

## Short title: Rights to pain management

### 1. Purpose

The purpose of this statement is:

- 1.1 To articulate ANZCA's ongoing commitment to realising human rights to health including pain management.
- 1.2 To clarify clinician responsibilities in relation to pain management that flow from these rights.

### 2. Scope

Although the information in the document may be of benefit to the healthcare community as a whole it is intended to apply to all specialist anaesthetists, specialist pain medicine physicians (SPMP), trainees and specialist international medical graduates (SIMG).

This statement considers the broadest principles of patients' rights to pain management. Within scope are:

- 2.1 All types of pain including acute pain whether incidental (labour pain, illness, injury, cancer) or iatrogenic (surgery, procedures); pain in palliative and end-of-life contexts; and chronic noncancer pain (CNCP).
- 2.2 All people experiencing pain inclusive of all ages and without discrimination.
- 2.3 All clinical settings including public and private health and state-run facilities (justice and refugee detention).
- 2.4 All pain management modalities.

The practitioner should apply these principles within the contexts of their individual scopes of practice, considering the certainty of evidence<sup>1</sup> for individual management approaches, judicious use of healthcare resources, and local regulations.

### 3. Background

- 3.1 **Human rights** are about recognising and respecting the inherent value and dignity of all people. Human rights agreements promote an ideal and require societies and their governments to have effective systems of human rights protection. Government compliance is contemplated as happening progressively, depending on available resources and competing priorities.
- 3.2 **Rights and the law**, some human rights agreements are ratified by individual countries and embedded in their national laws; others are not. Non-binding declarations may nevertheless have a significant impact, particularly when they achieve the status of customary international policy and practice<sup>2</sup>.
- 3.3 **The right to health** encompasses physical, mental, social and cultural wellbeing, and the environmental factors that enable and sustain health. It is a fundamental and universal human right enshrined in binding international agreements ratified by the Australian<sup>3</sup> and Aotearoa New Zealand<sup>4</sup> governments.

- 3.4 **The rights to pain management** were articulated in the 2010 Declaration of Montreal<sup>5</sup> to clarify the critical role of pain management to the realisation of the right to health. For a summary of discourse that motivated the Declaration refer to the background paper.
- 3.5 **Pain management** was the object of the Declaration of Montreal in preference to 'pain relief'. The latter might have been misconstrued as a right to a pain-free life, implying that all pain can be treated absolutely. In pursuit of this, people might expect total analgesia or the right to access all medications and procedures until that state is achieved. However, appropriate pain management requires simply that the professional response be both reasonable and proportionate to the level and character of the pain experienced, and balancing risk of harm.

#### 4. Rights to pain management

ANZCA upholds the Declaration of Montreal that access to pain management is a fundamental human right<sup>5</sup>, indivisible from the human right to health. All those involved in health care are responsible for establishing and delivering contemporary pain management within their scope of clinical practice. The Declaration is not reproduced in this document but can be read in full [here](#).

#### 5. Implementation

##### 5.1 Equity

To prevent inequitable pain management access and outcomes:

- 5.1.1 Clinicians should regularly reflect on their own gender perspective, culture, beliefs and unconscious biases, and how these influence intercultural interactions with individual patients and decision-making [ANZCA Unconscious bias toolkit](#). This is the foundation for culturally safe care for all persons.
- 5.1.2 All practitioners should strive for culturally safe practice as determined by Aboriginal, Torres Strait Islander and/or Māori peoples.
- 5.1.3 Fellows involved in acute and/or chronic pain service governance should work with their colleagues and institutions to develop systems for monitoring equity of access to and outcomes of their pain services and implement equity improvement strategies as indicated. Such strategies might include affirmative action with respect to patient triage and staffing.
- 5.1.4 ANZCA including FPM shall continue to work with governments and the healthcare delivery sector to improve training and workforce strategies that improve access and outcomes for people experiencing pain in regional, rural and remote areas.
- 5.1.5 Led by Asia Pacific regional partners, and within resources, ANZCA including FPM shall endeavour to support health professionals in those countries to improve pain assessment and management for their peoples.

##### 5.2 Patient-centred information

- 5.2.1 Clinicians should encourage patients (and their carers where appropriate) to participate in education regarding pain and in the development of realistic goals for their pain management.
- 5.2.2 Clinicians should provide patients (and their carers where appropriate) with quality information and safe guidance to achieve informed consent to pain management. This will generally include discussing alternative management options and the option of no treatment.
- 5.2.3 Fellows involved in service governance roles should recognise the value of partnering with individuals and consumer organisations representing people with lived experience of pain. This helps align our work with their aspirations<sup>6</sup>.

### 5.3 Pain assessment and validation<sup>a</sup>

- 5.3.1 Clinicians should develop their skills in multidimensional and trauma-informed pain assessment across the lifespan.
- 5.3.2 Trainees, SIMGs and fellows should tailor their multidimensional pain assessment to each individual patient and context, recognising that pain assessment is an iterative process.
- 5.3.3 Patient and/or carer pain accounts should be respected and validated recognising: that patients are experts on their lived experience, its impact and sociocultural meaning; that individuals vary in their responses to potentially painful predicaments; and that parents/carers have expert knowledge of their loved ones relevant to the assessment of their pain.
- 5.3.4 Diagnostic curiosity as to whether acute or chronic pain is experienced secondary to a biomedical condition might be important for identifying definitive treatments. Nevertheless, pain symptom management should commence alongside diagnostic evaluation.
- 5.3.5 Clinicians should have skills for validating and explaining chronic primary pain which is pain that is not secondary to a biomedical disease or lesion in the nervous system. They should de-stigmatise people experiencing chronic primary pain conditions and facilitate access to appropriate chronic primary pain management.

### 5.4 Pain management

- 5.4.1 Clinicians should acquire and maintain professional competencies in pain management relevant to their scope of practice and context. Should patients require pain management outside a clinician's scope of practice, clinicians should consult or refer to appropriate specialists.
- 5.4.2 Acute and/or chronic pain services should ensure that there are staff with knowledge and skills to enable provision of all reasonable pain management modalities within available resources and in a timely manner, including after-hours.
- 5.4.3 Access to best practice non-medication methods of pain management is important for all pain types. In the contexts of chronic pain and the palliative setting, patients should be able to access care that addresses physical, vocational, social, emotional, spiritual, and communal or whānau aspects and impacts of pain. This will typically involve the coordinated efforts of multiple disciplines.
- 5.4.4 Access to specialist-performed procedures and treatments in pain management will depend upon the resources of the region. Where such procedures are not locally available, healthcare institutions should have referral pathways for reasonable access to such procedures.
- 5.4.5 Patients have a right to appropriate planning for pain management during and after transitions in care, including during patient transport, after discharge from acute care, and beyond discharge from active chronic pain service care.
- 5.4.6 Healthcare institutions and their pain services are responsible for establishing policies, systems and referral networks that will facilitate, and will certainly not inhibit, the access of people in pain to adequate pain management as close to home as possible. When this capability is critically constrained by resource-limitation, healthcare institutions, pain services and clinicians have responsibilities to notify healthcare governance and funding bodies and to advocate for system solutions (see also 5.6).

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<sup>a</sup> For a definition and explanation of validation, see 4.3 in the accompanying background paper

## 5.5 Professional education

- 5.5.1 ANZCA recognises its role to train doctors in each of its specialties to deliver on the rights to pain management via our curricula, learning resources, unit accreditation processes and supervisors of training.
- 5.5.2 ANZCA including FPM seeks to use its intellectual capital and experience to improve undergraduate and postgraduate healthcare professional education as required.

## 5.6 Advocacy

- 5.6.1 ANZCA recognises its role to partner with lived experience advocates and relevant professional and academic societies to advocate for system solutions in settings wherein these rights cannot be substantively delivered.
- 5.6.2 Recognising the particular role SPMPs play in delivering on these rights in Australia and Aotearoa New Zealand, ANZCA recognises its role to partner with relevant national medical councils and professional societies to advocate for appropriate scope of practice recognition and service delineation.

## 6. Nuances

- 6.1 Infants, children and youth have a right to developmentally appropriate pain assessment and management. While all clinicians should hold basic competencies in paediatric pain relevant to emergent and acute situations, timely referral of children with complex or chronic needs to specialist paediatric pain services should be considered. When access to such services is impractical or materially delayed, consider consulting paediatric or adolescent medicine clinicians with experience in the management of complex pain.
- 6.2 People, particularly older adults, with frailty, multimorbidity, delirium, dementia and other forms of cognitive impairment, and residential care status, may face challenges communicating their needs and advocating for their rights to pain management. All clinicians should hold basic competencies in assessing pain and comorbidities in older, nonverbal and/or cognitively impaired people, and refer to, or collaborate with, a geriatrician or geriatric service when appropriate<sup>7</sup>.
- 6.3 Acute pain associated with labour and delivery is a highly personal experience. Maternal choice of timely labour pain management options is a fundamental component of rights-based care. Whilst so long as inequities in access to, and timeliness of, neuraxial and intravenous labour analgesia exist across facilities, maternal transfer pathways will remain necessary, alongside advocacy (see 5.4.4, 5.4.6 and 5.6.1).
- 6.4 The first obligation of clinicians is nonmaleficence, which is to do no harm. However, to effect net long-term benefit clinicians often inflict harm and/or consequent pain for example painful blood sampling, insertion of a chest tube or surgery. Arguably, clinicians have special obligations to honour the human right to pain management when they directly or vicariously permit iatrogenic pain.
- 6.5 The Declaration of Montreal allows that clinicians take into account the treatment resources reasonably available. When resources are not sufficient to treat all people experiencing pain, clinicians and healthcare managers, applying the principles of distributive justice, must determine the most just way to ration available resources, triaging those whose needs are greatest and/or who stand to benefit the most<sup>8</sup>.
- 6.6 It is imperative to balance the certainty of evidence of treatment benefit against the risk of potential harm for the individual patient. When the evidence of treatment benefit, comparative cost effectiveness, or risk of harms are unknown, very uncertain or contested, judgements about whether to offer and deploy such treatments falls outside rights-based care. The imperative to manage pain must be weighed against imprecise odds of benefit and harm in the individual context. For instance, the extent to which treatments might be used off-label with uncertain benefit and potential long-term harms differs between the chronic non-cancer pain and end-of-life pain care contexts.

- 6.7 In the context of chronic pain, patients who commenced a pathway of care, such as regular long-term opioid prescription or implantable neuromodulation, may need to change provider due to provider retirement or relocation. The rights of such patients to the continuation of treatment cannot be assumed, as other clinicians might make different judgements about the net merit of this care or be unable to continue it within their scope of practice or resources. Supported transition to other reasonable care or other providers is essential. Clinicians should consider the patient's stigma, and trauma and experiences, and manage this transition in a trauma-informed way.

**This document is accompanied by a background paper (PS45BP) which provides more detailed information regarding the rationale and interpretation of the position statement.**

## References

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7. Australian and New Zealand Society of Geriatric Medicine (ANZSGM). *The role of comprehensive geriatric assessment (CGA) in the management of pain in older people*. [Internet]. 2024. Available from: <https://anzsgm.org/wp-content/uploads/2025/08/ANZSGM-The-role-of-CGA-in-the-management-of-pain-in-the-older-person-FINAL.pdf>
8. Te Kaunihera Rata o Aotearoa. *Safe practice in an environment of resource limitation* [Internet]. 2018. Available from: <https://www.mcnz.org.nz/assets/standards/ca25302789/Safe-practice-in-an-environment-of-resource-limitation.pdf>.

## Related ANZCA documents

Standards for Anaesthesia  
 PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain 2021  
 PG03 Guideline for the management of major regional analgesia 2014  
 PG07 Guideline on pre-anaesthesia consultation and patient preparation 2024  
 PG09 Guideline on procedural sedation 2023  
 PS10(PM) Statement on "Medicinal Cannabis" with particular reference to its use in management of patients with chronic non-cancer pain 2021  
 PS11(PM) Procedures in Pain Medicine Clinical Care Standard 2020  
 PS12(PM) Position statement on the use of ketamine in the management of chronic non-cancer pain 2022

PS14(PM) Statement on the responsibility for co-prescription of oral and intrathecal opioids 2023  
PG15(POM) Guideline for the perioperative care of patients selected for day surgery procedures 2018  
PS15(PM) Statement on the clinical approach to persistent pelvic pain including endometriosis-associated pain 2024  
PG29(A) Guideline for the provision of anaesthesia to children 2020  
PS41(G) Position statement on acute pain management 2023  
PS62 Position statement on cultural competence and cultural safety 2023

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