
EXPERIENCES IN MIDDLE EASTERN POPULATIONS

Pain Relief is a Human Right

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Abstract

For centuries, medical and surgical treatment has emphasized saving the life of the patient rather than ameliorating the patient's pain, particularly when there were few options for the latter. Today at the dawn of the 21st century, the best available evidence indicates a major gap between an increasingly understanding of the pathophysiology of pain and widespread inadequacy of its treatment. Epidemiologic evidence has proven that chronic pain is a widespread public health issue. Studies of cancer patients' pain control consistently reveal that up to half of patients receive inadequate analgesia and 30% do not receive appropriate drugs for their pain. Equally, for patients suffering HIV/AIDS, 60%-100% will experience pain at some stage in their illness. In the developed world, this gap has prompted a series of declarations and actions by national and international bodies advocating better pain control. One response to the worldwide undertreatment of pain has been to promote the concept that pain relief is a public health issue of such critical importance as to constitute an international imperative and fundamental human right. The importance of pain relief as the core of the medical ethic is clear. Pain clinicians promote the status of pain management beyond that of appropriate clinical practice or even an ethic of good medicine. They advocate a paradigm shift in the medical professions' perspective on pain management, from simply good practice to an imperative founded on patient rights. There is a need to promote policies which create conditions where human beings can bear even incurable illnesses and death in a dignified manner. This must help health professionals or lay groups to initiate a powerful agenda to reform local statutes. The essential components of such legislation are: 1. Reasonable pain management is a right. 2. Doctors have a duty to listen to and reasonably respond to a patient's report of pain. 3. Provision of necessary pain relief is immune from potential legal liability. 4. Doctors who are notable or willing to ensure adequate analgesia must refer to a colleague who has this expertise. 5. Pain management must be a compulsory component of continuing medical education. For too long, pain and its management have been prisoners of myth, irrationality, ignorance, and cultural bias. We are confident that the Pain Relief and Palliative Care Working Group under the auspices of the Lebanese Cancer Society is the main promoter of Palliative Care in Lebanon whose main goal is to relieve suffering and improve quality of life of the cancer patients, and advocate pain relief as a human right.

Keywords: Pain relief - human right - Lebanon

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Introduction

Epidemiologic evidence has proven that chronic pain is a widespread public health issue. Several studies showed that 15%-25% of adults suffer from chronic pain at any given time; a figure that increases to 50% in those older than 65 yr (Verhaak et al., 1998). Medical and surgical treatment, for several centuries, has emphasized saving the life of the patient rather than ameliorating the patient's pain. Today at the end of the first decade of the 21st century, the best available evidence indicates a major gap between an increasingly understanding of the pathophysiology of pain (leading to a variety of pain treatment), and widespread inadequacy of its treatment.

Studies of cancer patients' pain control consistently reveal that up to half of patients receive inadequate analgesia, and 30% do not receive appropriate drugs for their pain (Crombie et al., 1999). Equally, for patients suffering HIV/AIDS, 60%-100% will experience pain at

some stage in their illness (Breitbart et al., 1996); therefore, insufficient pain management is a significant public health concern (European Federation of IASP Chapters, 2001). In the developed world, this gap has prompted a series of declarations and actions by national and international bodies advocating better pain control.

There is a need to promote policies which create conditions where human beings can bear even incurable illnesses and death in a dignified manner. Therefore, pain management is now being addressed across the disciplines of medicine and law. Their respective contributions are coalescing into a coherent position in which unreasonable failure to treat pain is poor medicine and unethical practice (Brennan et al., 2007).

Pain: Important Symptom in Cancer

There are 10 million new cases of cancer and 6 million deaths annually throughout the world. The World Health

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Table 1. Pain: Important Symptom in Cancer

- 20 – 40 % at diagnosis
- 40 – 70 % during treatment
- 70 – 90 % in advanced cancer and terminal care

Organization estimates that by 2020, that figure will double with approximately 70% occurring in developing countries reflecting better prevention strategies in the developed world (Selva, 1997).

Pain is prevalent among people who have cancer. Cancer patients may need pain relief at every stage of the disease. Estimates of the prevalence of cancer pain based on published studies range generally from 14% to 100% depending on the stage, severity, and site of cancer (Patrick et al., 2002; Gilson et al., 2007), (Table 1) making pain management a topic of continuing interest. More than two-thirds of patients with advanced cancer will experience pain, often severe (Burgess and Haworth, 1999). Moreover, pain experiences in patient with cancer are often influenced with psychological stress associated with the disease. An effective multidisciplinary approach to pain management and other symptoms is advocated where physicians need to work with other healthcare professionals (Burgess and Haworth, 1999; Thielking, 2003; Stearns et al., 2005; Gilson et al., 2007).

Inadequately Treated Pain and Consequences

Management of cancer pain has made significant progress in recent years, due to several guidelines suggested for cancer pain therapy (Zekry and Reddy, 1999). In spite of this progress, patients with advanced cancer described pain as moderate to severe in approximately 40%-50% and as very severe in 25%-30% (Von Roenn et al., 1993). Of terminal stage patients, 80% will have no analgesics they need.

In separate large studies of cancer patients in France (Larue et al., 1995), the United States (Cleeland et al., 1994), and China (Wang et al., 1999), the percentages of patients receiving inadequate analgesia were 51%, 42%, and 59%, respectively. Those at highest risk are listed in Table 2. Pain negatively affects the quality of life of patients with cancer (Gureje et al., 1998; Katz, 2002). Therefore pain management is crucial to reduce patients’ distress and increase productivity and functioning (Blyth et al., 2001; Siddall and Cousins, 2004). A World Health Organization (WHO) study revealed that individuals who live with chronic pain are four times more likely to suffer from depression or anxiety than those without pain (Gureje et al., 1998).

Chronic pain is linked with physical, psychological and social consequences, and can be regarded as a disease

Table 2. Patients Most at Risk for Undertreatment

- Children and elderly
- Cognitively impaired
- Patients who deny pain
- Different cultures
- History of substance abuse
- Uninsured and poor

Table 3. Barriers to Pain Relief

Professionals	o Poor assessment
	o Lack of knowledge
Health care systems	o Regulatory oversight
Patients	o Fear of addiction
	o Tolerance
	o Adverse effects

entity per se (European Federation of IASP Chapters, 2001). Physically, these responses include reduced mobility with loss of strength, disturbed sleep, immune impairment and increased susceptibility to disease, dependence on medication, and codependence with caregivers (Siddall and Cousins, 2004). In addition, chronic pain incurs massive social and economic costs to society. Persons with chronic pain are more than twice as likely to have difficulty working (Gureje et al., 1998; Katz, 2002). A prevalence study in Australia revealed a strong association between chronic pain and being unemployed for health reasons and receiving disability benefits (Blyth et al., 2001).

Barriers to Pain Management in Cancer

Several barriers to the adequate management of pain have been identified at different level: at the national policy level, in the provision of health care, and among patients themselves (Table 3). Barriers at the national policy level include restrictive laws and regulations limiting the medical use of narcotics, insufficient support for pain management programs by health authorities, and non recognition of pain management activities by financing authorities (Joranson, 1994).

Secondly, barriers in the provision of health services include insufficient education of healthcare professionals and physicians’ knowledge and attitudes about opioids, the underassessment of patients’ pain, divergent perceptions of patients’ needs among health professionals, and physicians’ reluctance to use potent analgesics, and overestimation of the effectiveness of prescribed treatments (Von Roenn et al., 1993; Larue et al., 1995).

Finally, patients themselves may be reluctant to report pain or to take analgesic medications, particularly morphine. Patients actually expect to experience pain in some medical situations or consider that pain management is not a priority with respect to other components of care. Furthermore, patients may report satisfaction with the management of their pain, even as they declare they are suffering from severe pain, and although their analgesic prescriptions seem to be inadequate (Ward and Gordon, 1994; Larue et al., 1999; Naccache et al., 2008). This has led pain advocates to seek legislative redress for this problem.

Pain Relief Is a Human Right

Pain is an international problem that requires an international solution. The Constitution of the WHO, as the supreme health agency of the UN, defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.” One

response to the worldwide undertreatment of pain has been to promote the concept that pain relief is a public health issue of such critical importance as to constitute an international imperative and fundamental human right (Cousins et al., 2004; Fishman Scott, 2007).

The high watermark of this advocacy was the inaugural “*Global Day Against Pain*” cosponsored by the “*International Association for the Study of Pain*” (IASP), the “*European Federation of IASP Chapters*” and World Health Organisation. It took place in October 2004 in Geneva, Switzerland; the theme of the day was “*Pain Relief Should Be a Human Right*”. It states that patients have a right to pain management, and they give content to that right. Such content includes the patient’s right to be believed in the expression of pain, the right to appropriate assessment and management of pain, the right to be cared for by health professionals with training and experience in assessment and management of pain (Brennan et al., 2007).

The importance of pain relief as the core of the medical ethic is clear. Pain clinicians promote the status of pain management beyond that of appropriate clinical practice or even an ethic of good medicine. They advocate a paradigm shift in the medical professions’ perspective on pain management, from simply good practice to an imperative founded on patient rights.

An example from the Australian Capital Territory, where the Medical Treatment Act of 1994 states “*a patient under the care of a health professional has a right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances, and the health professional shall pay due regard to the patient’s account of his or her level of pain and suffering*” (Medical Treatment Act 1994 (Australian Capital Territory), Section 23). Another example is a California statute that imposed three obligations. The first is a duty for doctors who refuse to prescribe opioids to a patient with severe chronic intractable pain to inform the patient that there are physicians who are specialize in the treatment of such pain. The second is a duty of all doctors to complete mandatory continuing education in pain management and the treatment of the terminally ill patients. The third is the requirement of the California Medical Board to develop a protocol for investigation of complaints concerning the undertreatment of pain.

These recent statutes in Australia and California are models for any future legislative activity, offering to professional or lay groups a powerful agenda to reform local statutes. The essential components of such legislation are (Brennan et al., 2007):

1. Reasonable pain management is a right.
2. Doctors have a duty to listen to and reasonably respond to a patient’s report of pain.
3. Provision of necessary pain relief is immune from potential legal liability.
4. Doctors who are not able or willing to ensure adequate analgesia must refer to a colleague who has this expertise.
5. Pain management must be a compulsory component of continuing medical education.

Policy and Pain Management in Lebanon

In Lebanon, national health and political authorities should designate improving pain management as a key objective of public health policy. It is important that individuals experiencing pain receive the best possible care to relieve their suffering. It is imperative that organized efforts on the part of all pain care providers occur at the local and state level to improve our health care policy (Abu-Saad Huijer and Daher, 2005; Abu-Saad Huijer and Dimassi, 2007). Adoption of policies that make pain management an expectation for all physicians may make adequate relief more accessible to all people with pain.

This will occur only when there are no other barriers in the health care system that will obstruct patient access to these important medications, such as the knowledge and attitudes of healthcare providers or restrictive reimbursement policies. Positive policy, with no implementation of a professional training, has little chance of affecting healthcare practice (Davis et al., 1999; Manchikanti, 2006). So balanced state policy is insufficient by itself to enhance pain management, but it is a necessary component to achieve this important objective (American Pain Society and the American Academy of Pain Medicine, 1996).

Achieving the appropriate social and medical change that will make pain management a fundamental component of health care is the next great challenge in our country. Education is an important component of our medical system, but there is no systematic approach to teaching pain management at any level of training. The lack of appropriate integration of pain management into medical education should lead to recent legal and regulatory mandates to bring such education to medical students and physicians (Katz, 2002; Abu-Saad Huijer and Dimassi, 2007). Unfortunately, we should be aware that these external mandates, too often result in fragmented approaches to pain education, with each specialty offering its own approach without integrating the multidisciplinary complexity of pain and its treatment into a comprehensive curriculum. On the other hand, there is a need to update medical board members’ knowledge about pain management and public policy (Daher et al., 2008).

Appropriate education of the public may reduce patients’ reluctance to express pain and to increase their demand for adequate pain management. Information and education of the general public may help to influence policy makers and should incite health institutions and professionals to improve pain management practices. It seems likely that increased awareness of pain management choices among the public will generate increased demand on health professionals to provide precise information and adequate care to address to each patient’s needs.

Healthcare professionals need to engage regulators in dialog to eliminate regulatory barriers that govern the prescribing and dispensing of opioids in our country. They have a professional responsibility as it is stated in the Code of Medical Ethics (Lebanon 1994) “Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care.

This include providing effective palliative treatment even though it may foreseeably hasten death". They have a professional obligation to understand the appropriate role of opioids in pain control and follow accepted guidelines when prescribing, administering, and dispensing these drugs. They also have a professional obligation to assist regulators and law enforcement personnel in identifying persons who may be involved in diverting opioids for non medical use.

Therefore, reform will require an integrated approach to address the problem of under-treated pain at all levels (Brennan et al., 2007):

1. Education for health undergraduates and graduates, including adult health professionals
2. Adoption of universal pain management standards by professional bodies
3. Promotion of legislative reform
4. Liberalization of national policies on opioid availability
5. Provision of affordable opioids
6. Promotion of pain control programs in all nations, irrespective of resources
7. Reimbursement issues for professional and facility services for pain care
8. Continuing collaboration with the foremost international pain relief organizations and the WHO.

Conclusion

For too long, pain and its management have been prisoners of myth, irrationality, ignorance, and cultural bias. The pain treatment gap is an international human rights crisis that needs to be addressed urgently both at the international and national level.

Therefore, the WHO recommends that countries developing public health programs in cancer pain relief and palliative care establish three process measures to monitor and evaluate programs. First, develop national policies to assure patients access to cancer pain and palliative care treatment. Second, establish educational programs for healthcare professionals and the public, such as medical and nursing curricula and media coverage about pain management. Finally, ensure analgesic drug availability, including recommendations to governments on ways to facilitate opioid availability for severe cancer pain (Scholten et al., 2007).

The evidence that effective pain management may be compromised by laws, regulations, and policies has led to systematic efforts to reform drug prescription laws, and state medical board policies and practices that impede effective use of opioids to relieve pain and suffering (Dahl, 2002; Joranson et al., 2002; Gilson et al., 2005). United Nations (UN) and regional human rights bodies should routinely remind countries of their obligation under human rights law to ensure adequate availability of pain medications. Human rights groups should include access to pain treatment and palliative care into their work, and submit shadow reports to UN treaty bodies.

Making real improvements in pain management will require the proactive efforts of many organizations, and we believe that education as well as discipline should be

the cornerstone of efforts to improve pain management. We are confident that the Pain Relief and Palliative Care Working Group under the auspices of the Lebanese Cancer Society is the main promoter of Palliative Care in Lebanon whose main goal is to relieve suffering and improve quality of life of the cancer patients (Daher et al., 2008).

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