Chronic-pain patients must cope with chronic lack of physician understanding

I was delighted to see Dr. Brian Goldman's article in *CMAJ* (1991; 144: 1492, 1494, 1495, 1497) about my own specialty, the more so as it was part of a mini-series. Initial impressions were good, but I was dismayed to read "in Alberta, where there are no clinics."

The pain clinic of which I am director was founded in 1976 at the Foothills Provincial General Hospital in Calgary and in 1984 became a multidisciplinary service. Since that time our program has developed to the point at which I believe we provide one of the most advanced and comprehensive multidisciplinary assessments available anywhere in North America.

However, I must agree with Goldman that pain clinics are unlikely to be a high-priority item, since in the 7½ years that we have been functioning there has been no improvement in the facilities within the hospital, although the number of patients and the complexity of their problems have increased dramatically. In the last 18 months or so we have lost our inpatient program at the Calgary General Hospital, and consequently a good many of the patients we assess cannot be treated appropriately.

It really does seem that even the chronic pain clinics that exist may soon disappear. What we need is someone highly placed in the federal government to develop a chronic pain problem and discover just how hard it is to get treatment without going abroad. Many studies have shown that multidisciplinary pain relief clinics are cost-effective and that relatively brief periods of intensive treatment not only restore patients to the work force but keep them out of the health care system. Surely this is what our patients and our economy need. Pain clinics are certainly too few and far between, but they do exist — even in Alberta.

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[The author responds:]

A thousand apologies to Dr. Clarke and colleagues at the Pain Relief Clinic at the Foothills Provincial General Hospital. In my attempt to portray the paucity of pain specialists in Alberta I inadvertently turned a relative lack of pain clinics into an absolute lack. Mea culpa.

I appreciated the opportunity of learning more about the clinic in a conversation with Clarke. It is truly a shining oasis in a desert of pain! Patients have their pain syndromes exhaustively evaluated by a multidisciplinary team. Then the patients are discussed by the entire team in a case conference, and appropriate action is taken.

This process is the very essence of the multidisciplinary approach. In other so-called multidisciplinary clinics patients are simply referred sequentially from one consultant to another and are never discussed in toto.

I am glad Clarke sympathizes with the remainder of the article. He tells me his clinic, a model of success, is threatened by government bureaucracy and the politics of pain. Even though effective pain treatments can lower disability and cost to society they are not being funded. I suspect this is because governments have decided that any new programs are inherently bad since they cost money — something that most governments don't have much of these days.

Brian Goldman, MD
Contributing editor, *CMAJ*

Ethics of euthanasia

I am quite disturbed by Dr. Kenneth J. Crowe's letter about euthanasia (*Can Med Assoc J* 1991; 144: 956). If a terminally ill patient is rational and wishes to terminate his or her life with the help of a physician what greater respect can a physician give than to accept such a wish? If the patient is also suffering great pain what kinder act can the physician perform than to help terminate that suffering?

As far as dignity is concerned how dignified can a person be who is terminally ill and must have tubes in various parts of the body to provide oxygen, food, medication and waste disposal? I consider that euthanasia is a dignified way to end a human life and that the physician can show no greater respect to the patient than to allow his or her final wish.

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[Dr. Crowe responds:]

Dr. Yuen asks what greater respect a physician can have than to accept the patient's wish for suicide. I suggest that a physician can show far greater respect by meeting that patient's needs. In Holland over 85% of terminally ill patients withdrew their request for death when they received appropriate palliative care.[1]

These patients want to know that they still have value to others, even if they do have a tube in their bladder. They need to know that the burden of care their illness may place on their family, friends and physician is manageable. Some have misconceptions about the dying process, fearing that it will be painful and that unnecessary procedures will be carried out. They need to be educated and reassured that this is not so, that their physician is