physician.

- While healthcare professionals appear to use current guidelines, "polypharmacy" [use of more than one medication from the same class to achieve the same result] exists.
- Multiple routes of administration are common in acute care settings. These tend to reduce the patients' understanding of their pain medications and to increase costs.

Patient identified barriers to effective pain relief are:

1. Failure of caregivers to believe complaints of pain.
2. Fear of addiction.
3. Undesirable side effects.
5. High costs of opiates.
5. Delay in response to requests to nurses for medication.

There is also a perception that many physicians, who have the greatest responsibility for pain management, have a less than optimal understanding of pain control. They have unreasonable concerns regarding the activities of the Drug Enforcement Administration [DEA], fear of lethal side effects and often underestimate the impact of pain on the lives of their patients.

Several health care institutions in the State of Hawaii have instituted pain management programs that have improved pain management in those institutions. This suggests that requiring pain management programs in health care institutions would have a major impact on the lives of patients receiving care in those institutions.

Including pain management as an educational requirement in all health care professional training and continuing education programs would also be of significant benefit.

We Recommend

1. That the Agency for Healthcare Policy and Research [AHCPR] guidelines for the treatment of pain be accepted as the community standard of care for all health care providers.[2]
2. That a right to skilled pain management be included in a "Patients Bill of Rights" at all Department of Health certified and/or licensed facilities.[3]
3. That pain management programs be instituted in each of those facilities.
4. That the AHCPR guidelines be accepted as practice standards in each of those facilities.
5. That educational course work in pain management be a required part of continuing education programs of licensed facilities.
6. That the Department of Health licensing and certification teams specifically include pain management when reviewing records, observing patient/client care, interviewing staff and clients, etc., in their overall review of patient care plans/management.
7. That the Department of Health cite any institution that it finds deficient in the areas noted above.
8. That pain management be part of the required curriculum of all medical, nursing and other health care professional schools in the State of Hawaii.
9. That professional organizations be challenged to adopt formally AHCPR standards and incorporate them in their peer review and continuing education programs.

References

1. Levy, M.H. Pharmocologic Treatment of Cancer Pain. *N. Eng. J Med.* 335; 1124-1132.
2. Management of Cancer Pain, Clinical Practice Guideline Number 9, U.S. Department of Health and Human Services, from the Agency for Health Care Policy and Research Publication No. 94-0592, March 1994, 257 pages.
3. Institutions to be monitored: Acute Care Hospitals, Skilled nursing and intermediate care facilities, Hospice programs and home health and home care agencies.

This issue contains two manuscripts related to psychiatry. It is not one of our "Special Issues," but does have information about care of psychiatric patients and should be of interest to all physicians.

Mahalo to Anders and Olson and to Patrick and associates for important data for Hawaii's psychiatric care givers and administrators.

President's Message

Leonard Howard MD
President, Hawaii Medical Association

The Governor's Blue Ribbon Committee on Living and Dying has submitted their report after 18 months of work. The majority of the committee urges the Governor to support any legislation allowing Physician Assisted Suicide (PAS) and/or Physician Assisted Death (PAD). A dissenting minority report was also submitted opposing the same. This, plus the special edition of the Hawaii Medical Journal, which was criticized by many members as indicating that the HMA supported PAS and PAD, has stimulated this personal opinion.

Your Hawaii Medical Association continues to support the AMA policy opposing both PAS and PAD. We support the efforts to improve pain management and end-of-life care to eliminate the horror stories of terminal suffering that we have all heard. The lead article in AMNews of November 15, 1996 said it very well: *"Although for some patients it might appear compassionate to intentionally cause death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death," they said. "Rather than recognize a right to physician-assisted suicide, our society instead should recognize the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all."* The AMA also submitted an amicus brief to the US Supreme Court when it was considering the issue of PAS in regard to the Oregon initiative. The AMA brief begins by affirming that: *"The right to control one's medical treatment is among the most important rights that the law affords each person." This includes the right to have unwanted life-prolonging treatment withheld or withdrawn and to have all medication necessary to alleviate physical pain, even where such medication would hasten death. Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process."* The AMA believes firmly that the lower court was wrong in taking the unprecedented step of announcing a right to control the timing and manner of one's death through the use of physician-assisted suicide. The power to assist in intentionally taking the life of a patient is counter to the health care profession's central mission of healing. It is a power that most health

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care professionals do not want and could not control. The brief concludes that *"The sentiment for physician-assisted suicide is not the right answer to the problem of inadequate care. Although for some patients it might appear compassionate to hasten death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death."* Rather than recognize a right to physician-assisted suicide, the AMA asserts that "we should recognize instead the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all."

At an Intensive Seminar in Bioethics sponsored by the Bioethics Consultation Group, Inc. of Berkeley, California, a full day was spent on Decisions at the End of Life. A message from that day stuck in my mind, and I have quoted it many times since hearing it. "The difference between withholding Nutrition and Lethal Injection is the difference between letting die and killing." To me this is the essence of the debate. Will we overthrow the teachings of the philosophers of the last 2000 years or will we hew to some new idea that physicians are to be the instrument by which an individual chooses to end his or her life? As for me, I will continue to support the concept that physicians preserve life as long as possible, but prevent suffering. If, by giving a dose of MS adequate to relieve pain I cause respiratory failure, then so be it. The patient's disease has been the essential reason for the death, not my action. On the other hand, if I inject a lethal dose of KCl or prescribe a lethal dose of barbiturate for a patient, then I am the primary cause of the death of the patient. It is the *intention* of our actions that determines their ethical nature. If the state wishes to provide a way that people can voluntarily end their own life for whatever reason, do so, but leave medicine out of it.

In closing, I wish to make it perfectly clear that the HMA leadership has NO control over what is or is not printed in the Hawaii Medical Journal. The content is determined by the Editorial Board and no other. This is as it should be and provides an opportunity for both sides of an issue to be heard.