



Ethics, Politics and Pain

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"Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium." Sydenham, 1682.

The opium poppy is the source of a class of medications called opioids, of which morphine is the gold standard. Opioids are still, as they were three centuries — indeed, probably thirty millennia — ago the best and often only balm for many kinds of pain. But American attitudes and policies about medications are so badly distorted that many suffering patients do not receive the one thing that could help them.

Important new research into the neurophysiology and biochemistry of pain, new understandings of addiction, and old but too-little known facts about opioids mean that we could now move beyond the habits which have led good clinicians to keep their patients in pain. But political structures and habits are slow to change. In the meantime doctors agonize and too many patients endure avoidable pain.

Dr. Lerner's Story

Imagine, for instance, a family physician, Dr. Christine Lerner. Her day begins at the hospital, where one of her patients has been admitted because of a pain crisis. He has metastatic cancer, and his pain has not responded even to the excellent home care hospice makes available for him. In spite of a continuous morphine infusion, the patient is still in considerable pain, and Dr. Lerner orders a bolus and increases the infusion rate. When she checks back twenty minutes later, the patient's pain is unrelieved. She orders another bolus. She notes responses on the faces of the residents and nurses — some impassive, some anxious.

Recognizing the power of myths about morphine, she points out some basic facts. First, one can prescribe whatever level of morphine the patient requires without endangering him as long as careful titration is performed. It's a matter of titrating the dose to the pain while monitoring his level of sedation and his respiratory rate. For years ethicists have argued that even if morphine endangered a patient, prescribing it might well be the ethically correct action. Life constantly demands risking some things for the sake of other, greater goods, and the relief of pain can be more important than postponing death as long as possible. But the facts about opioids make that analysis unnecessary. For most patients the threshold at which morphine relieves pain is clearly below the threshold at which respiration is impaired and sustained sedation occurs. Although the thresholds differ with each patient — and there is, in the abstract, no highest safe dosage of morphine — pain relief can be achieved safely in most patients. There is a clear pattern: at some dosage the pain is relieved, at a higher dosage the patient becomes drowsy, and only at a still

higher dosage will their breathing slow dangerously. For most patients pain relief can be achieved without risk. (The exception is pain that is wholly or partially opioid resistant, most typically neuropathic pain. These situations are easy to identify, since the patient will reach persistent sedation without the pain being fully relieved.)

The staff listens with an open mind, partially because they know Dr. Lerner uses a full spectrum of interventions to help her patients with their pain: not only opioids, but imagery, physical therapy, counseling, and so on. Those who want to remove opioids from the list usually have a number of misperceptions about the way morphine works. Dr. Lerner is used to encountering those misunderstandings and habitually chisels away at them. She hopes for the day that, like the Berlin Wall, they will simply disappear. She leaves the hospital satisfied, having relieved her patient's pain and educated some of the other clinicians involved in his care.

Back in the office she sees her first patient, a man whose chronic back pain did not respond to surgery and who got no help from consultations with a pain clinic. Dr. Lerner has been his primary physician for years. Regular use of long-acting morphine over the past year has allowed him to get his pain under control, which in turn allowed him to return to work after four years of disability. His family situation has improved markedly. A few weeks ago seeing this patient gave her a sense of deep satisfaction. Today just the sight of his chart gives her pause. She is worried.

She is not worried about addiction: although any patient will become physically dependent on morphine after a short period of regular use and may suffer withdrawal symptoms if it is discontinued, this is not the same thing as addiction. In some cases patients become tolerant, and require escalating doses to achieve the same analgesic effect; this too is not addiction. Addiction is now defined as psychological dependence, and the use of the medication for purposes other than pain relief. Fewer than 1% of those using opioids for pain become addicted.

So, no, Dr. Lerner is not worried that her patient will become addicted. And she is not deterred, although she is chronically irritated, by the paperwork required to prescribe narcotics. Her state, like eleven others, has deliberately burdened the prescribing of narcotics, in an effort to prevent the medications being diverted into drug trade, as well as out of fear of iatrogenic addiction. She's learned to surmount that barrier, too, without breaking stride. The special numbered forms are locked away; she gets them, laments that she cannot prescribe refills, warns the patient that the prescription must be filled within five days, and adds that the pharmacy will have to face its own set of hindrances in filling the prescription.

Dr. Lerner is worried, rather desperately so, not about her patient but about herself. Because morphine is usually underprescribed, anyone who prescribes it appropriately risks being investigated and disciplined. Dr. Lerner once felt safe, because she kept well versed on the proper use of opioids, kept careful records, and when in doubt consulted with a pain specialist. Just as she worked at debunking myths about morphine and respiratory depression, so she worked at debunking unfounded fears of disciplinary action.

Last week shattered this view of the world. She now knows that it is not only ignorance that keeps physicians from treating their patients' pain adequately. She learned that one of her most respected colleagues had his license suspended by the state board of medicine — for providing care that was appropriate by every standard of which Dr. Lerner knew. The more she looked into the story, the more chilled she became. For one thing, what had happened was not an isolated instance, in her state or in others.¹ State boards and governmental drug enforcement agencies must "interpret regulations . . . which typically contain broad, ambiguous, and vague language. . . . [Members] bring their own prejudices and misinformation to their decisions. . . ." ² One recent survey found "that only 75% of members thought the use of opioids was lawful and generally acceptable medical practice for patients with cancer pain. . . ." Less than half believed opioids should be prescribed for cancer patients with a history of abusing drugs. Only 12% "believed it

was acceptable to use opioids for chronic non-malignant pain" and only 1% approved such use for patients with a history of drug abuse.

For years she had been fighting this kind of ignorance, believing she was fighting from a place of safety. She used to tell her colleagues that the appropriate prescribing of opioids could not endanger their license — that such fears, like those about respiratory depression and addiction, were groundless. Now she knows she was wrong. She has called and talked with the physician whose license was suspended, and his suffering wracks her with sympathy and anxiety. The Board of Medicine's action was wrong, and everyone in the medical community conversant with pain research knows it was wrong. In spite of this he is seared by the public humiliation.

The Ethical Issues

Dr. Lerner faces a new form of a standard ethical issue: how much must a doctor sacrifice, or risk sacrificing, for the sake of her patients? What is the moral minimum, what is the ideal? The question has never been simple, but for many kinds of cases customs have developed. Medical students and residents suffer years of sleep-deprivation in order to learn medicine. They spend so much time working and learning that they risk losing their families. Most doctors face some risk of contracting TB, AIDS, and hepatitis: they can diminish the risk, but not eliminate it. Doctors in emergency rooms risk assault.

Interestingly, though, conventional wisdom allows avoiding other risks that seem less serious. Generous and idealistic doctors can retreat into self-protection when a lawsuit is even remotely possible. As incongruous as this stance might seem, and in spite of the fact that myths about lawsuits flourish in the insular world of medicine, it pays to attend seriously to these fears. Human beings can suffer in many different ways, and some of the deepest and most enduring are emotional. The thought of being summoned to court, of being publicly accused of negligence or incompetence, may be more frightening than the thought of pain, fatigue, or disease. Doctors for years were more willing to risk hepatitis than HIV, even when the risks were greater for the former. But death from hepatitis was not stigmatized, while death from AIDS was.

The point here is not that doctors are inconsistent, but that shame is one of the most powerfully negative experiences a human being can undergo. And that is part of what has paralyzed Dr. Lerner.

Even if it were clear that she should take the risk of public humiliation, she would still have to take into account her other patients. If her license was suspended or her prescribing privileges revoked, her patients would probably suffer. Many, perhaps most, doctors do not provide adequate pain relief. It is hard to overstate the challenge of living with chronic severe pain. For the sake of her patients, then, perhaps she should underprescribe? Is underprescription from her better than what they are likely to get from another doctor? On the other hand, underprescription may put her at just as much risk as adequate prescription. Many doctors think that any prescribing of opioids puts them at risk.

Finally, there is income. Her debts from medical school are not yet paid off, her husband is partially disabled, she will soon have two children in college. She has obligations to her family, too.

There is no easy answer to her dilemma. But it can be helpful to identify some of the variables she will have to keep in mind until the political situation becomes saner and safer. And the fact that the political picture is so significant adds one more element to the ethical demands she now faces: she must not only decide how much to risk for the sake of her patients, she must somehow, somehow, become politically active. Human beings do not live as hermits. Most of what we do

rests in part on the ordered framework made possible by the rule of law. We have some responsibility to try to shape that framework.

With that in mind, Dr. Lerner will have to consider the following:

How great is the patient's need? Of course the level of need is difficult to measure, and the most important element in measuring it is the patient's report. In the past Dr. Lerner has asked herself a "yes or no" question: does the patient require opiates or not? She may conclude that this remains the single question to ask, that the various risks to herself have no ethical relevance. It could be argued, however, that here as in other medical decisions she has a right to take into account dangers to herself and her other patients. What could not be defended would be a decision never to prescribe opiates now that she has learned of the licensure action. The most that could be defended would be a higher threshold for prescription: that is, denying opiates to some of the patients who need it. But that is a serious move, and so Dr. Lerner needs to ask other questions as well. (Even if she decides that her clinical decisions should remain unaffected, she still needs to ask these questions, out of prudence and because there may be an obligation to become politically involved.)

How great is the risk? There are many things to fear here — public humiliation, loss of income, her responsibilities to other patients. But just how likely is the licensure action that might bring them about? Granted, the risk is real: a highly respected colleague was punished entirely unreasonably. On the other hand, how many people prescribe responsibly without incident? The randomness of the risk is frightening; but many of the risks doctors take in stride are equally random (e.g., violence in the emergency room, contracting hepatitis, and so on). The risk may be so small that it does not justify any change in what she does for her patients. (Even if she has decided that no risk to herself would change the way she practices, she owes it to herself to be clear about the real extent of the risk. Her fears may be (understandably) disproportionate to the danger.)

Could her risk be lessened? Like other "random" dangers, steps can be taken to lessen the threat here. A number of proactive steps could help: consulting regularly with other experts in the field, getting second opinions on situations she knows might be misinterpreted; keeping excellent records; knowing and using the standards established by professional associations; working with other disciplines (psychology, social work, physician therapy, etc.) to offer her patients the whole spectrum of behavioral and emotional interventions that are known to help with chronic pain.

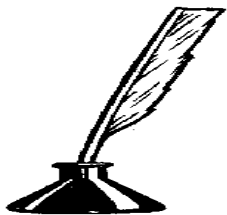
Finally, and most important, what can be done to improve the political situation? The state Board of Medicine created this dilemma, and the problem will not end until the board changes its ways. So the first political question is, how are the members of the board chosen? Are there any opportunities to educate them? Second, where are the political allies for change? She needs to join with others and assess the political landscape. In some states right-to-life organizations, because they oppose assisted suicide, fight against liberalized prescribing laws because they fear such laws would encourage assisted suicide. But in other states the parallel organizations recognize that unrelieved pain is a powerful impetus toward suicide, and so they work to support liberalized prescribing laws. Where do right-to-life organizations in her own state stand? Third, can a working relationship with a journalist be formed? The public shares many of the myths common among doctors, and the media have great power to direct the attention of the public and to educate them. Finally, are there others like herself with whom she can band together, for support and ideas?

There are no easy answers for Dr. Lerner as she weighs risks to herself and her patients. Ironically, however, there really are fairly simple answers available to us as a society. Sane prescribing regulations are easy to describe, and should be uncontroversial to an

educated public. Dr. Lerner's only salvation will come through helping to enlighten those around her. With enough public and political change suffering patients in the twenty first century will have access to the balm praised by Sydenham three hundred years ago, and used for millennia before that.

Notes

- 1 For one story, see Christine K. Cassel, "Narratives on Pain and Comfort: Dr. M's Story," *Journal of Law, Medicine & Ethics*, 24 (1996): 290-291.
- 2 "Opioid Regulations May Have Negative Impact on Ca Patients," *Oncology News International* February 1994.



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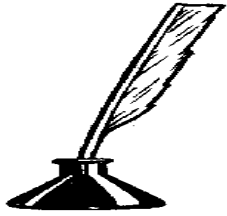
Pain in a Medieval Key

M. Teresa Tavormina, Ph.D.
Department of English

Medieval constructions of pain vary, depending on whose pain it is and in what kind of record it appears. Stories of martyrs often stress the saint's transcendence of excruciating tortures intended to turn him or (more commonly) her from Christianity. Such immunity to pain typically demonstrates divine power and anticipates pain-free heavenly bliss. This "meaning" of pain — or of its absence — seldom occurs outside of hagiographical genres, however, and may not have offered much room for ordinary people to identify with the saint's non-experience of pain.

Occasionally, we do find evidence for how those ordinary people understood their pain. Some reports suggest still-familiar religious meanings: pain as road to virtue, penalty for sin, God's inscrutable will. Other testimony focuses on more secular matters: specific symptoms, panic responses, attributions of causality. Diseases that physicians could not identify seem to have caused much higher anxiety among sufferers and their families. Sometimes descriptions of pain and infirmity are accompanied by reports of physicians making the problem worse. As with modern complaints about malpractice or iatrogenic disease, it is difficult to know whether such reports imply an exacerbation of suffering through the betrayal of patients' trust or its partial alleviation through external explanations.

The great interpretive difference between medieval and modern attitudes toward pain, however, is not the "faith gap" between the Middle Ages and the 20th century, but rather an "anesthesia gap." Religious or moralized interpretations of suffering are still useful to many people. Where earlier centuries really differ from ours concerning pain is in their silent assumption of the inescapability, barring miracles, of physical pain. Today we expect somewhat uncritically that most physical pain can at least be "managed." Despite their use of derivatives of the poppy and the vine, our forebears would have marveled at, and deeply envied our almost other-worldly expectations.



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Pain in Infants and Children

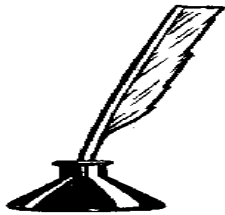
Elizabeth Seagull, PhD and William Weil, MD
Pediatrics and Human Development

Although there is a growing literature on pain management in adults, there is a considerably smaller literature on pain in children. Only in the past few years has pain relief for circumcision been commonly provided. Prior to the relatively recent demonstration that newborns can perceive pain, major surgical procedures were performed on neonates without any anesthesia. With infants and older children, many clinicians remain reluctant to administer any more analgesia than is required to stop the child's crying.

In children, as in adults, we know that pain is potentiated by anxiety and reduced by distractions. To reduce anxiety it helps to give accurate information to parents and honest explanations to children, and to provide interpersonally warm medical care environments. Hypnosis, guided imagery, and other distraction techniques are powerful adjuncts to pharmacotherapy. The combination of behavioral and pharmacological interventions is more effective than either alone.

While behavioral methods can be quite effective, their popularity points to one reason for the use of minimal analgesia in infants and children, i.e., concern that repeated use of potent analgesics for relief of pain can lead to drug dependency. While that concern has been reasonably repudiated for adults, there is no comparable body of literature for children. Another factor is the inappropriate belief that children are less likely to remember painful episodes or that their appreciation of pain is less cognitively significant.

The problem of pain is at least as important for children as it is for adults. Much greater emphasis on pain management in children is clearly warranted.



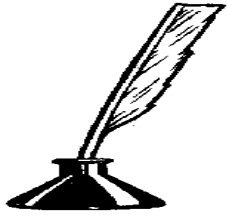
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Infrequent Use of Epidural Anesthesia During Labor by Japanese Women

Michael D. Fetters, MD, MPH, MA
University of Michigan

As director of the Japanese Family Health Program at the University of Michigan I frequently provide prenatal care to Japanese women. In doing so I have been struck by the reluctance of most to use analgesia during labor. In my experience with about 40 pregnancies, patients who had used epidural anesthesia in Japan were few. Occasionally the women for whom I cared would ask for *mutsu bunben*, "painless delivery" with an epidural, stating that they would like to try it once. The more common response was that they wanted *futsu bunben*, "natural delivery" without analgesia, if they could bear it. Most indicated concerns about the baby's safety as the primary reason for not having analgesia.

While epidural anesthesia may make the newborn more drowsy and less vigorous at birth, the cultural practice of not using anesthesia also appears to reflect relative availability of analgesia during childbirth in Japan. There are only about 1.4 obstetricians per obstetric facility there, and very few anesthesiologists are available. Ordinarily the obstetrician must attend to both the delivery and the analgesia. Given this, and the fact that epidurals require regular monitoring, one can understand why obstetricians might be reluctant to provide them. The social organization of obstetrics thus discourages the availability of analgesia for laboring women. While it would be tempting to call the current situation unethical, it is noteworthy that the perinatal and infant mortality rates in Japan are the lowest in the world and the maternal mortality rate is similar to that in the U.S. In Japan an increased use of complex anesthetic procedures such as epidurals might indeed endanger laboring women. When a Japanese woman plans to give birth in the United States her clinician should discuss these sociocultural differences in order to be sure that her decision is an informed one.



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A Surgeon's Brief Thoughts About Pain

Keith Apelgren, M.D.
Department of Surgery

Pain is not always bad. It's a significant symptom which physicians use to help diagnose a problem. Treatment of pain therefore is not always good, especially if one does not know the cause of the pain. Pain medications are withheld in patients who might have surgical illnesses until the patient is seen by a surgeon so that a condition requiring treatment is not missed. Postoperative pain out of proportion to the expected recovery process may indicate a complication. Therefore, pain is sometimes a physician's friend rather than enemy.

Related Reading

Cassell, Eric J. *The Nature of Suffering and the Goals of Medicine*. Oxford University Press, 1994.

Gawande, Atul. The Pain Perplex, *The New Yorker*, 21 Sept 1998, pp. 86ff.

Needless Suffering at the End of Life, <<http://www.msnbc.com/news/230347.asp>>



Fleck Receives Award

Congratulations to Len Fleck. Fleck was one of five national recipients of the Ernest A. Lynton Award for Faculty Professional Service and Academic Outreach. The award was presented in January at the annual conference of the American Association of Higher Education in San Diego, California. Fleck was selected for this award for his work with the "Just Caring" project over a 15-year period, especially his effort to develop an effective model of rational democratic deliberation. He is currently working on a project to promote community dialogue on ethical issues in human genetics.



News and Announcements

Sarah Dann joined the Center staff as secretary in October. Sarah will be working half-time, providing clerical assistance to the faculty and staff. In addition to her other duties, Sarah will take care of distributing the MHR. She can be reached at 355-3474.

Len Fleck contributed a case commentary, "Balancing a Plan's Obligations to Individual Patients and Its Enrolled Population," to *Ethical Challenges in Managed Care: A Casebook*, edited by Karen Gervais and others (Georgetown University Press, 1999), 17-26.

Judith Andre and **Margaret Holmes-Rovner**, published "Ethical Challenge," *Society for Medical Decision-Making*, Vol. 9, No. 2 (Summer 1998) 7.

In November **Len Fleck** conducted a workshop, "Genethics: Ethical Issues in Testing for Breast Cancer Genes," for a breast cancer conference sponsored by the Michigan State Medical Society, Brighton, MI.

Len Fleck conducted a workshop and presented lectures for an ethics conference sponsored by Chelsea Community Hospital, Chelsea, MI in December. The presentations were titled "Emerging Ethical Issues in the Care of the Elderly: Fair Treatment, Futile Treatment, Fatal Treatment," and "Shades of Gray: Ethical Issues in Providing Services to Older Persons with Mental Illness and Persons with Dementia."

Judith Andre with Bruce Miller, conducted a workshop on "Honesty and the Cancer Patient," for the annual meeting of the Michigan Association of Oncology Nurses.

Judith Andre spoke on "Respect for Cultural Diversity at the End of Life," for an ethics conference at St Mary's Medical Center, Saginaw.

In February **Len Fleck** will lead a seminar, "Just Caring: Health Care Rationing and Rational Democratic Deliberation," for the National Institutes of Health in Washington D.C. The seminar is under the sponsorship of the Department of Clinical Bioethics.