflicts arise when details are sought. How much narcotic? How many sleeping pills should this patient have access to? When should the ventilator be discontinued? The huge literature that has erupted in response to such ethically charged issues as inadequate pain management and assisted suicide is strong evidence that the conflicts arise in the details, in what actually happens between the patient and the physician at the bedside. The debate becomes painfully heated when the discussion moves from the theoretical to the specific requests of a specific patient. For example, a patient is asking for “anything to stop this suffering” and the physician knows that some treatments may land him in the criminal court system accused of murder. Dr. Quill’s eloquent description of his experiences with his patient, Diane, introduced him to the grand jury in New York, defending himself against murder. Unfortunately, his encounter with the law is not unique.

Can there be a “law” for every case, an ethical discussion of every request, of every scenario? Obviously this is not possible. Moving from the general attitude to the specific treatment of a patient is fraught with misunderstanding. In law, politics, medicine, and in most “real life” situations, society depends on the individual in charge (in this case, a physician taking care of a patient) to be able to make judgments and rational decisions at that moment. At a particular “real” moment, will doctor, nurse, patient, and family agree to what had been planned when the topic was “theoretical”? Is the plan legal? Even with the most detailed “protocols,” physicians have to be at the bedside, have to talk to families and patients, and have to think, reevaluate, and respond by amending agreements and plans as a patient’s status evolves. This is a huge responsibility, and a million articles about ethical behavior cannot replace the bedside interaction. No one who has never been at the bedside should be too ready to judge or jail.

On the other hand, physicians who do not go to the bedside to abide by Dr. Quill’s challenge for “non-abandonment” of patients should be censored and rational consequences assigned. This, too, is simple to write, and impossible to guarantee. After all, who can demand or guarantee that surgery will be successful, that antibiotics will be effective, that antidepressants will prevent suicide, or that all the “right” decisions about these treatments will be made at the “right” time? Reviewing decisions (or data) retrospectively is associated with high incidence of error. Was there negligence? Was it intentional? Looking “backwards,” deciding who and what was “right” is
treacherous. Treating pain and suffering is often more emotionally complicated than surgery or treating infection and is associated with a wider variety of personal options and individual interpretation of “right.” Prospectively defining every scenario will never be possible, but continuing research, expanding teaching, and setting guidelines (not laws) for accountability are critical for improving care. Accepting the limitations in this area of medicine is also critical.

For example, in the setting of “pain and suffering,” protocols that are reasonable and effective in other medical arenas are often insensitive and even insulting. The same dose of morphine that is optimal to treat pain after a hernia repair may not be anywhere near sufficient for this same patient one year later when he is dying from metastatic prostate cancer. “Clipboard medicine” is not the appropriate path for treating our patients who are suffering. Standard doses and/or routine medications may not be effective. Alternative therapies, drugs, and practitioners should be consulted and offered as options when customary and routine techniques and doses are not providing relief. All caregivers need to remind themselves frequently, “Do I need advice from someone else? Have I exhausted what I am comfortable with providing this patient?” Physicians need to listen to requests from their patients and seek answers to questions and concerns, even when, from their own viewpoints, these requests may sound far-fetched and pointless.

Teaching about Pain and Suffering

Ignoring the topic of pain, suffering, and dying in medical school and postgraduate training because molecular and cellular mechanisms are not yet clearly defined is unacceptable. The standard medical school curricula and residency training programs are often inconsistent and deficient in exposing students to the challenges of treating dying patients. There is much to learn and to teach about providing the means of quiet death to our patients. The practice of discussing pain and death is critical to establish at an early stage of training because if this topic is ignored, the pattern of “not dealing” may be difficult to reverse later in a career. The dilemma is that teaching a topic that is not relevant is often of limited impact. Medical students are seldom involved with dying patients. Instead, they are still naïve and eager to “cure.” Introducing the palliative model along with the curative is theoretically appealing and worthwhile, but we must realize that “cure” is a more idealistic concept that medical students often cling to until clinical experience introduces a reality check. Knowing this, medical educators must move past lectures about pain and suffering. “Stories” about dying may be powerful, but they remain abstract to a student in a classroom.

One model of incorporating education about dying patients has been introduced at Yale University. In this setting, dying patients are given a “teaching role.” Additionally, readings from medical journals, cultural anthropology, literature, and sociology all combine to teach students the impact of culture, ethnic origin, and religion on the attitudes of patients toward pain and suffering at death. The value of “mutual support and collaboration” is emphasized in the care of dying patients. Such training inevitably has an impact on a student’s integration of limits in the arena of “curative medicine” and the tremendous overlap of palliation in caring for patients compassionately.

A growing awareness of and respect for end-of-life care has clearly expanded over the last 5–10 years. Striking evi-
rence for this is the National Consensus Conference on Medical Education for Care Near the End of Life held in Washington, D.C., in 1997. The working groups of this conference established the current status and then focused on opportunities for improving teaching and delivery of end-of-life care. For example, the Working Group for the Preclinical years of medical school outlined five specific domains necessary to establish competency in basic end-of-life care: (1) psychological, sociologic, cultural and spiritual issues; (2) interviewing and communication skills; (3) management of common symptoms; (4) ethical issues; and (5) self-knowledge and self-reflection.

The recommendation is that every medical school include a curriculum and a means to assess the curriculum to educate students in end-of-life care. The exciting opportunities to teach via a variety of interactive, technologically advanced methods should have a radical impact on curricular options for our students. Innovative audio-visual technology is being developed at a logarithmic rate and, hopefully, it will revolutionize the types of alternative teaching offered to medical students and physicians-in-training. The concept that “the worst thing is not death” needs to be introduced early in medical education, but not in a classroom lecture. That tactic is too far removed from the power and emotion of a real patient.

Can we teach empathy? Can we eradicate or at least minimize arrogance from our repertoire in medicine? As physicians gain experience and are humbled in the course of medical school, postgraduate training, and practice, some are wise enough to accept that a patient’s medical course doesn’t always match what the book describes or what was taught during training. That is, as we practice medicine we learn that anecdotes are of immense value. Remembering the huge amount of morphine that a specific patient required for pain relief can have a tremendous impact on a physician’s view of possible options for other patients in the future. Such an experience with a specific patient will certainly “override” the traditional advice and teaching of what is “an appropriate amount of morphine.” Similarly, a combination of drugs may be effective for one patient but described as ineffective at a national conference. Both the “data” and the patient are likely to be “accurate.” That is, we are traditionally taught that we must develop treatment plans based on scientific data, large collaborative studies, and careful statistical analysis. We counsel patients based on a “30% chance of survival” or a “95% chance of remission” or a “20% incidence of complications.” But, for a specific patient, the results of treatment are often 0% or 100%. The patient who did not enter into remission of his leukemia is not comforted by the knowledge that 95% of patients who received the same therapy do. Similarly, a patient who receives a certain drug at a certain dose, but who gets no pain relief, is not relieved to hear that at least 95% of people who receive the same treatment feel better. The patient who is relieved of some degree of suffering after a so-called ineffective therapy is not bothered by a negative description of that treatment in a famous medical journal. Frequently, physicians are more eager to present “data” to patients rather than exploring what fundamental values and fears might govern their decisions about treatment, no treatment, death, and “do not resuscitate” orders.

Too often, therapies for patients are amended based only on “scientific proof” that a certain treatment is effective (or ineffective). Probably nowhere in medicine is the interaction of organic disease, psychological reactions, learned behavior, and religious and family tra-
ditions so complicated and variable as in the setting of “pain and suffering.” Dying patients, patients in pain, and patients who are suffering are probably more different from each other than they are alike. Treating pain is a concept that is difficult to “teach”; it is not like learning the anatomy of the hand, or how to interpret an EKG or an MRI, or how to treat hypertension.

Another aspect of Dr. Rich’s discussion of “irrational beliefs contributing to ineffective pain management” should be noted. I doubt that many physicians who routinely care for chronic pain patients, patients with cancer, or postoperative patients have as a major concern that their patients will become “addicted” if pain medications are given in sufficient quantities to allow comfort. But physicians who do not deal with patients in pain may have many such misconceptions. The contention that physicians should all know how to treat pain expertly is an oversimplification. For example, Pain Management is a subspecialty of Anesthesia, with subspecialty board certification. Anesthesia residents routinely rotate to acute and chronic pain services. That we should simply “teach doctors how to treat pain” is a naïve view. A basic level of competence should be expected of all physicians, similar to the level of competence by all physicians to read EKGs, manage an airway, and interpret a chest X ray. But all physicians are not cardiologists, or anesthesiologists, or radiologists. Clearly, that many patients with pain are inadequately treated is well established, as Dr. Rich reports. What is critical in this era is teaching our students and residents how complicated pain management can be and when and how to get consultation.

Pain and Suffering—and the Law

Although I agree with Dr. Rich’s contention that a physician has “a moral responsibility to patients in spite of legal consequences,” regulatory scrutiny is very likely a significant factor in defining a physician’s willingness to treat pain and suffering aggressively. Hospitals do need to demand that patients have a right and physicians a duty to treat pain. Once again, this general goal is not debatable; however, the details are. I contend that the overwhelming majority of physicians are not interested in being co-conspirators in the federal regulators’ “war on drugs.” Instead, I propose that physicians are increasingly aware of the intense, and sometimes irrational, scrutiny of medical boards. At least in California, the medical board is not composed entirely of physicians. Of those members who are physicians, I doubt that many are experts in pain management. A major segment of our medical board consists of laypersons, who have no first-hand experience in the care of patients. Many who investigate the complaints against physicians are former investigators for law enforcement agencies. Such individuals are not likely to be capable of analyzing the care of patients who are receiving treatment for chronic or acute pain, for cancer, or for progressive neurological disease. The variability from patient to patient concerning the quantity and types of therapy needed to achieve comfort in such complicated medical situations is striking. To analyze such practice accurately and to pass judgment on a physician is not a simple “review of a protocol.” For example, at the end of life, a patient may be requiring 20–30 mg (or more) per hour of morphine to provide pain relief. This dose may not have been appropriate in the prior month, but now 30 mg is the compassionate treatment. This high dose of morphine may induce apnea and death in a healthy patient and, in fact, may hasten death in any patient. The medical boards, the
lawyers, and the police have trouble with these types of judgments. Medical boards have an enormous responsibility to the general public, but with increasing frequency, there are citations delivered in the guise of “getting rid of the bad doctor” when, in fact, a patient may be receiving a therapy or drug that is “beyond traditional boundaries” but appropriate. Although review of such cases may be warranted, enough questionable accusations have been handed down to physicians that fears concerning prosecution are real. I do not believe that the majority of physicians are part of an “organized war on drug use.”

Some physicians should be sanctioned for inappropriately treating a patient (too little, too much), but who will analyze the data accurately? To insist that a physician maintain a “moral ground” in treating his patient, ignoring the risk of prosecution, is overly simplistic. The emotional and financial toll on physicians who are sanctioned by medical boards is enormous, so that a desire to avoid this ordeal is, at times, justified. Yes, the ethical duty to take care of our patients is supreme. But there should be no need to choose between sanction and adequately treating pain. A physician needs to prescribe responsibly, evaluate patients thoroughly, and carefully document the basis of his or her practice. In reality, the tactic is to provide documentation with the degree of detail analogous to that currently required for successful billing of Medicare and other third-party payers.

In addition to withdrawal of life support and failure to initiate a specific therapy, the principle of “double effect” is currently legal in every state in the United States. This principle requires that the physician intend to relieve the patient’s suffering, not to cause death. For many patients, aggressive treatment of physical pain might be effective in improving quality of life. In some patients, adequate treatment of pain may eventually hasten death—the double effect—thereby providing an appropriate, legal, ethical alternative to the intolerable suffering of physical pain. In other words, it is legal and ethical to treat a patient with whatever dose of narcotic (or other agents) necessary to control pain, dyspnea, or delirium, even if in the process of this treatment, death is hastened. In addition to the setting of titrating narcotics to effectively treat pain, the principle of double effect is relevant to other clinical settings. For example, administering barbiturates is easily justified to provide deep sedation to terminally ill patients. The indication for such treatment is to recognize that suffering is not necessarily limited to physical pain, and, at times, sleep (escape from suffering) may be what is indicated. In both cases (providing narcotics or barbiturates), the theoretical ethics are difficult to translate into clinical decisions, and the strict boundaries of “ethical” and “legal” become less distinct at the bedside of a patient who is asking for help. Additionally, in rare circumstances, physicians extremely skilled and committed to the care of dying patients admit that the pain incurred by some patients has been uncontrollable. This is one group of patients that is the target for physician-assisted suicide.

In spite of this narrow range of what is legal, no physician has been convicted of murder in any case of aid-in-dying. But Congressional Bill S.1272, the Pain Relief Promotion Act, threatens to criminalize the act of prescribing pain medication if in doing so a patient’s death is hastened. A 20-year mandatory prison sentence is attached to a conviction. Has this bill been introduced in response to the legalizing of physician-assisted suicide in Oregon? In some Critical Care Units, aggressive management of pain, anxiety, and
dyspnea is common practice. At least in one study, 75% of patients undergoing “withdrawal of life support” received “large doses” of drugs to treat pain, anxiety, and air hunger. Only patients who were deeply comatose did not receive such treatment. The authors did not report if patients or families were satisfied with treatment. Hence, it is unclear whether the doses given were adequate to eliminate the symptoms. In the case of 36% of the patients, the physicians ordering the medications acknowledged that “hastening death” was one of the reasons (but never the only reason) that the drugs were given. That this type of supportive care of patients and families could be criminalized can only add more fear and hesitation to treat pain and suffering aggressively.

A worthwhile exercise is to carefully examine the case of Diane, Dr. Quill’s patient. In developing a therapeutic plan with Diane, Quill concentrated on “shared decisionmaking.” That is, he obtained accurate data about the patient’s particular disease, allowed Diane access to consultants and their expertise, repeated the “options” and their consequences to Diane, but, in the end, allowed the patient and her family to make decisions (informed consent). He then developed a detailed treatment plan with Diane and her family—transfusions, pain medications, and so forth—that was revised as her status changed. He did not “withdraw support”; he did not abandon Diane when she “refused treatment.” Diane and her family needed incredible nontechnological support, which was adjusted to meet her needs at the various stages of her course.

Diane did end her life via ingestion of barbiturates. She was alone, requesting that neither her physician nor any family member be present, desiring for all to escape the legal consequences of being present at her death. Nonetheless, after his report, Dr. Quill was identified and submitted to both a grand jury investigation for murder and a medical board investigation. Dr. Quill was never charged with the crime; however, this same process is currently a possibility for any physician who honors his patient’s request for aid in dying. Additionally, along with the criminal accusations, proceedings by state medical licensing boards are automatic and consequences can be severe. The so-called Pain Relief Promotion Act (Congressional Bill S.1272) can only encourage similar legal response to aggressive supportive care to suffering patients.

Although pain is an extremely common symptom in dying patients (especially those dying from cancer or AIDS), at least one survey documents that the requests for suicide commonly come from patients who are not in pain. Depression is common. Although less well recognized, powerful forces other than pain concern patients at the end of life. These include fear of future loss of control and dignity or becoming a burden to their family, and they may be the primary reasons for wanting to die.

I do not have the confidence in the legal system (e.g., the Pain Relief Promotion Act, Congressional Bill S.1272) or the medical board to responsibly effect policy ensuring adequate treatment of pain and suffering. A criminal lawyer once explained to me that he would rather have 10 guilty persons on the street than one innocent person in jail. I feel the same way about physicians and judging about their treatment of pain, suffering, and end-of-life decisions. I am ferocious in my attempts to treat pain aggressively, but I have witnessed superb physicians called to the medical board and by the medical examiner because the “blood level of morphine was too high.” The destruction wrought by inappropriate sanction of excellent physicians by medical boards is real. In all cases and at all
times, assuring patients of continued support and reassessment of goals of therapy and treatment of pain, offering to obtain a “second opinion,” and honoring of “advance directives” are essential. Reducing this process to a legal issue is impossible and frightening.

The Future

I respect Dr. Rich’s concern about demanding a higher degree of accountability for delivering ineffective or insufficient pain management. I contend that the medical board (or the courts) is far too distant from the bedside to assume this responsibility. Local scrutiny is more appropriate. For example, as a start, hospital-based ethics committees, including experts in the field of pain management and end-of-life care, could review policy and develop implementation procedures. Obviously, extending this standard to clinics, nursing homes, and physicians’ offices will be challenging. Establishing a general standard instruction to patients concerning pain-management options could be developed, analogous to the required information about “advance directives” routinely given on admission to the hospital. Multidisciplinary pain services are functioning actively at most major medical centers, especially for patients with cancer and postoperative patients. With the degree of communication systems available currently (e.g., video-conferencing, phone conferencing), consultations to rural hospitals, clinics, and physicians’ offices can be established. To believe that a medical board will initiate such activity is naive. The medical board is often “punitive” in its review as well as nonconstructive, uncreative, and dogmatic in issuing criticisms.

In the current era, upper- and middle-class patients seldom have “blind faith” in their doctors and frequently arrive for medical care having reviewed a disease, its treatment, and sites of experimental therapy via the Internet and other resources. On the other hand, patients are seldom prepared for what really happens in the medical center during such events as complicated surgery, bone marrow transplant, and ICU admissions. Seldom can reading and talking about these topics prepare patients or their families for the reality of pain and suffering that is bound to accompany hospitalization and illness. These patients may need incredible support when they realize that “the book” didn’t tell the whole story. And, when their course doesn’t follow the pattern that was predicted on the Internet or in the textbook, these patients may be particularly needy of support. This may be a more striking problem in our computer-literate population than the “irrational beliefs about addiction and dependence.”

Considering pain management from an ethical viewpoint is powerful, relevant, and critical to be prepared to move from the theoretical to the bedside. As usual, simple solutions are seldom available for problems that involve real people with illness. The trend toward improving teaching during training is exciting. But, human beings are seldom predictable, rarely content, and usually scared when sick. Words such as “ethical” and “moral” elicit strong emotions. Establishing strict rules for treating pain and suffering is likely to cause more confusion. I have read and reread this quote by Paul Armstrong (who represented the families of Karen Ann Quinlan and Nancy Ellen Jobes before the New Jersey courts) and B. D. Colen (Pulitzer Prize winner, 1984, for coverage of the Baby Jane Doe case):

Physicians and hospital administrators have repeatedly forced these cases into court, begging for guidance and freedom from civil and criminal lia-
bility. They have repeatedly been given both the guidance and the mantle of legal protection, and have been given it in such a way that they can return to the bedside and resume their traditional role. If they continue to rush to court every time they are confronted by a hard ethical choice, it becomes more and more likely that they will not like what they are told. While not all will agree with his view on the relative role of physician decision making and patient autonomy, we would all do well to remember the admonition issued shortly after the decision by C. Everett Koop, the pediatric surgeon . . . the Surgeon General of the United States: “There is no way that there can be a set of rules to govern this circumstance. Guidelines perhaps are possible, but not rules. I can think of no more tragic circumstance to come on the practice of medicine and no more tragic circumstance for a future patient to face than to have a legal decision made by someone in the field of jurisprudence who has not lived through these circumstances and who could not in a lifetime of testimony understand what the problems are and how they should be handled. His training, experience and his emotions have not been intimately involved with similar circumstances in the past where his decision and his decision alone is the one that must answer all the questions, no matter how inadequately.”

Notes


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Educating Ourselves and Educating Patients

Daniel Maison

Pain management continues to pose a challenge to the healthcare profession in the United States. There are a host of barriers and many of these are very well laid out in the article by Dr. Rich. As a hospice physician, I confront these challenges daily.

Until very recently, the practice of pain management and hospice medicine has been largely marginalized within the medical profession in the United States. Only within the last few years have a few programs of specialty training been established to provide fellowship-level training in pain management. This does not even speak to the dearth of basic training provided to medical students.

During my medical school classes, we spent a total of approximately three to four hours on pain management in my two years of preclinical classwork. As I recall, an equal emphasis was placed on side effects and addiction as was given to adequate control of pain. When I have asked colleagues, they reported a similar cursory exposure prior to entering the hospital as third-year medical students.

The majority of what I first learned about pain control was gleaned from transcribing the orders dictated by senior surgical residents as patients were being wheeled out of the operating room. My education was combination of generic, “one size fits all” medication orders, punctuated frequently with warnings about oversedation and “drug-seeking” patients.

As Dr. Rich points out, pain is often at the bottom of priorities in the therapeutic interaction between patient and physician. This is not a one-sided exchange however. Both physician and patient often view pain control as secondary to establishing diagnosis or curing a condition. Many patients, worried about distracting their physicians from what they view as more important, either downplay or fail to even mention their pain during conversations with their physician. Patients might also mistakenly assume that there is little that can be done about their pain and that it is an inevitable consequence of their illness.

Additionally, patients often do not want to be seen as complainers. They feel that if they report their pain, they might be viewed as a problem patient. Further hampering an evaluation of a patient’s pain, many fear addiction or being seen as an addict. They therefore will not even ask for pain medications. We often hear patients talk of saving medications “until they really need them,” the fear being that pain medications will stop working and they will be left in horrible pain in the future.

Far from excusing physicians and other healthcare professionals, these challenges posed by the patients themselves make it even more imperative that pain issues be dealt with directly and explored actively with each and every patient. As we educate ourselves, so too do we have to educate our patients that pain is an important issue. We can provide excellent control of pain in the majority of cases. By validating their concerns and helping to dispel myths about pain and pain medication, we can empower them to actively participate in their own pain management. The establishment of an open, ongoing dialogue about pain is essential if we wish to be able to treat the patient’s pain effectively.

But before we can educate our patients, we need first to educate ourselves. How can we expect physicians to provide adequate pain management when they receive almost no formal training in the subject? The
importance of training in pain management needs to be embraced at all levels of physician education. In this era of cloning, invasive monitoring, and the ubiquitous computer, it is easy for pain management to get lost in the shuffle as medical schools try to prioritize how to have their medical students spend the four short years these schools have to transform college students into physicians. I would argue that as technologies become more advanced and it becomes possible to prolong life ever longer, knowledge in pain management will become even more important. This has already been borne out in studies referenced by Dr. Rich, where among those who owe their last few days of life to the latest technologies that medicine has to provide, 50% were suffering from modest to severe pain. Fifty years ago, these patients would likely have died long before and never lived to experience their undertreated pain in an ICU.

This is not to belittle the amazing advances in life support and inpatient hospital care found in the ICU. Rather, it points to a necessity of the medical profession to improve the caliber of pain management offered in intensive care settings to keep pace with the other technologic advances in use there.

From the beginning of medical school, to the recertifications that physicians in practice have to take periodically, competence in pain management needs to be taught and evaluated. An educational system that lacks adequate training in pain management fails to prepare a physician to perform one of the most sacred and time-honored duties of the profession, the alleviation of suffering.

In this environment of sparse education, half-truths and myths abound about opiate analgesics. These are unfortunately passed from generation to generation and remain very pervasive in the healthcare world today. Much as research and evidence-based medicine has served to improve the quality of care in other areas of medicine, so too will the propagation of scientifically proven information help to replace hearsay with validated fact. We need to arm students with these facts to help them combat and dispel the dogma of their older colleagues.

As if inadequate education and self-perpetuating mythology do not provide enough of a challenge, outside regulatory bodies further complicate matters. At the current time, the fear of sanction for overprescribing opiate analgesics is clearly greater than worry over being called to the carpet for undertreating pain. Dr. Rich states that the medical profession, on one level or another, has played along with the agenda of those embroiled in the war on drugs. Until we as a group decide that adequate pain management is more important than stopping the occasional overuse of opiate medications, this situation will not change.

Clearly, many challenges lie ahead for the coming years. Things, however, are beginning to change. Thankfully, pain management is now making the radar of medical literature in an ever-increasing fashion, as evidenced by Dr. Rich’s article. As we become more aware of the deficiencies of pain control among patients, so too will the public. Already, regulatory agencies are making pain control a priority in their review of institutions. This past September, Oregon became the first state to sanction a physician for undertreating a patient’s pain. Other states are sure to follow suit.

We have the tools. We have the knowledge. What’s left for us is to put what’s available to us in action. We need to reembrace our duty to do all we can to alleviate the suffering of those who have entrusted us to care for them.