

Short title: Pain rights and responsibilities BP

1. Purpose of review / introduction

The purpose of this revision was to consider whether the subject continued to be relevant and then update the document since it was last reviewed in 2008. Recognising that people in Australia and Aotearoa New Zealand still experience significant variability in access to knowledgeable and skilled clinicians¹ and significant variance in access to pain treatments and outcomes^{2, 3}, the document development group (DDG) decided the topic has contemporary relevance⁴.

To improve safety, quality and equity, the professional document was updated based on a pragmatic literature review and expert consensus-based recommendations. In addition, the format needed to be revised to align with the ANZCA Professional Document style guide which includes the addition of a background paper.

2. Background

Between 2001 when the professional document was originally created, and 2010, Professor Michael Cousins AO and others undertook collaborative academic inquiry and advocacy. Seminal discussion documents from that period included:

- Cousins MJ, Brennan F, Carr DB. Editorial – Pain relief: a universal human right. **Pain** 112 (2004) 1-4. — This heralded and justified the theme of the first Global Day Against Pain launched with the WHO.
- Brennan F, Cousins MJ. Pain relief as a human right. *Pain Clinical Updates* XII(5) (2004) 1-4. — This included discussion of the unintended consequences of promoting pain relief as a human right. Focus shifted from opioid access to a right to reasonable and proportionate pain management.
- Brennan F, Carr DB, Cousins MJ. Pain management: a fundamental human right. **Pain Medicine** 105 (2007) 205-221. — This built on the themes of the above works and set out a reform agenda to move from assertion of rights to delivery of pain management.
- Brennan F. Palliative Care as an International Human Right. *Journal of Pain and Symptom Management* 33(5) (2007) 499-499. — This examines the assertion of a human right to pain management in the context of international human rights law.

This thought leadership and advocacy led to the National Pain Summit in Australia in March 2010 and to the First International Pain Summit held in Montreal in September that same year. Whilst the purpose of the National Summit was to refine and ratify Australia's National Pain Strategy⁵, the World Summit was focused on a consensus declaration that access to pain management is a fundamental human right – that became known as the Declaration of Montreal (DOM)⁶.

Literature scanning (method below) revealed that the 2010 DOM has not been superseded, so the DDG used this as the foundation for the document review. The DDG also considered broadly how the DOM intersects with other human rights instruments including: the Universal Declaration of Human Rights⁷, the International Covenant on Economic, Social and Cultural Rights⁸ including health (article 12(1)), the United Nations Declaration of the Rights of the Child⁹, the United Nations Declaration on the Rights of Indigenous Peoples¹⁰, and the Prague Charter on the right to palliative care¹¹.

The 2010 DOM notes: *This Declaration has been prepared having due regard to current general circumstances and modes of health care delivery in the developed and developing world. Nevertheless, it is the responsibility of: governments, of those involved at every level of health care administration, and health professionals to update the modes of implementation of the Articles of this Declaration as new frameworks for pain management are developed*⁶. Consequently, the DDG considered global pain management knowledge and system changes and challenges 2010-2024. Amongst these were the compiled evidence of inequities in pain burden and treatment between high-income countries (HIC) and low- and middle-income countries (LMIC), as well as within countries based on factors such as race, culture, sex, gender, socioeconomic status, age, and rural and remote residence^{12, 13}. In particular, the group considered carefully the tension between the challenges of:

- Inadequate access to appropriately-trained clinicians and high-value pain treatments (including pharmaceuticals on the WHO essential medicines list¹⁴) in LMICs compared with HICs; and
- Relatively unfettered access in some HICs to even low-value pain treatments. The chronic non-cancer pain 'opioid crisis' in HICs is but one example.

Considering this background the DDG aimed to clarify how clinicians can implement the DOM through actionable recommendations pertaining to professionalism, individual patient care, and service governance. The DDG also considered how the college as an institution might contribute to the aspirations of the DOM. The DOM can be read in full [here](#)⁶.

3. Review of issues

3.1 Methods

- Search topic: Universal human right to pain management: developments in ethics, policy and/or law since 2010.
- Search terms: pain; pain perception; pain, postoperative; chronic pain; pain management; pain clinics; pain treatment*; pain therap**; human rights; ethics, nursing; ethics, medical; principle-based ethics; "codes of ethics"; ethics, professional; ethics clinical; human rights; disparities; health service accessibility; quality of healthcare.
- Limits: 2010 to current in English language only
- Databases and (number of results): Medline (64), Embase (10), Criminal Justice Abstracts (15), HeinOnline (10), Google scholar & World Health Organization Repository for Information Sharing Grey Literature Search (4).
- Two DDG members (SML, NW) reviewed titles and abstracts and distilled those relevant to the aims of this revision.

3.2 Issues considered and omitted

Given that the DOM was intended to apply to all healthcare professionals, ANZCA categorically recognises the valuable contributions of a wide range of other generalist and specialist doctors, dentists, nursing, allied health care professionals, cultural health workers or practitioners to the pain management endeavour. However, the purpose of ANZCA's professional documents is to set standards for and guide its own members. ANZCA does not have authority to set standards for other professional groups. For that reason, the document scope was not expanded but does welcome application by the healthcare community as a whole.

The group considered including a discussion of patient *Rights in Healthcare*¹⁵. These are empowering person-centred statements that help people understand their rights within healthcare systems. Rights in healthcare include the rights to: access, safety, respect, partnership, information, privacy and the right to give feedback. While these rights are

undisputed, the DDG felt the concepts were not specific to pain and were already covered in undergraduate and post graduate training.

The group recognised the frequent conflation of the right to pain management in the palliative setting, end-of-life analgesia, the doctrine of double-effect and, more-recently, voluntary assisted dying (VAD). During the review period, prolonged by the interceding pandemic, VAD laws were introduced to various jurisdictions. However, those topics are not covered herein because the DDG felt strongly that the right to access pain management is universal and stands independent of disease- and life-stage, and independent of any decision to end life.

The group considered whether to include a statement on patient responsibilities akin to section 3 of the original 2010 professional document and decided against this for several reasons: patient responsibilities are not articulated in the Declaration of Montreal⁶ nor in other rights-based instruments; a person's rights are not negated by any failure to adhere to the 2010 statement of patient/carer responsibilities; and restating those 'responsibilities' could be construed by people with lived experience as coming from a place of doctor-patient distrust, whereas ANZCA and FPM respect the intelligence, integrity and autonomy of people experiencing pain.

4. Explanation of included issues

4.1 Equity

DOM Article 1 requires implementation without discrimination⁶. The footnotes cite key human rights conventions excepting the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Recognising that these UN charters on rights are indivisible, this later charter was considered amongst the others in the DDG deliberation.

Another minor difference from previous versions is the inclusion within scope of people in remand, justice and refugee detention facilities. Although it is recognised that prisoners' human rights to health are not extinguished or diminished by incarceration, the human rights commission¹²⁶ is watching this space closely.

The DDG considered the value of critical self-reflection on gender and cultural bias and its impacts. Given evidence of the epidemiology of pain, higher burden and poorer access for women and people who identify as LGBTQI+, reflection on gender perspectives in care relationships is vital to the delivery of these rights without discrimination.

Self-reflection on cultural bias is important for all intercultural clinical encounters. The decision to reify cultural safety with respect to Aboriginal, Torres Strait Islander and Māori people was based on recognition of the particular impacts of cultural injury caused by violent colonisation and subjection to past and present colonial policies. Experiencing cultural safety in healthcare is essential to access and outcomes.

The DDG considered how fellows could implement the articles of the DOM through various roles in practice including medical expert, manager and leader. Accordingly, consensus considered it essential to include obligations of those in governance roles. Akin to quality improvement cycles, the concept of equity improvement cycles is introduced – measuring and iteratively improving equity of access and outcomes within services.

The inclusion in 5.1.3 of 'Such strategies might include affirmative action' was discussed and included because it was felt that many clinicians may not be aware that affirmative action based on cultural identity is legally permissible and indeed required in some jurisdictions. Examples of affirmative action may include triaging Aboriginal, Torres Strait Islander or Māori people to the shortest possible wait-times for pain assessment and management and affirmative recruitment of Aboriginal and/or Torres Strait Islander people to general, targeted and identified positions¹⁷ to improve whole-of-service cultural safety¹⁸.

4.2 Patient-centred information

This section was without contention. However, differences between jurisdictions were noted with respect to whether consumer partnerships and community-facing information are recommended or mandated.

4.3 Pain assessment and validation

The focus on multidimensional and iterative pain assessment across all settings is in line with understandings that treatment based on ordinal pain intensity scores, taken out of context, is unwise and potentially unsafe.

Deliberation as to the importance of taking a trauma-informed approach to pain management led to inclusion of this descriptor in 5.3.1. The college's definitions for trauma informed anaesthesia and pain medicine care have been approved, and are available^a. Although the college's framework is still under development, the DDG considered that there are ample generic definitions to enable implementation^{13, 14}. Those unfamiliar with the concepts are encouraged to review these references pending more specific college guidance.

Furthermore, in this section the DDG has added to the art of listening respectfully, the active practice of validation. Emotional invalidation involves rejecting, ignoring or judging another person's emotional experience. Conversely, validation means accepting another person's identity, perspective and emotions as being valid in their context, overtly acknowledging this, and communicating that it matters. Patients who feel their experience is heard and valid—that they matter—will engage better in pain management and healthcare more broadly.

Recognising that stigma continues to surround chronic primary pain, even amongst medical professionals, the DDG felt that the statement in 5.3.5 needed to be explicit. The prevalence and burden of chronic primary pain conditions are such that every clinician should have some level of understanding and skills to explain, treat and/or refer, lest these patients' rights be violated. Examples of chronic primary pain conditions include migraine, functional gastrointestinal disorders, chronic primary musculoskeletal pain, and complex regional pain syndrome.

4.4 Pain management

The DDG considered at length how to frame recommendations to include the full range of pain types, clinicians and settings. Recommendations have been couched in terms of optimising available resources and staying within clinician scope of clinical practice. Setting standards for appropriate training and scopes of practice is outside the scope of this document - see instead other [ANZCA and external documents](#)^{21, 22, 23}.

With regard to specialist-performed procedures and treatments, the term 'reasonable access' encompasses what would be considered reasonable by a group of independent peers taking into account the level/certainty of evidence of benefit, general and patient-specific harms, comparative cost effectiveness, and judicious use of limited resources.

4.5 Nuances

The statements in this section of the foreground paper highlight specific patient groups and clinical scenarios that warranted mention and considerable discussion.

Delivering on children's rights to pain management requires that healthcare delivery systems must balance availability of: i) generalist clinicians with sufficient knowledge and skills to initiate safe and timely pain management for children of all ages as close to home as possible; with ii) specialist paediatric anaesthetists and children's pain management services to deliver or guide care in more complex cases. Recognising this challenge, ANZCA's FPM is embarking on a more-detailed professional document on this topic.

People with cognitive impairment have intersecting challenges with communicating their pain and treatment preferences, and multimorbidity limiting their treatment choice. Delivering procedural

^a [https://www.anzca.edu.au/about-us/our-culture/trauma-informed-care-\(tic\)](https://www.anzca.edu.au/about-us/our-culture/trauma-informed-care-(tic))

sedation and analgesia emerged as another scenario in which the implementation of rights-based care is nuanced. Ethical tension arises between the aspiration to prevent pain and the need to inflict pain in the course of essential medical care. Clinicians often resolve this by considering net benefit, and by mitigating iatrogenic pain. Nuances include:

- Particularly in the very young, traumatic memory formation during potentially threatening procedures may be heightened by the experience of pain.
- Parents, nursing, allied and other health professionals witness to the procedure may be vicariously traumatised by the child's expressed pain and distress, potentially influencing analgesia independent of the needs and rights of the child per se.
- Many young people report benefits of attending to pain during repeat procedures to maintain and build their sense of agency and self-efficacy in healthcare. In such scenarios mitigating all awareness of pain may not be desired.
- Clinicians have to balance the harms of acute procedural pain and the harms associated with sedation and analgesia for the individual. Finding the ideal balance between pain, analgesia and sedation may be elusive.
- The DDG, cognisant of these challenging 'balancing acts', argued that 'clinicians have special obligations to honour the human right to pain management when they directly or vicariously permit iatrogenic pain' but leave the way they honour these special obligations to fellows' good judgement.

The implementation of human rights by governments is contemplated as happening progressively, depending on available resources and competing priorities. Given that the Australian and Aotearoa New Zealand health systems are far from replete, this means clinicians will have peculiar obligations until such time as systems are funded and fit for purpose—by default, it falls to clinicians to distribute limited resources according to principles that are relevant to the individuals and communities they serve. Those involved in governance and policy are encouraged to explore further reading on public health ethics and distributive justice¹⁵. Following consultation, section 5.6 was added to highlight the roles of ANZCA and healthcare funders in advocating for and implementing system solutions when delivery of rights is critically compromised by resource-limitation or mal-distribution.

The remaining sections pertain to the following conundrum: a right to access treatment presumes that the treatment is definitely in the best interests of a person's health and wellbeing; yet it was recognised that many treatments in pain medicine, particularly in chronic pain management, are fraught with insufficient or contested evidence of treatment benefit, comparative cost effectiveness, and risk of harms. In such circumstances, judgements about whether to offer and deploy 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.

The imperative to manage pain must be balanced against the evidence of benefits and harms and may lead to different treatment decisions. Particularly, in the end-of-life care context, the ethical imperative for timely pain relief might carry more weight than considerations of harms such as opioid-induced ventilatory impairment (OIVI) or opioid-induced hyperalgesia (OIH). Another conundrum arises when clinician opinion varies as to what is clearly in the patients' best interests, and what lies outside that envelope of certainty. When care is ended with one clinician, it is conceivable that the next treating clinician may make a different assessment. Point 6.5 asserts that, even when a new clinician cannot sustain a certain course of treatment, patients have a right to supported and safe transition from their legacy treatment to the new pain management plan.

5. Implications for ANZCA

[ANZCA's purpose](#) is aligned with protecting human rights to health and pain management without discrimination. Accordingly, ANZCA undertakes to promote professional standards, education, research

and advocacy that advance our nations' progress towards equitably delivering on those rights. Levers for ANZCA's efforts in this space include its: [Gender Equity Sub-committee](#) and assets, and [Indigenous Health Committee](#) and assets, including our [Reconciliation Action Plan \(RAP\)](#) and [Te Tiriti o Waitangi Roadmap](#).

ANZCA including FPM continues to work with governments, vocational education and healthcare sectors to improve training and workforce strategies that improve access and outcomes for people experiencing pain in [regional, rural and remote areas](#).

ANZCA through its Global Development Committee (GDC) acknowledges and is led by Asia Pacific regional partners to support health professionals in those countries to improve pain assessment and management for their peoples.

ANZCA including FPM aspires to develop and maintain community-facing plain language online information to help patients and their carers understand pain assessment and management, and our related professional standards.

6. Summary

Whilst human rights conventions and declarations remain stable, their interpretation and implementation need to be iteratively revised to ensure alignment with contemporary principles and models of care. Since the last revision, global society has withstood the 'opioid epidemic' and the COVID pandemic and learned much from both. It remains important that clinicians at all career levels are trained in pain management, and in balancing individual and public health ethical imperatives without compromising human rights. Treatments need to be accessible, affordable, equitably distributed within resource limitations, and stewarded in the best interests of the public.

Related ANZCA documents

PS41(G) Position statement on acute pain management
PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain
PG03(A) Guideline for the management of major regional analgesia
PS62 Position statement on cultural competence and cultural safety
ANZCA Unconscious bias toolkit

References

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Further reading

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