

PHYSICIANS FOR COMPASSIONATE CARE NEWS

Affirming An Ethic That All Human Life is Inherently Valuable

Vol.3, No.2, Summer 2000

Pain Relief Promotion Act

FLOOR DEBATE SET FOR SEPTEMBER

The U.S. Senate promises to bring the Pain Relief Promotion Act (PRPA) to the floor in September, after the August recess. The PRPA passed the U.S. House of Representatives in October, 1999, with solid bipartisan support and has moved through the Senate committees. It is ready for a full Senate vote.

The PRPA will make certain that aggressive pain management is considered a legitimate use of controlled substances. And for the first time, this wording will be included in the federal Controlled Substances Act (CSA). The CSA amendment states: “(i) (1) For purposes of this Act and any regulations to implement this Act, alleviation of pain or discomfort in the usual course of professional practice is a legitimate medical purpose of the dispensing, distributing, or administering of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death (HR 2260; Title I sec. 101.lines10-16).”

The bill promotes better understanding of palliative care and supports training programs for health professionals to incorporate the best available methods for pain and symptom management into their practices. The Public Health Service Act (42 USC 299 et seq.) is amended by adding to its purpose: “(1) Promote and advance scientific understanding of palliative care, (2) Collect and disseminate protocols and evidence-based practices regarding palliative care with priority given to pain management for terminally ill patients and make such information available to public and private health care programs and providers, health professions schools and hospices, and to the general public. (HR 2260 Title II sec. 906 lines5-13).” Furthermore, the amendment gives the Agency for Health Care Policy and Research and the Health Resources and Services Administration an increase of \$5 million a year for five years to fund educational grants.

Finally, the PRPA protects doctors, nurses, and patients through legitimizing the aggressive use of controlled substances, but does not alter the role of the federal and state governments in the practice of medicine, nor does it create new federal authority. The CSA amendment states: (B) Paragraph (3) “Nothing in this subsection shall be construed to alter the roles of the Federal and State governments in regulating the practice of medicine.”

In response to the request of physicians and medical organizations, the PRPA reassures doctors by making clear that it does not create any new authority: “(4) Nothing in the Pain Relief Promotion Act of 2000 (including the amendments made by such Act) shall be construed...to provide the Attorney General with the authority to issue national standards for pain management and palliative care clinical practice, research or quality...” (HR 2260 Title II sec. 201). This provision clarifies that medical standards are still determined by doctors, as they always have been.

Thus, it is no surprise the PRPA enjoys the support of the nation’s leading medical organizations, including the American Medical Association, the American Society of Anesthesiologists, the National Hospice Association, and the American Academy for Pain Management, as well as Americans for Integrity in Palliative Care, Physicians for Compassionate Care, the National Legal Center for the Medically Dependent and Disabled and numerous others.

Detractors’ claims that the bill could lead to a decrease in doctors’ willingness to prescribe pain medications are unfounded. In fact, we have witnessed exactly the opposite effect in the states that have passed laws similar to the PRPA. These states have demonstrated an increase in per capita morphine use. In Rhode Island, morphine use doubled after such a law was passed.

If the PRPA passes the Senate, it will be sent to the President for his signature. In 1997, when signing the Assisted Suicide Funding Restriction Act, which assures that the federal government would not fund assisted suicides, Bill Clinton said: “Truly assisted suicide is too dangerous.”

Make your opinion on the PRPA known to your senators by addressing letters to them at the United States Senate, Washington DC, 20510.

CLINICAL GUIDELINES:
Non-Participation in Doctor Assisted Suicide

These recommendations are intended to protect your patients, preserve your own moral integrity, and maintain your right not to participate in assisted suicides.

Post a copy of your professional ethics so that patients are informed in advance of your principles. *

Refrain from suggesting assisted suicide by naming it as a treatment option, since assisted suicide is not a treatment. Initiating the discussion of assisted suicide may suggest suicide and may also imply the doctor's approval of patient suicides.

Continue to treat all suicidal ideation as a symptom requiring diagnosis and treatment. Just as with any other patient who brings up suicide, if the seriously ill patient expresses suicidal thoughts, this symptom should be taken seriously, even if the suicidal plan involves thoughts of an assisted suicide. Suicidal thoughts should be explored thoroughly. (A mental health history, history of suicidal ideation and /or suicide attempts and family history of suicides should be taken. Always use a mental status examination to assess the patient for possible suicidal ideation. A treatment plan for dealing with the suicidal patient is always necessary. The psychological as well as the physical distress must both be addressed. Medication evaluation, case consultation, family meetings, psychiatry referral, referral for counseling, pastoral care, pain management consults, and palliative care evaluation may all be appropriate treatment interventions for the suicidal, seriously ill patient.)

Let the seriously ill suicidal patient know you value his or her life. As with other suicidal patients it may be appropriate to say such things as: "I don't want you to kill yourself. And I assure you that your treatment team and I will care for you in such a way that you won't have to take your life through suicide," or "I don't want you to kill yourself. If you get to feeling suicidal again, you call me and we'll take care of your pain or fear or whatever, so you don't feel like you have to take your own life."

If the patient insists that his/her suicidal ideation is a political "right" rather than a clinical problem, remind the patient that you value all human life including theirs, that you wouldn't condone any type of suicide and that you want to continue to work with them with that understanding in mind.

Reassure the patient. Recent health division reports show fear of the future, not pain, leads to assisted suicide. Tell them they will be able to handle their illness and the changes that come with it. Address their fears of disabling symptoms. Dispel any bias they might have against people with decreased functioning or people who need help. Impart confidence by telling them that you and the treatment team will be able to manage their pain, discomfort, or anxiety, if they ever become a problem.

Continue to offer good care. The patient is free to transfer to another doctor at their own initiative without your suggesting such a move.

Decline to refer for assisted suicide. Remember that the law does not require the physician to refer the patient to a doctor who will participate in the suicide. Such a requirement would violate your right to non-participation, since referral to facilitate assisted suicide would constitute a form of material participation in assisted suicide. Referral for suicide may contribute to the patient's discouragement and may lead them to suicide. It would compromise the physician's moral integrity. The law states specifically, "No health care provider shall be under any duty, whether by contract, by state or by any other legal requirement to participate..."(127.885 4.01.Immunities. no. (4)).

* The PCC ethics statement is printed inside this issue. A copy of the professionally printed ethics statement is available from PCC (a donation for costs and mailing is appreciated.)

ENHANCING THE END OF LIFE:

The fourth Annual Compassionate Care Conference
Saturday, September 30, 2000
8:00am to 4:30pm

LOCATION:

OREGON CONVENTION CENTER
PORTLAND, OREGON

PRESENTED BY:

Physicians for Compassionate Care and Providence Health System

Educational Goals and Objectives:

Comfort care and relief of symptoms often requires greater knowledge, skill, and judgment than does curative care. The goal of this conference is to equip physicians and nurses with the information and tools they need to better care for the seriously ill.

Program objectives include:

Learning communication skills and techniques in end-of-life care. Treating pain and other symptoms with narcotics, other medications, and radiation therapy.

Resolving social, spiritual and emotional end-of-life issues.

Use of integrated palliative care.

Special highlight before lunch:

Singer-songwriter, Cindy Bullens will perform ballads from her newly released CD called, "Between Heaven and Earth," an experience of a parent losing a child. Ms. Bullen's songs are inspired by the living and dying of her daughter who had cancer.

For more information about registration, call PCC at 533-8154.

New Standards For Pain Management

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued new pain management standards. The standards are a result of the work of panelists including physicians, nurses, pharmacists and other health care organizations and are consistent with guidelines issued by the Agency for Healthcare Research and Quality and the American Pain Society (APS).

JCAHO's Director of Standards Interpretations defines the six standard areas as follows: Rights and Ethic, recognize the right of individuals to appropriate assessment and management of pain; Assessment of Persons With Pain, assess the existence and, if present, the nature and intensity of pain in all patients; Care of Persons With Pain, establish policies and procedures that support the appropriate prescribing or ordering of effective pain medications; Education of Persons With Pain, educate patients and families about effective pain management; Continuum of Care, address the individual's needs for symptom management in the discharge planning process; Improvement of Organization Performance, incorporate pain management into the organization's performance measurement and improvement program.

The standards are to go into effect in January, 2001, and have been published in overview form with examples of implementation by the Joint Commission Resources, Inc., a subsidiary of JCAHO. The Publication is available for \$35 from the Web site <http://www.jcaho.org> or by calling (630) 792-5800. The Publication is called: Pain Assessment and Management: An Organizational Approach.

PCC Officers

N. Gregory Hamilton, MD

President

William M. Petty, MD

Vice President

Mark Kummer, MD

Treasurer

Miles J. Edwards, MD

Secretary

William L. Toffler, MD

National Director

Board Members

Pamela J. Edwards, MD

Thomas Pitre, MD

Kenneth R. Stevens, MD

Paul D. Stull, MD

Regional Directors

Gerald B. Ahmann, MD

Medford

Thomas Comerford, MD

Bend

Carl R. Jenson, MD

Coos Bay

Marvin M. John, MD

Hermiston

Robert DuPriest, MD

Eugene

Richard M. Thorne, MD

Salem

George Middlekauf, MD

Roseburg

PCC ADDRESS:

P.O. Box 6042

Portland, Oregon 97228

503-533-8154 Phone

503-533-0429 Fax

www.pccef.org

PCC News Editor: Catherine Hamilton