Why We Shouldn't Legalize Assisting Suicide, Part II:

Pain Control

By Burke J. Balch, J.D., and David Waters[1]

Proponents of euthanasia argue that "mercy-killing" is necessary because patients, particularly those with terminal illness, experience uncontrollable pain. They argue that the only way to alleviate the pain is to eliminate the patient.[*] But is there a better way?

The better response to patients in pain is not to kill them, but to make sure that the medicine and technology currently available to control pain is used more widely and completely. According to a 1992 manual produced by the Washington Medical Association, *Pain Management and Care of the Terminal Patient*, **"adequate interventions exist to control pain in 90 to 99% of patients."**[2] The problem is that uninformed medical personnel using outdated or inadequate methods often fail in practice to bring patients relief from pain that today's advanced techniques make possible.

Doctor Kathleen Foley, Chief of Pain Services at the Memorial Sloan-Kettering Cancer Center in New York, explained in the July 1991 *Journal of Pain and Symptom Management* how proper pain management has mitigated patient wishes for assisted suicide:

> We frequently see patients referred to our Pain Clinic who request physician-assisted suicide because of uncontrolled pain. We commonly see such ideation and requests dissolve with adequate control of pain and other symptoms, using combinations of pharmacologic, neurosurgical, anesthetic, or psychological approaches.[3]

Approaches to Effective Pain Management

Treating "Total Pain"[4]

The social and mental pain suffered by terminally ill patients may exacerbate the physical pain they experience.[5] Dr. Matthew Conolly points out, "[F]ailure to remember this complexity is one of the most common reasons why patients fail to achieve adequate symptomatic relief."[6] Effective pain control therefore requires a team effort of doctors, nurses, psychiatrists, and counselors to address the "total pain" a patient is suffering.

Severe Pain

Proper administration of an opioid, particularly morphine, has been proven to provide effective pain management in the majority of patients with severe pain. A February 1993 article in *Anesthesiology* notes:

> In the setting of widespread cancer, although more than half of patients will experience pain, their pain is manageable by oral administration of opioids alone in 70-80% of cases.[7]

And many methods other than opioids are available. Some patients may benefit from radiation therapy, nerve blocks (including even spino-thalamic tractotomy in selected cases), non-steroidal anti-inflammatory drugs, and non-pharmacological methods, which include distraction and relaxation.[8] Transcutaneous electrical nerve stimulation and direct spinal cord (dorsal column) stimulation may be valuable.[9]

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[*] *In fact, euthanasia proponents support legalizing the assistance of suicide in far more cases than those of terminal illness -- and there are strong constitutional arguments that such legalization could not be confined either to terminal illness or to voluntary euthanasia. Terminal illness with acute pain is simply the "hard case" often used to soften up opposition to legalization.*

Technological Advances

Technological advances have greatly increased the available options in administering opioids. One of these, Patient Controlled Analgesia (PCA) (a pump which can deliver a continuous infusion of a drug such as morphine, as well as allow patient-activated doses for breakthrough pain), eliminates the delay in receiving pain relief caused by having to wait for a nurse to administer the necessary medicine.[10] Studies have shown that PCA may actually lower the amount of medicine administered to patients, while providing them with a safe and effective way to have more control over their treatment.[11,12]

Another technological advance is the availability of a 72 hour patch made by Alza Corporation which releases controlled amounts of the opioid fentanyl through the skin. This patch allows patients to sleep through the night, avoiding the need to to wake up to take more medicine.[13] The development of time released morphine provides this same benefit. There is increasing interest in infusing opiates directly into the spinal column, sometimes using an implanted pump. This allows effective pain relief with a much lower total dose so that fewer systemic side effects are encountered.[14]

Barriers to Effective Pain Control

Despite our ability to control pain through medicine and technology, there are some patients who are needlessly suffering due to beliefs and practices which disrupt proper pain management. Poor pain assessment by physicians, patient reluctance to report pain, and patient hesitance to take and physician reluctance to prescribe appropriate medication, are some barriers that prevent proper pain management.

These practices are based on several myths, related to addiction, tolerance, and side effects. Some doctors do not prescribe adequate opioid medication because they fear their patients will become addicted. **Research shows, however, that only 0.04% of patients treated with morphine become addicted.**[15] Side effects associated with opioids, such as constipation, nausea, and vomiting, can be effectively managed by other medication and careful opiate titration. While a patient may develop a degree of tolerance to morphine over time, this is never total, and therefore increased doses of the opioid continue to provide relief.

Efforts to Educate Doctors and the Public

In an effort to counter beliefs and practices which disrupt proper pain management, health care professionals in 27 states are promoting cancer pain initiatives.[16] These initiatives provide education for doctors, patients, and the general public about effective pain management, especially in terminal patients. The U.S. Department of Health and Human Services has produced a series of *Clinical Practice Guidelines for Acute Pain Management* and is now working on additional guidelines specifically for cancer pain.

We have the technology and the medicine effectively to control pain. While there do exist some barriers to the implementation of that medicine and technology, efforts are being made to remove those barriers. Instead of trying to legalize the killing of patients in pain, the public should be making sure that doctors are taught, and use, effective pain management.

NOTES

1. Burke J. Balch is the Director of the Department of Medical Ethics for the National Right to Life Committee and David Waters was a Research Assistant to Mr. Balch. The authors of this piece gratefully acknowledge the assistance of Dr. Matthew Conolly, associate professor of medicine and pharmacology at the University of California-Los Angeles (UCLA).
2. Albert Einstein, "Overview of Cancer Pain Management," in Judy Kornell, ed., *Pain Management and Care of the Terminal Patient* (Washington: Washington State Medical Association, 1992), p. 4.
3. Kathleen M. Foley, "The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide," *Journal of Pain and Symptom Management* v. 6 (July 1991): p. 290.
4. "Total pain" is a concept developed by Dr. Saunders. See, Cicely Saunders, The Management of Terminal Malignant Disease, (1984), p. 232.
5. C. Richard Chapman, "The Psychology of Cancer Pain," Supra Note 1, p. 21.
6. Matthew Conolly, "Alternative to Euthanasia: Pain Management," *Issues in Law and Medicine* v. 4 (Spring 1989): p. 499.
7. Robert Truog and Charles Berde, "Pain, Euthanasia, and Anesthesiologists," *Anesthesiology* v. 78 (Feb. 1993): p. 357.
8. American Cancer Society in Association With the National Cancer Institute, "Questions and Answers about Pain Control," (1992), pp. 43-51.
9. Matthew Conolly, M.D., letter to author, August 2, 1993.
10. Louis Saeger, "Patient Controlled Analgesia (PCA) in Caner Pain Management," Supra Note 1, pp. 149-53.
11. Ibid.
12. Chuck Michelini, "Patients Put in Control of Their Pain Medication," *Medical Tribune* (October 29, 1986): p. 46.
13. Gene Bylinsky, "New Gains in the Fight Against Pain," *Fortune* (March 22, 1993): p. 116.
14. Matthew Conolly, M.D., letter to author, August 2, 1993.
15. Jane M. Anderson, "Pain Management: Challenging the Myths," *Medical World News* (April 1992): p. 20.
16. David E. Weissman, June L. Dahl, and John W. Beasley, "The Caner Pain Role Model Program of the Wisconsin Cancer Pain Initiative", *Journal of Pain and Symptom Management* v. 8 (January 1993): p. 29.