Relief of Pain, the Physician's Formidable Challenge

The American Medical Association and the Public Health Service sponsored the Conference on the Care of Patients with Severe Chronic Pain in Terminal Illness. Following are excerpts from the address of the Assistant Secretary for Health to the conference participants on January 28, 1983.

The control and management of severe chronic pain among terminally ill patients ought to be a matter of special interest to every physician, but this is not yet the case. We tend to lay the blame for this situation at the feet of our medical educators and ask them to do better on this subject. But the issue is more complex than that. The overwhelming emphasis of medical education—of everyone's medical ambition—is to save lives. As a result, relatively little time is spent on learning how to care best for patients during their last days of life.

I think that has to change. I grant that we have a prodigious and growing reservoir of information to help physicians save lives and prevent disease and disability—to triumph over death—and I also grant that such information will continue to command our attention most of the time. But I also believe that many new developments in medicine—and in society—are making health professionals more sensitive to the needs of the patient with pain who asks for more than science is able to give. We must be able to make our peace with this patient, even as he or she makes peace with a life to be closed too soon.

Our great challenge is to gain more time and attention for this issue of caring for patients with severe chronic pain in the midst of many conflicting issues that the medical practitioner faces. The Federal Government and the medical profession came together 6 years ago to discuss new therapies for the alleviation of pain and discomfort. A committee with just such a name was established in the Department of Health, Education, and Welfare. The tasks and materials that have come from that committee served to sharpen further many research efforts at the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration concerning pain. They also helped focus the attention of the Food and Drug Administration on the pain-related drugs in its I.N.D. (investigational new drug) and N.D.A. (new drug approval) pipeline.

After half a dozen years, we may be somewhat disappointed at the modest level of attention given to pain management in medical education and bedside practice. But we can take heart that we are building together an incremental and important record from which improved patient care will no doubt come.

In the past few years, probably more than at any time in the history of medicine, independent-minded physicians have become more keenly aware of the interdependence of the health professions and how vital it is to the achievement of quality patient care. In an increasing number of areas, physicians are the principal actors, but they do not act alone. They share the responsibility and the concern, the joy of success, and the anguish of defeat and human loss.

As we physicians pursue the paths of biobehavioral research in the management of severe chronic pain, especially as it affects the terminally ill patient, we need to be sensitive to the roles played by others —medical support personnel, social service personnel, spiritual counselors and clergy, psychology and psychiatry staff, and the patient's own support circle of family and friends.

We tend to couch research efforts and conclusions almost exclusively in pharmacological or biomedical terms. But in fact, there is a seamless web of circumstance and human skill that surrounds and lends strength to a terminally ill patient during those last difficult days of life. We know that the central nervous system employs suggestion and emotion as a kind of internal, self-administered analgesic. How and why it does that are questions for which we do not now have all the answers.

One of the assumptions of this conference is that medicine now has a rather varied armamentarium of opiate and nonopiate analgesics. There is a good

beginning knowledge of the human response to terminal illness, severe pain, and imminent death. We physicians really do accept the notion of a partnership on this issue with other health professionals for whom science and compassion are complementary and natural aspects of their service. And I think it will be appropriate and desirable soon to broaden the arc of inquiry to include the management of recurrent but less severe pain among patients who are ill but not terminal.

There are many times the number of patients who each year suffer pain and remain alive than the number who suffer pain and die. But medical practice is uneven in its handling of those patients as well. The most frequent criticism is that physicians tend to be reactive, stimulated by the overt signals of their patients. They also tend not to prepare their patients adequately for pain, for its emotional and psychological as well as physiological consequences. As a result, neither physician nor patient is able to anticipate the phenomenon of pain, to truly understand it and learn from it, and ultimately to raise the necessary protective mechanisms to avert it. Year by year we are doing better, but for many thousands of patients, I would say we are not doing enough.

The Department has a number of research projects in this field, but they may not be receiving the attention that they deserve. Also, they may not be adequate, in terms of scope and support, relative to the significance of the issue. But research is not enough. We need to spend more time clarifying our strategy for getting the results of research out among the practitioners of medicine, those who are devoted to the art and science of patient care.

It is critical, therefore, to keep in mind the attitudes and needs of the practitioners of direct patient care. We must encourage them to give more time and attention to this issue of pain, to learn more about the therapeutic methods already available, and to use them for maximum effectiveness. I suspect that physicians can accomplish much more than they already do in alleviating pain, if they would only take better advantage of the materials and techniques now at hand. If they did, then we would be building our record of research and application on a much sturdier base.

Through a partnership of research and practice, we will surely gain additional insight into the phenomenon of severe chronic pain as it affects the terminally ill patient, and we will be able to prevent, control, or interrupt the phenomenon of severe, chronic, refractory, intractable pain.

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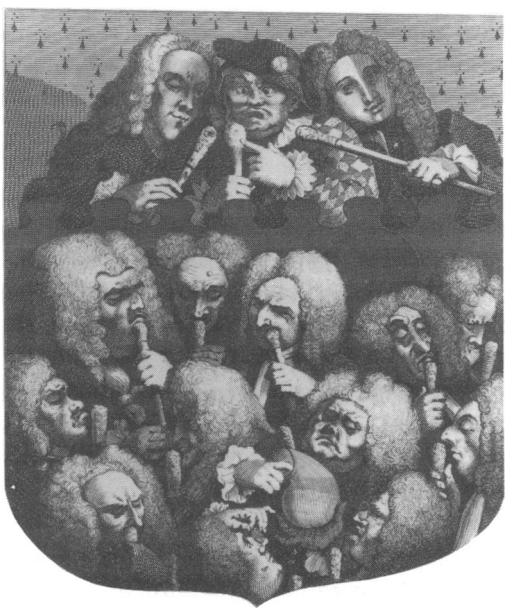

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