Palliative and Supportive Care (2009), **7**, 517–520.

doi:10.1017/S1478951509990538

ESSAY/PERSONAL REFLECTIONS

This won't hurt a bit: The ethics of promising pain relief

HANNAH KAUFMAN, MSS, MHSc
Joint Centre for Bioethics, University of Toronto, Toronto, Canada

Karl hunched over, scrubbing hard at Fitzgerald's knees, hurting him. Karl said, "One thing you learn in medicine is that wounds heal. Almost all bleeding stops with pressure." He scrubbed hard, and Fitzgerald tensed his thigh. "Also, there's some pain."

—Vincent Lam, *Bloodletting and Miraculous Cures*, 2006

INTRODUCTION

Pain is an unfortunate though common occurrence for patients during illness or injury. Health care professionals frequently make promises of pain relief that are well intentioned but unrealistic. Although we feel we are helping patients, such reassurances can cause patients to lose their trust in us when pain does occur, causing relational and physical harm. Surely we can give patients a more realistic yet hopeful indication of how we can help manage their pain.

Extensive literature exists about the ethical imperative to treat pain, the ethical challenges physicians and other health care providers face in their endeavors (Cassell, 1982; Post et al., 1996; Sullivan et al., 2001), truth telling, and promise keeping (Jackson, 1991; Benn, 2001; Sullivan et al., 2001; Hébert et al., 1997; Hébert, 2009). However, no mention is made of the ethical obligation to tell patients the truth about when and if they might experience pain and how likely we are to help manage it.

There may be unique circumstances when it is not appropriate or possible to fully explain this information. Hébert (2009) and others describe legitimate exceptions to disclosure of health information: patient waiver, incapacity, medical emergencies, and therapeutic privilege. It is beyond the scope of this article to fully explore these issues. Excluding these situations, telling the truth about pain is important.

This article explores the ethical problems of making promises, both overt and covert, to patients regarding pain relief and control. Strategies for communicating about pain management that are ethically based, drawn from palliative care and supportive care literature, are then suggested.

DO WE FALSELY PROMISE PAIN RELIEF?

Sometimes we unrealistically tell patients they will not feel pain. Sincerely seeking to decrease anxiety, we falsely promise they will not feel pain: "Just a little prick now." Others are meant sincerely: "You won't die in pain." And others are downright deceitful: "Don't worry, this surgery won't bother you."

False promises about pain and its relief occur both explicitly and implicitly. Pharma-sponsored, Canadian Cancer Society-endorsed videos such as "Managing Your Pain" (Librach et al., 1994) proclaim that patients do not have to live in pain. Well-known figures in palliative medicine, among them Ira Byock, former president of the American Academy of Hospice and Palliative Medicine, have declared that relief from pain is "*always* possible" (Byock, 1997). Patients may believe pain will not occur when health care professionals omit information about pain during procedures. In a study on respirologists explaining intubation and mechanical ventilation, 6 of the 15 respirologists did not emphasize discomfort (Sullivan et al., 1996).

Explicit promises about pain and its relief are uttered every day by physicians and other health care workers. I have witnessed and been guilty of

Address correspondence and reprint requests to: Hannah Kaufman, Joint Centre for Bioethics, University of Toronto, 88 College Street, Toronto, Ontario, M5G 1L4, Canada. E-mail: kaufman.hannah@gmail.com

sincere but false assurances to patients such as, "The palliative care doctors will be able to control your pain," and "You'll be on a pain pump post-op to keep your pain under control."

The centrality of physician as healer and reliever of pain may be at the core of such promises (Cassell, 1982; Post et al., 1996). The Canadian Medical Association (2004) and the American Medical Association (2001) proclaim in their Codes of Ethics that relieving pain is one of the most important goals of medicine. Additionally, leaders in the field of palliative care, pain, hospice, HIV, cancer, and psychooncology call for the recognition of pain treatment as a human right (Breitbart, 2008).

ARGUMENTS FOR PROMISING PAIN RELIEF

Many health care providers believe that talking about the potential of pain and the difficulties of relieving pain will cause anxiety, suffering, and loss of hope. They are aware of the links between anxiety and pain (Woodruff, 2004) and the connection between suffering and fear of uncontrolled pain (Cassell, 1982; Kuhn, 2003). Those practitioners may believe they are doing good and diminishing the risk of harm by softening or withholding information about pain and its management. Imagine the following scenario:

> Ms. M. is a woman with end-stage breast cancer that has metastasized to the bone. She wants to stay at home and be alert as long as possible. However, Ms. M. is also worried about a painful death. Dr. L. assures her that home hospice services are available so she will not die in pain.

How likely is it that Dr. L. is telling the truth about the care Ms. M. will receive? According to the World Health Organization (2009), 80%–90% of cancer pain can be controlled using their pain control ladder. So, perhaps Dr. L. is telling the truth. Is a 10%–20% chance of experiencing difficult-to-treat pain low enough that this promise can be made?

ARGUMENTS FOR TELLING THE TRUTH

We should not promise a pain-free experience or complete pain relief because pain is a byproduct of disease, injury, natural processes like childbirth, and some medical interventions. Many patients will experience moderate to severe pain (Dolin et al., 2002; Watt-Watson et al., 2004). Twenty-five percent to 50% of cancer patients who experience pain report moderate to severe levels (Ventafridda et al., 1990; Zeppetella et al., 2000). The SUPPORT study of 1,947 seriously ill patients with chronic obstructive pulmonary disease (COPD) and lung cancer in five U.S. teaching hospitals revealed that 28% and 21% of patients with COPD and cancer, respectively, had severe pain (Claessens et al., 2000). As well, patients can expect varying degrees of relief depending on pain etiology, health care setting, and patients' gender, ethnicity, culture, geography, socioeconomic class, and age (Schafheutle et al., 2000; Brown et al., 2003; Rupp & Delaney, 2004). For example, those without health care coverage may not be able to afford analgesics, adequate home nursing and attendant care, hospitalization, or physician visits. Children and the elderly are undertreated for pain in emergency departments (McEachin et al., 2002; Brown et al., 2003).

Second, it is difficult at times for health care staff to provide optimal pain relief. Despite the fact that governments and professional organizations have long recognized that undertreatment of pain is a serious and neglected public health problem (Physician Data Query, 2008) doctors and nurses are still poorly educated in pain management (Ziment, 1998; Hunter, 2000; Seers et al., 2006). Barriers to provision of optimal pain management, such as staff shortages and cultural and religious biases, negatively impact pain assessment and discussion about pain and its management. Additionally, patients in institutional settings and at home may have to convince a nurse they are indeed in pain and will have to wait for orders to be written, medication to be fetched, and then for the medication to take effect (Tucker, 2004). The lucky ones will have a self-administered pain pump and long-acting oral analgesics, prescribed by an up-to-date surgeon or knowledgeable specialist. The very unlucky will have pain that, despite optimal circumstances, will just not go away.

Third, telling the truth is the right thing to do. When it is told well, we show respect for patients, reduce risks of harm, promote trust relationships between doctor and patient, and reduce the risk of physician liability (Jackson, 1991). The principle of providing patients with accurate information is conceptually embedded into Western medical codes of ethics and vision statements (Canadian Medical Association, 2000, 2004; American Medical Association, 2001; American Pain Society, n.d.). Grave consequences result when pain information is not disclosed. Patients may consent to interventions without fully understanding the upcoming experience. Consequently, when pain occurs they may feel deliberately deceived and lose trust in their health care providers. They may not seek help or follow medical recommendations (Hall et al., 2002) disbelieving that relief can occur or that *their* provider can do the job correctly.

Moreover, they may withdraw from treatments or refuse further intervention if unexpected pain occurs. Perhaps most damaging, patients and their caregivers may lose trust in their own judgment and experiences or feel a sense of personal failure or weakness. Imagine having that feeling during the last days of life. Imagine being in chronic pain and having that feeling *all* of your life.

Lastly, most patients want to know the truth about their health conditions (Hall et al., 2002; Kuhn, 2003; Heyland et al., 2006). Patients in pain are fearful about their future, perhaps related to a fear of inadequate pain management (Godkin, 2008; Utne et al., 2008; Singer et al., 1999). They may not expressly request information about pain due to reasons explored in this article, perceived power differences between them and health care professionals, and perhaps other reasons. However, we should presume that patients want the truth. If this fact is in doubt with individual patients, the health care professional must raise the issue. Patients can then decide how much information they desire.

Telling the truth about pain can address false hopes and beliefs. Many patients enter a health care system believing their pain will be relieved. They gain their understanding from such varied sources as brochures and commercials, which portray smiling patients and families. As well, they trust respected organizations such as the World Health Organization (2009) and the International Association for the Study of Pain (Charlton, 2005) that assert that the prevention or alleviation of pain is a physician's duty. These organizations declare that health care providers who see patients suffering unnecessarily have a moral responsibility to help them.

Health care professionals can also be damaged by not telling the truth about their ability to treat pain or the inevitability of a painful experience. They may lose confidence in their healing skills when the symptom believed remediable occurs. The loss of patient or family trust can be devastating to a physician, especially if the patient subsequently refuses medical help. Great financial and professional harm can occur when lawsuits are launched for breach of promise of pain relief. Lawsuits have been launched and some won in the United States and Canada claiming broken implicit and explicit promises about pain management (Lowry, 1995; Tucker, 2004). Patients and physicians both likely bore financial and emotional burdens.

GUIDELINES FOR TALKING ABOUT PAIN MANAGEMENT

Telling the truth to patients about potential pain need not be difficult. Much has been written about telling patients bad news. These suggested principles and guidelines can be applied when talking about pain and its management: Be straightforward and honest, watch patients for nonverbal cues, be well prepared, and share information in ways that are understandable and applicable to that particular patient (Hébert, 2009). Hope for alleviation of pain should be supported. This can be accomplished by discussing how you and the patient can work together to manage (not get rid of) pain. And, lastly, patients should be reassured that you will not abandon them (Cassell, 1982) and that you will respect their wishes for pain management.

In many situations patients themselves anticipate that they will experience pain, such as prior to surgery or a procedure, during physiotherapy sessions, in advance directives (Godkin, 2008), and at the end of life. Therefore, a straightforward discussion is likely to be reassuring once the initial anxiety about broaching the subject has passed. In the case of Ms. M. above, Dr. L. could have more truthfully said, "It is possible or even likely that you will have pain as your disease progresses. We will work very hard with you to minimize and manage your pain as much as possible. Would you like me to tell you some of the ways we can do that?" Such a statement realistically and honestly responds to the patient's concerns. It also opens a discussion that might provide a sense of hope, trust, and security. It may actually relieve anxiety and suffering, as patients feel they will not be abandoned and that their physician is being realistic. The physician can discuss the patient's values, ascertaining if a patient such as Ms. M wants to remain alert, but be as pain free as possible, versus complete sedation at the end of life in order to minimize the risk of feeling pain. Talking about pain in this way also gives the patient a sense of control, as they are a part of the management strategy. Moreover, those with any type of pain—chronic, end-of-life, postoperative, and so on—benefit from these strategies.

Talking with patients openly and honestly about their pain experiences will enhance your trust relationship. In doing so you will not have to witness the look of betrayal in a patient's eyes when pain relief was promised, but not achieved. Why not just tell the truth?

ACKNOWLEDGMENTS

Thank you to Peter A. Singer, colleagues, and former classmates from the Joint Centre for Bioethics, University of Toronto, for their guidance and support in the development of this article. I am grateful to the many patients, health care providers, and friends who honestly shared their personal stories about compassionate care and false promises,

both given and received. Thank you to M. Kaufman, Hospital for Sick Children, for suggesting the title.

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