

ARTICLE

Is There a Legal Right to Pain Relief in New Zealand?

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Some pain is so severe that those who suffer it are disheartened, crippled and prevented from living ordinary lives. Because it is—at a minimum—unkind and unethical to fail to provide a person who suffers severe pain with available and effective pain relief options, this article asks whether such a failure is also unlawful. In doing so, it is predominantly concerned with the position of this question at New Zealand law, but also inquires into the status of a legal right to pain relief internationally. It is postulated that a right to effective pain relief is not immediately apparent in New Zealand but can be found through appropriate interpretation of statute.

In reaching this view, the question whether there is a legal right to pain relief is assessed according to a three-pronged inquiry. First, it is asked whether the provision of effective pain relief is an ethical obligation. This is a pivotal question because doctors are often legally required to act ethically. Secondly, it is asked whether a right to pain relief is discernible in New Zealand's statute, in international instruments to which New Zealand is a party and in foreign legislation. It is then asked whether decision-making bodies have been inclined to find a right of pain relief in New Zealand and abroad. It is shown that some Courts have been prepared to find a legal right to effective pain relief without delay, and it is argued that such a legal right is not only practically workable, but highly desirable.

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I Introduction

Pleasure is oft a visitant; but pain
Clings cruelly to us ...

—John Keats¹

Plagued by rheumatoid arthritis and in extreme pain, Lillian Boyes begged for her life to be ended. After administering a dose of potassium chloride that inevitably stopped Ms Boyes' heart and caused her death, Dr Cox, a consultant rheumatologist, was convicted of attempted murder.² The case epitomises the fact that pain can be so severe that some people will do anything to avoid having to endure it. Indeed, in a seminal study, experts have noted that “many persons would rather be dead, than unloved, abandoned and, too often, left in pain”.³ The authors went on to argue the existence of pain relief as a fundamental human right.

The fact that pain can have such a catastrophic impact that it might supersede the inexorable instinct to preserve life begs the question, is pain relief a legal right? Prompted by research indicating the prevalence of chronic pain in New Zealand and the inefficiency and ineffectiveness of pain relief globally, I seek to explore this question.⁴ In this article, I explore whether there is an international consensus on the existence of a legal right to pain relief, while focusing on the New Zealand situation. Although the predominant inquiry is whether there is a *legal* right to pain relief, the article is also concerned with whether there is an *ethical* right to pain relief.

In Part II, I examine the ethical imperatives of pain relief. Which ethics guide the provision of pain relief? What do ethics say about the necessity of adequate pain management? What is the relevance of medical ethics to the question whether there is a right to pain relief in New Zealand? Informed by a variety of deontological, utilitarian and virtue ethics theories, I introduce the notion of *right action* and explain how, except in extreme outlying circumstances, there is an ethical right to pain relief. At the same time, it is concluded that such an ethical right falls short of providing a *legal* right to effective pain relief.

Part III involves an examination of the statutory framework in New Zealand. In this part I ask whether New Zealand legislation mandates a particular response to the need for pain relief and whether the law prohibits any particular behaviour in relation to providing pain relief. I review clinical guidance about assessment and treatment of pain conditions. Further, I survey the right to be treated with dignity and respect, the right to treatment that complies with ethical and professional standards, and the right to treatment of an appropriate standard. In addition, I compare New Zealand's statutory framework against international instruments and foreign legislation.

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- 1 John Keats *Endymion: A Poetic Romance* (Taylor and Hessey, London, 1818) at line 907.
 - 2 Richard Hannaford “Euthanasia: An overview” (12 May 2009) BBC News <www.bbc.com/news>.
 - 3 MA Somerville “Death of pain: pain, suffering and ethics” in GF Gebhart, DL Hammond and TS Jensen (eds) *Proceedings of the 7th World Congress on Pain* (IASP Press, Seattle, 1994) at 44 as cited in Michael J Cousins, Frank Brennan and Daniel B Carr “Pain relief: a universal human right” (2004) 112 Pain 1 at 2.
 - 4 For a useful recent overview of chronic pain in New Zealand, see Clare H Dominick, Fiona M Blyth and Michael K Nicholas “Unpacking the burden: Understanding the relationships between chronic pain and comorbidity in the general population” (2012) 153 Pain 293.

In Part IV, I explore judicial approaches to the provision of pain relief, and chart the difficulties associated with receiving and providing pain treatment. I describe the clear trend amongst healthcare practitioners and decision-making bodies towards recognising a right to pain relief. At the same time, I note the distinct lack—in New Zealand particularly—of explicit discussion concerning a *right* to pain relief. I look at how the courts, the Health and Disability Commissioner, and other professional bodies have approached the topic. If a consensus exists in international judicial commentary, is this likely to persuade judicial commentators in New Zealand?

Finally, Part V probes some difficult issues in the provision of pain relief. In this part, the feasibility of a right to pain relief is critiqued, and attention is given to the impact of resource allocation on the question whether effective pain relief is a legal right.

II Terminology

Before going further, it is necessary to define some common terms in this article.

Pain relief is used in this article in a holistic sense. It recognises the fact that some pain is normal and protective: this pain helps avoid harm and aids recovery from injury.⁵ At the same time, pain can be crippling and prohibitive so that pain relief will include relief from the way pain affects a patient's work, family, social and recreational life.⁶ Thus, references to pain relief include relief of both *pain* and the *consequences* of pain.

Moreover, references to a right to pain relief in this article do not denote a right to be free from pain. I agree with Joseph Janeti and John C Liebeskind in stating, “freedom from pain should be a basic human right, limited only by our knowledge to achieve it”.⁷ Unrealistic expectations that chronic pain will be eliminated is a factor in failed pain treatments, and it is not helpful to participate in a discourse that sees complete relief of pain as something a patient may claim as of right.⁸ This is untenable because it fails to recognise the limitations of current medicine and the exigencies of pain diseases. For this reason, *inter alia*, references to a right to pain relief in this article refer only to a right to reasonably available and effective pain relief. In addition, I accept that pain relief is not the sole responsibility of the practitioner, but that it “contemplates ... [an] obligation, albeit perhaps only morally”, on the patient to take steps to deal with her pain in ways available to her.⁹

A Ethical imperatives relating to pain relief

Whether there is a right to pain relief may turn on the existence of an ethical obligation on the part of health practitioners to provide adequate pain relief. The term *right* is a “convenient way to promote an ideal and enforce a duty”, and there is logically a co-

5 Jennifer Gill and David Taylor *Relieving Persistent Pain, Improving Health Outcomes* (University College of London School of Pharmacy and the United Kingdom Clinic Pharmacy Association, January 2012) at 1.

6 Michael J Cousins, Frank Brennan and Daniel B Carr “PAIN: comment in reply to Dr David Knapp's Letter Pain relief: a universal right” (2005) 114 *Pain* 520 at 520.

7 John C Liebeskind and Ronald Melzack “The International Pain Foundation: Meeting a Need for Education in Pain Management” (1987) 30 *Pain* 1 as cited in Joseph Janeti and John C Liebeskind “A call for national initiatives on pain” (1994) 59 *Pain* 5 at 6.

8 Dennis C Turk and Thomas E Rudy “Neglected factors in chronic pain treatment outcome studies—referral patterns, failure to enter treatment, and attrition” (1990) 43 *Pain* 7 at 14.

9 JA Devereux *Australian Medical Law* (3rd ed, Routledge-Cavendish, Oxford, 2007) at 1104.

relative relationship between rights and responsibilities.¹⁰ However, an ethical duty does not necessarily point to a legal duty; Lord CJ Coleridge famously stated in *R v Instan* that “it would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation”.¹¹ Therefore, even if the provision of effective pain relief is ethically essential, this does not necessarily indicate the existence of a legal obligation. Professional standards continue to be guided, however, by ethical standards, and health practitioners are subconsciously and consciously guided by their own ethics in clinical decision making. For example, JK Mason, RA McCall Smith and GT Laurie note “the single-handed doctor will unhesitatingly choose the patient in great pain for treatment, despite the fact that this will simultaneously delay the treatment of those in lesser pain”.¹² Therefore, if an ethical obligation to provide pain relief can be established, this has important implications in practice.

Practitioners are informed by a range of ethics. We are now far from one of the earliest statements, found in the Hippocratic corpus, which pronounced the need “to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless”.¹³ This statement drew attention to the fact that treatment of terminal patients was pointless and perhaps harmful, but is now questionable in light of the fact that pain relief is at least one form of treatment, which continues to be relevant even when a patient is terminal. Physicians today might well reject the “old idea that ‘nothing more can be done’”.¹⁴ Now, there are perhaps five focal virtues that apply to clinicians: compassion, discernment, trustworthiness, integrity and conscientiousness.¹⁵ Of these, TL Beauchamp and JF Childress postulate that compassion “is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person”.¹⁶ If compassion can be seen in attempts to alleviate pain, compassion must be relevant to a right to pain relief.

(1) Deontological theory

Turning to ethical theories, the question arises whether provision of effective pain relief is always the right action. Deontological theory may provide an answer, albeit an ambivalent one. Deontology applies the following framework:¹⁷

1. An action is right [if and only if] it is in accordance with a moral rule or principle; ...
2. A moral rule is one that ... would be the object of choice of all rational beings.

10 Frank Brennan, Daniel B Carr and Michael Cousins “Pain Management: A Fundamental Human Right” (2007) 105(1) *Anesth Analg* 205 at 211.

11 See *R v Instan* (1893) 1 QB 450 at 453 as cited in JK Mason, RA McCall Smith and GT Laurie *Law and Medical Ethics* (6th ed, LexisNexis, London, 2002) at 41.

12 JK Mason, RA McCall Smith and GT Laurie *Law and Medical Ethics* (6th ed, LexisNexis, London, 2002) at 428.

13 See Kenneth Boyd “Medical Ethics: Hippocratic and Democratic Ideals” in Sheila McLean (ed) *First Do No Harm: Law, Ethics and Healthcare* (Ashgate, London, 2006) 29 at 32.

14 At 32.

15 TL Beauchamp and JF Childress *Principles of Biomedical Ethics* (5th ed, Oxford University Press, New York, 2001) at 32–38.

16 At 32.

17 Rosalind Hursthouse “Virtue Theory and Abortion” in Michael Freeman (ed) *Ethics and Medical Decision-Making* (Ashgate, Aldershot, 2001) 369 at 370.

The question, then, is whether receiving pain relief would be the object of choice of all rational beings. The answer cannot be an absolute yes; it may be that in some instances pain relief will be declined. A patient may dislike certain drugs, have an allergy, or simply not be willing to enter hospital or participate in other processes to receive pain relief. As a result, there cannot be a moral *rule* that pain relief would be the object of choice of all rational beings. Deontological theory cannot support a conclusion that giving pain relief is invariably, or absolutely, the *right* action. At the same time, deontology would appear to support the general premise that providing pain relief is in accordance with what most rational beings would choose, and therefore is *prima facie* a morally right action.

(2) Act utilitarianism

Act utilitarianism begins with a different premise but reaches the same conclusion. Act utilitarianism provides that:¹⁸

1. An action is right [if and only if] it promotes the best consequences; ...
2. The best consequences are those in which happiness is maximized.

By this understanding, pain relief is a right if and only if happiness is maximised by providing it. If pain relief is withheld despite the desires of the person who suffers from pain, the clinician has likely failed to act in a way that is consistent with the best consequences. It is unlikely that denial of pain treatment will maximise happiness, especially considering the adverse physiological and psychological effects of pain.¹⁹ However, where pain relief is administered despite the refusal of the patient or a proxy, this may not maximise happiness and promote the best consequences. Because act utilitarianism condones any action that promotes maximum happiness—including torture, in certain circumstances—it appears to be incapable of recognising any absolute rights at all. I therefore consider act utilitarianism to be an outlier in a rights-based discussion, which is of some but limited relevancy when assessing whether pain relief is an ethical obligation.

(3) Virtue ethics

Perhaps the best way to address the ethical imperatives of providing pain treatment is by a virtue ethics framework. This is because a virtue ethics framework applies current medical ethics, and some virtues are already endorsed in clinical guidelines.²⁰ Virtue ethics says that:²¹

18 At 371.

19 See generally SA Schug “2011—the global year against acute pain” (2011) 39 *Anaesth Intensive Care* 11 at 12.

20 For example, doctors are expected to be trustworthy, moral, honest and accountable. Susan J Hawken and Hamish Wilson “The doctor patient relationship” in Ian St George (ed) *Cole’s Medical practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) 35 at 36.

21 Hursthouse, above n 17, at 371.

1. An action is right [if and only if] it is what a virtuous agent would do in the circumstances; ...
2. A virtuous agent is one who acts virtuously, that is, one who has and exercises the virtues.

Ethical virtues include compassion, respect for autonomy, nonmaleficence, and beneficence.²² Since pain relief is a product of compassion, a person who fails to alleviate pain might be considered to be acting unethically. Alternatively, respect for autonomy—another virtue—requires a doctor to respect a patient’s ability to say no. Thus, a virtuous clinician would not provide pain relief where it is refused. Without seeking to labour the point, a virtue ethics approach suggests that where relief of pain is compassionate or beneficent, it is probably right. However, as with act utilitarianism and deontology, it allows for countervailing virtues and therefore does not view pain relief as something that is unconditionally right.²³

Other forms of virtue ethics may clarify the argument. Frank Brennan, Daniel B Carr and Michael Cousins have postulated that “[t]he relief of pain is a classic example of the bioethical principle of beneficence.”²⁴ Craig D Blinderman suggests that because pain is bad, “we are morally obligated to assist someone suffering from pain.”²⁵ This is merely part of the philosophy that “[c]entral to the good actions of doctors is the relief of pain and suffering.”²⁶ Nonmaleficence, on the other hand, requires that no harm is inflicted. Brennan, Carr and Cousins advocate the view that “failing to reasonably treat a patient in pain *causes* harm ... pain has both physical and psychological effects on the patient.”²⁷ Thus, it could be seen, from a virtue ethics framework, that the virtuous agent who fulfils the virtues of nonmaleficence or beneficence will ordinarily relieve pain. This indicates a *prima facie* or conditional ethical obligation to relieve pain. If this is so, a co-relative ethical right to receive pain relief might be found to exist in the majority of instances, as a corollary to the ethical duty to provide pain relief.

Understanding pain relief as a basic ethical right is consistent with several policy documents. For example, the American Academy of Pain Management (AAPM) provides that relief from pain is an “ethical imperative” that requires all physicians to treat the person in pain with competence and compassion.²⁸ Notably, the AAPM falls short of extending this “ethical imperative” to an enforceable right. The International Association for the Study of Pain (IASP) discusses a “moral responsibility” of all those who witness a patient’s suffering, but unhelpfully leaves open what that moral responsibility entails.²⁹ Thus, homage is paid to a skeleton “obligation”, but no flesh is given to it: does it require the clinician to actually relieve pain, to attempt to relieve pain, or simply to provide access

22 Beauchamp and Childress, above n 15, at 39.

23 Linda Farber Post and others “Pain: Ethics, Culture, and Informed Consent to Relief” (1996) 24 *JL Med & Ethics* 348 at 349 noted “The obligation of physicians to relieve pain is what moral philosophers call a *prima facie* or condition obligation, something physicians ought to do unless some other duty or moral consideration takes precedence. “

24 Brennan, Carr and Cousins, above n 10, at 210.

25 Craig D Blinderman “Do Surrogates Have a Right to Refuse Pain Medications for Incompetent Patients?” (2012) 43 *Journal of Pain and Symptom Management* 299 at 302.

26 Brennan, Carr and Cousins, above n 10, at 210.

27 At 210.

28 American Academy of Pain Medicine Council on Ethics “AAPM Position Statement on Ethical Practice of Pain Medicine” (December 2007)..

29 See “Ethical Standards in Pain Management and Research” in J Edmond Charlton (ed) *Core Curriculum for Professional Education in Pain* (IASP Press, Seattle, 2005).

to pain relief? The IASP does note that “[p]reventing or alleviating such pain is not merely a matter of charity”, but an aspect of “a duty to prevent harm”.³⁰ Similarly, the Royal College of Anaesthetists has highlighted the central role of *good acute pain relief as a humanitarian imperative*, implying that pain relief is a humanitarian and ethical imperative.³¹ Notably, this ethical imperative is not confined to pain specialists, but applies to all clinicians. Thus, the Canadian Nurses Association notes that the ethical responsibilities of nurses includes “in all practice settings ... work[ing] to relieve pain and suffering, including appropriate and effective symptom and pain management”.³²

Ultimately, the ethical framework supports a prima facie responsibility to relieve pain. On all views, ethical theories conceive of offering effective pain relief as right action or generally right action. Even if pain relief is generally right, however, this does not necessarily demonstrate that the provision of effective pain relief is a legal right. Indeed, it has been shown that an ethical analysis generally requires medical practitioners to provide access to pain relief, but there cannot be an absolute and unconditional obligation to provide effective pain relief. As discussed above, a natural corollary to an ethical duty to provide access to effective pain relief is an ethical right to pain relief.

III Statutory Approaches to Pain Relief

Having established that there are compelling grounds for the view that pain relief is an ethical right, I now consider whether the statutory framework is consistent with this. In this part, I look at domestic, foreign and international instruments. Health and Disability Commissioner decisions and other judicial approaches to the potential right to pain relief are considered below in Subpart C, and for this reason Subpart B is solely concerned with a textual analysis. I consider laws that compel the provision of pain relief, and laws that prohibit a failure to relieve pain.

A Law that compels a particular behaviour—positive rights and responsibilities

There is no statutory provision in New Zealand that states a practitioner must provide pain relief. Domestic legislation appears to skirt the issue of pain relief altogether, and, within the body of legislation regarding medical practice, the term “pain” appears only in the Care of Children Act 2004.³³ Even here, there is simply a statutory justification for giving treatment where pain relief is a goal, and the Act does not compel any specific behaviour. On the face of it, pain relief is not recognised in New Zealand legislation.

Despite this, many would argue that a right to pain relief is implicitly supported by other statutory duties, including by several of the duties set out in the Code of Health and Disability Services Consumers’ Rights.³⁴ The Code is delegated legislation which has full

30 Charlton, above n 29, at 27.

31 DN James “Anaesthesia services for acute pain management” in *Guidelines for the Provision of Anaesthetic Services 2013* (The Royal College of Anaesthetists, April 2013) at 1.

32 Canadian Nurses Association *Code of Ethics for Registered Nurses* (Ottawa, June 2008) at 14. See also Nancy Loveridge “Ethical Implications of Achieving Pain Management Through Advocacy” (2000) 8(3) *Emergency Nurse* 16 at 16.

33 Care of Children Act 2004, s 37. This section relates to immunity for doctors who give blood transfusions to children to, among other reasons, save the patient from prolonged and avoidable pain and suffering.

34 Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996.

legal authority under the Health and Disability Commissioner Act 1994.³⁵ Relevant to this article are the following rights:

- Right 1—Right to be treated with respect;
- Right 3—Right to dignity and independence;
- Right 4—Right to services of an appropriate standard.

Right 1 establishes the right to be treated with respect. This includes the right to be provided with services that take into account the needs, values and beliefs of different cultural and ethnic groups. It might be said that a practitioner who inadequately treats pain has failed to respect the patient, and that his behaviour suggests a lack of “active regard for [the patient’s] welfare”.³⁶ This view acknowledges that treating a patient’s pain is part of looking at the patient and recognising their humanity; it is disrespectful to neglect a patient, and rude to ignore their pleas for help. Moreover, where inadequate pain relief flows from a failure to have regard to the needs and values of a particular patient, this would constitute a failure to recognise the intrinsic value and uniqueness of each individual. As Robyn Stent noted, this is the core element of the right to respect.³⁷

It has also been said that pain relief is a “moral duty, based on both beneficence and respect”.³⁸ Inarguably, patients have a right to have their complaint of pain respected and taken seriously.³⁹ A right to pain relief also has a bearing on the right to be treated with respect under the Code because culture and ethnicity are sometimes seen as factors that influence pain care.⁴⁰ Pain may be inadequately addressed for a variety of reasons including cultural,⁴¹ and if pain relief is adversely impacted by a practitioner’s failure to respect a patient’s culture there is a potential breach of the right to respect. Indeed, the practitioner must take into account the fact that pain is an individual, multifactorial experience “influenced, among other things, by culture”.⁴² Although falling far short of establishing a tangible right to pain relief, Right 1 of the Code does foreshadow the fact that where a clinician fails to take into account the individual, cultural or ethnic aspects of pain, he runs the risk of breaching the right to respect. Physicians are compelled by the concept of respect to take pain seriously, and to listen respectfully when patients describe pain.

Right 3 is more useful for ascertaining a right to pain relief. It provides that a consumer has the right to have services provided in a manner that respects the dignity and independence of the individual. If, as Justice Breyer of the United States Supreme Court stated, the “core of the interest in dying with dignity” involves “the avoidance of unnecessary and severe physical suffering”, it might well be said that a right to dignity necessitates the relief of pain.⁴³ The relationship between pain relief and individual dignity

35 Ron Paterson and PDG Skegg “The Code of Patients’ Rights” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 23 at 24.

36 Beauchamp and Childress, above n 15, at 32.

37 Robyn Stent *Unravelling the Code: The Code of Health and Disability Services Consumers’ Rights Significant Issues and Developments* (Health and Disability Commissioner, 29 April 1998) at 2.

38 Bettina Schoene-Seifert and James F Childress “How Much Should the Cancer Patient Know and Decide?” (1986) 36 CA-A Cancer Journal for Clinicians 85 at 90 as cited in Post and others, above n 23, at 354.

39 *Statement on Patients’ Rights to Pain Management and Associated Responsibilities* (Australian and New Zealand College of Anaesthetists, 2010) at 1.

40 Carmen Green and others “Disparities in Pain: Ethical Issues” (2006) 7 Pain Medicine 530 at 532.

41 Brennan, Carr and Cousins, above n 10, at 207.

42 Kiran K Koneti and Martin Jones “Management of acute pain” (2013) 31 Surgery 77 at 77.

43 Brennan, Carr and Cousins, above n 10, at 211. For an excellent account of the way pain affects a person’s dignity, see Post and others, above n 23, at 349.

was given substance by the IASP, which declared: “recognizing the *intrinsic dignity* of all persons and that withholding of pain treatment is profoundly wrong ... we declare ... the right of all people to have access to pain management”.⁴⁴

Dignity and pain relief are particularly important considerations in palliative care. Their inter-related nature is seen in General Comment 14 to art 12 of the International Covenant on Economic, Social and Cultural Rights, which emphasises the importance of sparing patients “avoidable pain and enabling them to die with dignity”.⁴⁵ Again, art 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms has been said to provide a “right to die with dignity and the right to be protected ... from a lack of treatment, which will result in one dying in avoidably distressing circumstances”.⁴⁶ Both these provisions recognise the relationship between dignity and distress. Invariably, the right to die with dignity requires “assessment of, and adequate relief from, pain and other distressing symptoms, and appropriate support and nursing care”.⁴⁷ The proposition that a right to dignity must include relief of pain and distress seems fairly well established, then, and Right 3 of the Code may prove valuable for those who seek to find or enforce a right to adequate pain relief.

If an argument framed in terms of respect and dignity fails, Right 4 of the Code may compel the provision of adequate pain relief. Several aspects of Right 4 are relevant:

- (1) Every consumer has the right to have services provided with reasonable care and skill.
- (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standard.
- (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
- (4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consume.

Because Right 4 demands an appropriate standard of care, adequate pain relief may be part of the right to receive services with reasonable care and skill. When a clinician’s behaviour falls below reasonable care and skill, a breach of Right 4(1) exists. This assessment is distinct from a *Bolam v Friern Hospital Management Committee* test, which inquires whether an action or omission was of a standard accepted as proper by a responsible body of professional opinion.⁴⁸ However, accepted professional practice

44 Declaration of Montréal (adopted 3 September 2010), art 1 (emphasis added). For the text of the Declaration, see International Association for the Study of Pain “Declaration of Montréal” <www.iasp-pain.org>.

45 World Health Organization *Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines* (WHO/EDM/QSM/2000.4, 2011) at 22.

46 *R (on the application of Burke) v General Medical Council* [2005] QB 424, [2004] EWHC 1879 (Admin) at [137].

47 *Withholding and withdrawing - guidance for doctors* (General Medical Council, August 2002) at [26] as cited in *R (on the application of Burke) v General Medical Council*, above n 46, at Appendix.

48 Paterson and Skegg, above n 35, at 37. See *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (HC).

seems the appropriate measure, and the Commissioner will be largely reliant on that advice.⁴⁹ As Joanna Manning notes:⁵⁰

... the fact that the practitioner has done or omitted to do something in contravention of accepted professional practice is relevant and indeed “good evidence” of negligence, but is not conclusive.

Pain relief may be required even where it would not be accepted professional practice, since the Commissioner can find that professional practice does itself fail to provide an appropriate standard of pain relief.⁵¹

Right 4 demands that practitioners act in a competent manner, and in doing so it addresses the concept of negligence. Thus, Margaret Somerville’s argument that “the unreasonable failure to provide adequate pain relief constitutes negligence” is relevant.⁵² Ways in which pain relief can be substandard are legion and include a failure to take an adequate history, a failure to adequately treat the pain, and an unreasonable failure to consult an expert.⁵³ Moreover, since practitioners are generally seen as fiduciaries,⁵⁴ the law demands that the practitioner avoids harming the patient and provides the highest standards of care.⁵⁵ In palliative care, pain relief is widely recognised as an essential component of adequate care, and in an acute setting, patients have a right to receive “appropriate assessment and management of pain”.⁵⁶ Chronic pain is perhaps unique inasmuch as it is a disease in itself.⁵⁷ If chronic pain is a condition in its own right, it follows that a failure to appropriately treat chronic pain is akin to a failure to treat any other illness. Therefore, inadequate pain relief in relation to palliative, acute or chronic pain is likely to be a failure to act with reasonable care and skill, in breach of Right 4(1).

Right 4(2) also provides that every consumer has the right to have services provided in a manner consistent with ethical and professional standards. As discussed above, ethical standards clearly invoke a right to adequate pain relief. Likewise, professional standards in New Zealand require health practitioners to “take steps to alleviate pain and distress whether or not a cure is possible”.⁵⁸ Supplementary guidance from the Medical Council of New Zealand also outlines the professional duty to take steps to ensure palliative care patients die “with as little suffering as possible”.⁵⁹ Remembering that the logical corollary of an obligation to alleviate pain and distress is a right to relief from pain, these professional standards are good evidence for the existence of a right to pain relief.

49 Rosemary Godbold and Antoinette McCallin “Setting the standard? New Zealand’s approach to ensuring health and disability services of an appropriate standard” (2005) 13 JLM 125 at 127.

50 Joanna Manning “Determining Breach of the Standard of Care” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 97 at [4.2].

51 Paterson and Skegg, above n 35, at 38. See also *Director of Proceedings v Norfolk Court Rest Home Ltd* [2011] NZHRRT 12.

52 Brennan, Carr and Cousins, above n 10, at 212.

53 At 212.

54 At least in regard to doctors. See generally Paterson and Skegg, above n 35, at 37.

55 See generally John K Hall and Mark V Boswell “Ethics, Law, and Pain Management as a Patient Right” (2009) 12 Pain Physician 499 at 502.

56 See, for example, New York State Department of Health *Pain Management: A Guide for Patients* (November 2012).

57 Michael J Cousins “Unrelieved pain: a major health care priority” (2012) 196 Med J of Aust 373 at 373.

58 Medical Council of New Zealand “Good medical practice” in Ian St George (ed) *Cole’s Medical Practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) 5 at 9.

59 At 13.

The right is explicitly recognised in professional standards promulgated by the Australia and New Zealand College of Anaesthetists (ANZCA). In its Statement on Patients' Rights to Pain Management, ANZCA acknowledges a right to have pain managed, requiring the "professional response be reasonable and proportionate to the level and character of the pain experience and that the assessment and management of a patient's pain be appropriate to that patient".⁶⁰ *Effective treatment* appears to be the primary concern of these standards, which focus on a right to have pain "respected and taken seriously".⁶¹ "Pain management" is also the preferred term, and is said to address the physical and psychological aspects of pain.⁶² Use of the phrase *pain management* may indicate an attempt to distance the Statement from a right to *pain relief*, where that phrase would unreasonably imply that all pain "can or will be treated successfully, that all patients will be free from pain, or that any analgesic treatment will necessarily be provided on demand".⁶³ Thus, a right to pain relief can be found in the Statement only inasmuch as it requires the professional response to be proportionate to the patient's pain. From this perspective, a practitioner who fails to reasonably manage a patient's pain will likely be in breach of professional and ethical standards, and therefore of Right 4(2). As with any breach of the Code, cl 3 may provide a defence where a practitioner can show that she has taken reasonable steps in the circumstances to give effect to her professional and ethical duties.

Patients may also have a right to receive services in a manner consistent with their needs, under Right 4(3) of the Code. This provision means that pain relief ought to be extended to all people in a manner that takes account their individual needs. Some groups, such as children, pregnant women, the elderly, Māori and Polynesian, non-English speaking people and patients with a substance abuse disorder have unique needs and may require particular attention since they are at increased risk of receiving substandard pain relief.⁶⁴ The effect of Right 4(3) can be understood to provide all people with a legal right to request pain relief in a manner that renders it effective regardless of the uniqueness or peculiarity of his or her particular needs. In addition, Right 4(3) likely extends a right to pain relief to patients who have a hypersensitivity to pain or a phobia or dislike of certain routes of receiving analgesia. For example, a patient who has needle phobia will have a right under 4(3) to be treated other than by intramuscular or intravenous routes. Right 4(3) therefore has a pivotal impact on a right to pain relief by ensuring that it applies to everyone who needs it, in a way consistent with their needs. The effect of Right 4(3) is not, however, to provide patients with the ability to pain relief on demand; any health care provider will find protection in cl 3 of the Code and its subsets, which render right 4(3) subject to reasonable limitations such as the consumer's clinical circumstances and the provider's resource constraints.

It must also be emphasised that Right 4(3) impels practitioners to act consistently with the *needs* rather than the *wants* of a consumer.⁶⁵ On a plain reading of the language used in Right 4(3), it appears to provide that a patient may request any and all types of pain relief but will only have a legal right to these where necessary. Accordingly, patients cannot

60 *Statement on Patients' Rights to Pain Management and Associated Responsibilities*, above n 39, at 2.

61 At 1.

62 At 1.

63 At 2.

64 See generally *Guidelines on Acute Pain Management* (Australian and New Zealand College of Anaesthetists, 2013) at [2.7].

65 Paterson and Skegg, above n 35, at 39.

have a right to analgesia of a certain type or quantity on demand. Issues raised by Right 4(3) include, for example, the question whether non-pharmacological therapies must be provided where they are relevant to the treatment of pain. If at the core of Right 4(3) lies a recognition that the treatment of pain “should be tailored to [an] individual patient’s assessment and requirements”, then a subjective approach must be taken to the assessment of pain.⁶⁶ That is, pain relief should be administered on the basis of what an individual patient *needs*. In answer to the difficult question of what can rightly be seen as a need, Mason, McCall Smith and Laurie state that a “need ... can be defined as existing ‘when an individual has an illness [such as pain] ... for which there is an effective and acceptable treatment’”.⁶⁷ Adopting this reasoning, I consider that Right 4(3) provides an equal right to pharmacological and therapeutic options, where these are effective and acceptable treatments to relieve a patient’s pain. Of course, this must be caveated again by the disclaimer that a clinician would appear to be protected by Clause 3 of the Code where he fails to provide a therapeutic or pharmacological option that is outside of her area of expertise.

Finally, a right to pain relief is evident in Right 4(4) of the Code. This promotes the right of consumers to have “services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer”. “[O]ptimise the quality of life” is given an expansive interpretation in cl 4 of the Code, which defines it as taking a “holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances”. Right 4(4) will be relevant where there is any failure to minimise harm. This has some overlap with the principle of nonmaleficence, and will in practice require pain relief to be administered as a part of optimising the quality of life of the consumer. Effectively treating pain is also part of minimising the potential harm to the patient. In this respect, Brennan, Carr and Cousins argue that a failure to treat a patient in pain *causes* harm, not simply in terms of the continuation of pain but by the physical and psychological effects that pain has on the patient.⁶⁸ This argument is problematic given that it conflates act with omission; the practitioner cannot cause harm by failing to treat it, he simply allows it to continue. The point remains, however, that *minimising* potential harm to the patient must require a practitioner to adequately treat pain.

Causation issues aside, the observation of Brennan, Carr and Cousins valuably illustrates the fact that pain has harmful, and at times catastrophic, effects. Experiencing pain is “central to the harm caused by many forms of ill health”,⁶⁹ and inadequately treated, it has major ramifications for patients, their families and societies.⁷⁰ Some research indicates a positive association between chronic pain and the risk of anxiety or depressive disorder, elucidating the possible harmful consequences of pain.⁷¹ Given the harm that pain can cause, it is possible to see a right to pain relief as incidental to the right to have services provided in a manner that minimises the potential harm to the consumer. This is especially true because adequate treatment of acute pain will minimise the risk of it progressing to chronic pain, thereby minimising future harm.⁷²

66 Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations, Right 4(3).

67 Mason, McCall Smith and Laurie, above n 12, at 428.

68 Brennan, Carr and Cousins, above n 10, at 210.

69 Gill and Taylor, above n 5, at 1.

70 Brennan, Carr and Cousins, above n 10, at 205.

71 Dominick, Blyth and Nicholas, above n 4, at 299.

72 Cousins, above n 57, at 374.

In summary, the Code establishes a range of rights that independently and cumulatively impact on the existence of a right to pain relief. Right 1 of the Code has some bearing on the right to effective pain relief, but does not appear capable of establishing pain relief as a right in its own terms. Right 3 provides a stronger basis for a right to pain relief, but is hindered by problems in the interpretation of what dignity entails. I suggest that a common sense approach would find that a patient who suffers from crippling and prohibitive pain is not in a particularly dignified position. Respect for his dignity must include providing pain relief. And the clearest indication that a right to pain relief exists in New Zealand is found in Right 4. Each of the subsections in Right 4 points to the conclusion that an appropriate standard of care entails the adequate relief of pain. To say otherwise is to fail to take into account consumers' needs, the physician's duty to minimise harm and the prevailing ethical and professional standards.

B Law that prohibits a particular behaviour—negative rights and responsibilities

Much like the state of legislation *compelling* particular behaviours with regard to pain relief, New Zealand has few statutes that prohibit certain behaviours relating to pain relief.

For the purposes of this article, only the New Zealand Bill of Rights Act 1990 (BORA) is relevant. Section 9 of the BORA guarantees everyone the right not to be subjected to torture, cruel or degrading treatment.⁷³ Although the Act has limited applicability,⁷⁴ it elucidates how pain relief might be a right where to withhold it would be cruel. The threshold under BORA is high. For a breach of s 9 to be found the conduct must be able to be characterised as “so excessive as to outrage standards of decency’ ... or ‘so severe as to shock the national conscience’”.⁷⁵ In the United Kingdom, Buxton LJ made it clear that “inhuman and degrading treatment ‘addresses positive conduct ... of a high degree of seriousness and opprobrium. It has never been applied to merely policy decisions on the allocation of resources’”.⁷⁶ A failure to provide pain relief is therefore unlikely to constitute cruel and degrading treatment where it is caused by poor resource allocation. This principle is seen in *R v Bedford Primary Care Trust*, which concerned a man who suffered serious pain while waiting for a hip replacement for one year.⁷⁷ He was unable to establish that his constant pain was an inhuman and degrading treatment “[or] so severe or humiliating” as to amount to ill-treatment, in part because of resource limitations.⁷⁸ Thus, although never properly tested in New Zealand, it seems the law relating to cruelty and degrading treatment does little to assist patients who do not receive adequate pain relief. What it does establish is the possibility that the absence of pain relief might be considered cruel in very extreme cases of severe, unnecessary pain.

73 New Zealand Bill of Rights Act 1990, s 9.

74 Section 3 restricts its application to acts done “by the legislative, executive, or judicial branches of the Government of New Zealand”, or “by any person ... in the performance of any public function”.

75 *M v Minister of Immigration* [2013] NZSC 9, [2013] 2 NZLR 1 at [37].

76 Ben White, Fiona McDonald and Lindy Willmott *Health Law in Australia* (Thomson Reuters, Pyrmont (NSW), 2010) at 82.

77 *R (on the application of Watts) v Bedford Primary Care Trust* [2003] EWHC 2228 (Admin).

78 At [54].

C *International instruments*

It is well established that international instruments to which New Zealand has acceded are permissive though not mandatory considerations.⁷⁹ International instruments have no binding authority unless and until incorporated into domestic legislation by Parliament, which holds a monopoly on the passage of statute law.⁸⁰ Ultimately, judges retain a considerable degree of discretion,⁸¹ but in general international obligations—and particularly those relating to human rights—are intended to be taken seriously, and the courts will strive to ensure they are not “window-dressing”.⁸²

The *Universal Declaration of Human Rights* is one instrument relevant in considering whether a right to pain relief exists.⁸³ As an over-arching principle, the *Declaration* establishes that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself”, including medical care.⁸⁴ Thus, a right to pain relief may exist as an integral part of ensuring the health and well-being of a person. This is echoed by the International Covenant on Economic, Social and Cultural Rights.⁸⁵ Article 12 of the Covenant says that each person has the right to “enjoyment of the highest attainable standard of physical and mental health”. Remembering the clear nexus between physical pain and poor mental health, this aspirational Covenant can be seen as implying a right to pain relief as an incidental part of the right to physical and mental health. Indeed, the Joint Commission on Accreditation of Healthcare Organisations has noted that “unrelieved pain has adverse physical and psychological effects”, reaffirming the adverse effects of pain on physical health.⁸⁶ In a similar vein, the World Health Organisation noted the relationship between the availability of narcotics for pain relief and “human rights principles”, such as the right to health.⁸⁷

In addition to these, a range of international documents have been agreed to by professional bodies in New Zealand. These form part of New Zealand statute law inasmuch as they are part of the professional standards that govern practitioner’s behaviour, which might be considered under Right 4(2) of the Code. First among these is the Declaration of Montréal. Promulgated by the IASP and endorsed by the Faculty of Pain Medicine, ANZCA, the Declaration announces the “right of all people to have access to pain management without discrimination”.⁸⁸ In addition, the Declaration of Montréal states that a practitioner has a duty to “offer to a patient in pain the management that would be offered by a reasonably careful and competent health care professional in that field of practice”.⁸⁹

79 See *Ashby v Minister of Immigration* [1981] 1 NZLR 222 (CA). See also David Dyzenhaus, Murray Hunt and Michael Taggart “The Principle of Legality in Administrative Law: Internationalisation as Constitutionalisation” (2001) 1 OJCLJ 5 at 7.

80 *Ashby v Minister of Immigration*, above n 79, at 224.

81 Andrew Butler and Petra Butler “The Judicial Use of International Human Rights Law in New Zealand” (1999) 29 VUWLR 173 at 180.

82 At 190.

83 *Universal Declaration of Human Rights* GA Res 217A (1948).

84 Article 25.

85 International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976)

86 *Pain Standards for 2001* (Joint Commission on Accreditation of Healthcare Organizations, 2001) as cited in George J Annas *The Rights of Patients: The Authoritative ACLU Guide to the Rights of Patients* (3rd ed, New York University Press, New York, 2004) at 300.

87 *Ensuring Balance in National Policies on Controlled Substances*, above n 45, at 12.

88 Declaration of Montréal, art 1.

89 Article 1.

In this way, it plainly creates a right to access pain relief and a duty to offer pain management.

The Declaration of Tokyo, promulgated by the World Medical Association (WMA) and acceded to by the New Zealand Medical Association, is also relevant.⁹⁰ Article 7 of the Declaration of Tokyo notes the physician's "fundamental role is to alleviate ... distress", but stops short of providing an enforceable right. Although the Declaration of Tokyo is specifically concerned with torture and degrading treatment, its wording is broad and of general applicability. Six years later, the WMA built on this by promulgating the Declaration of Lisbon on the Rights of the Patient.⁹¹ This Declaration encapsulates a right to "relief of his/her suffering according to the current state of knowledge", which at once acknowledges a right to pain relief and recognises that this is limited by medical knowledge.⁹² Taken together, these international instruments make plain the necessity of pain relief, and are permissible considerations for relevant professional standards.

D Foreign legislation—how does New Zealand compare?

I now consider a range of foreign statutes that have recognised a right to pain relief. This is relevant since they provide potential models for future legislative activity in New Zealand.⁹³ I look briefly at Californian legislation before turning to Australian legislation and French legislation.

The Californian Pain Patient's Bill of Rights, effective in 1998, is a primary example of the way in which pain relief might be incorporated into statute. It states that:⁹⁴

- (d) A patient suffering from severe chronic intractable pain should have access to proper treatment for his or her pain.
- ...
- (h) A patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her severe chronic intractable pain.

Interestingly, the right to pain relief is framed only as a right to access to proper treatment. This makes sense in light of the fact that pain elimination might be impossible, but the right is further watered down by the words "should" and "chronic intractable pain". It is questionable whether pain relief ought to be limited to those suffering chronic intractable pain. Certainly, this seems *prima facie* inconsistent with the view that all patients have a right to relief of their suffering. The Californian Pain Patient's Bill of Rights is open to criticism on this basis, although California goes further than New Zealand simply by addressing in statute the right to proper treatment of pain.

90 Declaration of Tokyo (adopted October 1975). For the text of the Declaration, see World Medical Association "WMA Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment" <www.wma.net>.

91 Declaration of Lisbon on the Rights of the Patient (adopted September/October 1981). For the text of the Declaration, see World Medical Association "WMA Declaration of Lisbon on the Rights of the Patient" <www.wma.net>.

92 Article 10(b).

93 Brennan, Carr and Cousins, above n 10, at 212.

94 Pain Patient's Bill of Rights, California Health and Safety Code § 124960–124961.

In light of these problems, the Medical Treatment Act 1994 (ACT) offers what can be seen as a better approach. This enshrines the right of “a patient under the care of a health professional” to “receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances”.⁹⁵ Balanced only against a reasonableness test—similar to cl 3 of the Code of Patients’ Rights—s 23(2) also requires the professional to “pay due regard to the patient’s account of his or her level of pain and suffering”.

In 2005, France joined California and the Australian Capital Territory by introducing a new legal framework regarding pain relief by amending the Code of Public Health. This Code stipulates that “[e]veryone has the right to receive treatment to relieve his pain. This must be prevented at all times, evaluated, considered and treated.”⁹⁶

The provision unequivocally announces a right to relief of pain. It goes further than the Californian or Australian Capital Territory provisions in stating that pain must be prevented as well as treated. Taken together, the Californian, Australian and French examples indicate the relative ease with which pain relief can be incorporated into domestic legislation. Although New Zealand is among the majority in its failure to provide explicitly for a right to pain relief, this is not to say that the New Zealand’s legislation should maintain its silence on the issue. The practical competency of a court to determine whether there has been a breach by a health care practitioner of his or her duty to provide pain relief where it is available to do so is confirmed by malpractice suits in the United States in which civil courts have been prepared to award damages for under provision of analgesics and pain relief options.⁹⁷

In light of the prohibitive impact of the Accident Compensation Corporation (ACC) scheme on a patient’s ability to sue in cases of negligence, it seems especially important to codify the right in New Zealand.⁹⁸ Indeed, since the effect of ACC is for the State to cover the health care of every person who suffers an accidental injury in New Zealand but also to remove their ability to sue except for—rarely awarded—exemplary damages, health care practitioners are less incentivised to practice to a high level than might be the case in more litigation-friendly jurisdictions. An explicit right and obligation would therefore impress the importance of adequate pain relief on practitioners, and make it easier for those who have suffered unnecessary pain to pursue other forms of redress, as summarised below.

IV Judicial Approaches to Pain Relief

Having established that a right to pain relief can plainly be found in domestic and international instruments, I now consider judicial approaches to pain relief in New Zealand, the United Kingdom and the United States. I look at professional review bodies and their approach to practitioners who fail to provide adequate pain relief, and explore how the Health and Disability Commissioner has dealt with a right to pain relief.

A Case law

The most apparent thing about a right to pain relief in New Zealand case law is the lack of discussion of it. Nonetheless, obiter in the landmark decision *Auckland Area Health Board*

95 Medical Treatment Act 1994 (ACT), s 23(1).

96 Code de la Santé Publique, art L1110–5 (translation: Code of Public Health).

97 Hall and Boswell, above n 55, at 503.

98 Accident Compensation Act 2001, ss 317 and 319.

v Attorney-General may prove useful.⁹⁹ In that case, the applicants sought a statutory declaration that they would not be guilty of culpable homicide for withdrawing ventilation from Mr L. Thomas J considered that when the system was withdrawn, death would be instantaneous and painless.¹⁰⁰ Importantly, he held that a doctor was under a duty to act in good faith, and emphasised the values of human dignity and personal privacy.¹⁰¹ Citing Devlin J's instruction to the jury in *R v Adams*, Thomas J said that doctors may alleviate a patient's terminal pain even though the treatment may accelerate the patient's death.¹⁰² Most notable for the purposes of this article is that pain relief was seen as being of such vital importance that it qualified the principle that life is sacred and the absolute protection of it is a fundamental necessity. It is possible to conclude that Thomas J implicitly accepted that a patient has a *right* to be relieved from his pain and suffering.

Also useful is Hillyer J's decision in *Re X*.¹⁰³ In that case, Hillyer J held that a hysterectomy to prevent menstruation on a 15-year-old child, X, was for her benefit. Crucial to this decision was the fact that X had an inability to cope with the attendant pain of menstruation, and the belief that X went through enough pain and agony without menstruation. When discussing the importance of pain to its assessment of X's best interests, the Court noted the Australian decision *Re a Teenager*, commenting that:¹⁰⁴

... it was said that a meaningless retention of the right to reproduce would have been ... a direct breach of the child's constitutional right to be protected against unnecessary pain and suffering ...

By referencing this case, the Court clearly gave attention to a right to be free from pain and suffering.

In the United Kingdom, the Queen's Bench addressed the necessity of providing adequate analgesia in *Marcus v Medway Primary Care Trust*.¹⁰⁵ There, a failure to provide adequate pain relief for severe pain caused by ischemia in the foot prompted the Court to award damages. This was on the basis that "pain was not relieved as it should have been by appropriate analgesia. The analgesia negligently prescribed ... will, on the evidence, have had little effect".¹⁰⁶ The decision plainly shows a right to be free from pain and suffering, and confirms the legal requirement that doctors provide an appropriate standard of pain relief.

Further supplementing these judgments are a variety of cases from the United States that establish a right to relief of pain. In the United States, Blinderman suggests that the legal basis for the right to pain relief "can be found in the Supreme Court case of *Vacco v Quill*".¹⁰⁷ In that case it was accepted that a physician may provide aggressive palliative care, including "in some cases, painkilling drugs [that] may hasten a patient's death".¹⁰⁸ The existence of the right has been stated more directly, however, in *Franklin v Dudley*, where the United States District Court for the Eastern District of California held in 2011

99 *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235 (HC).

100 At 238.

101 At 245.

102 At 249.

103 *Re X (sterilisation: parental consent)* [1991] 2 NZLR 365 (HC).

104 At 378.

105 *Sebastian Marcus v Medway Primary Care Trust* [2010] EWHC 1888 (QB).

106 At [71].

107 Blinderman, above n 25, at 302.

108 *Vacco v Quill* 521 US 793 (1997) at 802.

that a right to adequate pain medication exists.¹⁰⁹ In reaching that decision, the Court cited the judgment in *Prewitt v Roos*, where the failure to provide a detainee with prescribed pain medication, causing his pain to be considerably exacerbated, violated the detainee's constitutional right.¹¹⁰ As the Judge noted in *Franklin*, "inmates ... have the right to adequate pain medication. Defendant's suggestion that no such right exists is without merit."¹¹¹

The United States Court of Appeals for the Ninth Circuit has widened this right to pain relief to include a right to pain relief without inappropriate delay. In *McGuckin v Smith* the prisoner sued the State for a breach of his constitutional right to medical care.¹¹² He alleged a delay in receiving surgery was caused by deliberate medical indifference. McGuckin suffered seven months of unnecessary pain, prompting the Court to hold that "McGuckin may well have a valid claim under § 1983 that his federal constitutional rights were violated by his woefully inadequate medical treatment".¹¹³ However, procedural errors meant that McGuckin could not make out fault on the part of the named defendants.

Ultimately, while it is acknowledged that United States jurisprudence has limited relevance here—and especially so when it is based on the existence of a Constitutional document—these cases are important indicators of the link between appropriate medical care and pain relief. Given the unsatisfactory state of New Zealand jurisprudence, I argue that these cases are not insignificant. Although many concern a breach of a duty to provide adequate pain relief, it is not difficult to deduce a right to adequate pain relief from these findings.

B Professional review bodies

The findings of professional conduct bodies are important indicators of how practitioners themselves view the duty to provide pain relief.

In New Zealand, the Health Practitioners Disciplinary Tribunal hears disciplinary proceedings brought against health practitioners. Cases relating to pain relief are infrequent although one is relevant here. Dr Enrique Tomeu, an obstetrician and gynaecologist, was found not guilty of professional misconduct in respect of five particular charge including treating the patient disrespectfully.¹¹⁴ The patient was experiencing considerable hip pain, which continued unabated despite administering pethidine. The Tribunal found that the patient was obviously in significant pain, and that the situation was "exacerbated with the absence of pain relief".¹¹⁵ However, the Director of Proceedings did not allege a failure to provide adequate pain relief. There is no indication why this was, but in cases before the New Zealand Human Rights Review Tribunal (HRRT), the Director has laid charges on those grounds.

The Director of Proceedings addressed the issue of pain relief directly in *Director of Proceedings v Norfolk Court Rest Home*.¹¹⁶ By agreement of the parties, the HRRT made a declaration that the defendant breached the Health and Disability Regulations 1996 by

109 *Franklin v Dudley* ED Cal, June 22 2011 at 7.

110 *Prewitt v Roos* 160 Fed Appx 609 (9th Cir 2005).

111 *Franklin*, above n 109, at 8.

112 *McGuckin v Smith* 974 F 2d 1050 (9th Cir 1992) at 1052.

113 At 1062.

114 *Re Enrique Jose Tomeu* 234/Med08/107D, 3 July 2009.

115 At [38].

116 *Director of Proceedings v Norfolk Court Rest Home Ltd* [2011] NZHRRT 12.

failing to have an adequate pain management policy in place, failing to assess pain properly and failing to respond to pain by the administration of pain relief. This caused the consumer to suffer significant pain over four months. The decision to lay charges in respect of the failure to provide pain relief speaks loudly about the existence of a right to adequate pain relief. Moreover, since the Commissioner refers only the most serious cases are referred to the Director of Proceedings, this also demonstrates the particularly egregious nature of a failure to provide pain relief. This case is supported by a materially similar decision in *Director of Proceedings v Sisson*, in which the HRRT found the patient's rights were breached by "the lack of care planning and inadequate response to her pressure areas [which] caused her unnecessary pain and discomfort".¹¹⁷

Professional review boards in Australia, Canada and the United Kingdom have also indicated that insufficient management of pain may breach a patient's rights. In *Fiek v Nurses Board of Victoria*, the Victorian Civil and Administrative Tribunal set aside a finding of unprofessional conduct because the facts did not sufficiently demonstrate an unreasonable delay in providing pain relief.¹¹⁸ Nevertheless, the Tribunal appeared to accept as a general principle that a failure to administer adequate pain relief can be grounds for a finding of unprofessional conduct. And in Canada, the Health Professions Appeal and Review Board upheld a decision that the Respondent adequately controlled the patient's pain, but noted that other courses of action might have resulted in a more positive experience for the patient.¹¹⁹ The Board's conclusion that the Respondent met professional standards was described as being "within a range of possible, acceptable outcomes", opening the possibility that a breach finding could have been made.¹²⁰ This decision accords with the United Kingdom decision in *Nagiub v General Medical Council*. Here, the Queen's Bench refused to interfere with the Council's finding that Dr Nagiub's failure to provide "adequate pain relieving medication and analgesia" amounted to misconduct.¹²¹ *Nagiub* signals the importance of providing appropriate pain relief as part of good professional behaviour. Each of these cases highlights how a failure to appropriately relieve pain may amount to seriously substandard, unethical behaviour and a finding of unlawful breach of the patient's right to relief from unnecessary pain.

C Health and Disability Commissioner decisions

The primary decision-making authority in relation to patients' rights is the Health and Disability Commissioner. Decisions by the Commissioner that insufficient pain management has breached the Code are significant and demonstrate that adequate pain relief is both a duty and a right. Indeed, a finding that inadequate pain management has breached the Code implicitly involves a finding that there is a right to pain relief.

The basic principle was recently enunciated by the Deputy Health and Disability Commissioner, who held that "[e]ffective pain control is an integral part of palliative care, irrespective of where and by whom the care is being provided."¹²² Although focused on palliative care, the Deputy Commissioner referred to the importance of assessing pain relief requirements in a formal and structured way, and echoed the independent adviser's view that "[h]aving any resident in pain is unacceptable with the resources available in the

117 *Director of Proceedings v Sisson* HRRT22/06, 10 August 2007 at [84].

118 *Fiek v Nurses Board of Victoria* [2006] VCAT 1968.

119 *CM v NHVDK HPARB* 10-CRV-0460, 15 December 2011 at [36].

120 At [37].

121 *Nagiub v General Medical Council* [2011] EWHC 366 (QB) at [46].

122 Deputy Health and Disability Commissioner *Opinion 09HDC01783* (28 March 2011) at [103].

health service.”¹²³ This decision is in keeping with a prior one made by a previous Commissioner, who found that a woman in childbirth had a right to “adequate pain relief”.¹²⁴ This included having her distress responded to with “appropriate pain management”.¹²⁵

The Commissioner has also held that asserting an increased degree of difficulty in the provision of pain relief is not a legal excuse for a failure to provide effective pain relief. In the case of Mrs A—a 72-year-old woman who had a history of stroke and dysphagia—Mrs A’s family were convinced that she was in terrible pain and, particularly alarmingly, that she died in severe pain.¹²⁶ The Commissioner found that although the pain was difficult to control, the pain management provided was insufficient to cope with the breakthrough pain suffered by Mrs A. The Commissioner subsequently found that Rights 4(1) and 4(2) of the Code were breached.¹²⁷ Reasonable skill and care required earlier assessment and ongoing monitoring of Mrs A’s pain.¹²⁸ An additional breach was found in respect of the Rest Home, which failed to ensure there were adequate systems in place to provide ongoing assessment and monitoring of Mrs A.¹²⁹ Thus, the right to pain relief requires not only practitioners but also their employers to act to relieve a consumer’s pain.

Importantly, the Commissioner has accepted that a right to pain relief cannot be a right to be pain free. For this reason, the Commissioner has held that staff did not breach the right to receive an appropriate standard of care where they were vigilant about pain levels and regularly administered appropriate pain relief.¹³⁰

V Issues in the Provision of Pain Relief

So far, I have established the ethical, professional, statutory, judicial and quasi-judicial grounds in which a right to pain relief can be found. I now consider the difficulties inherent in such a right. In this part of the article, I suggest that the right to pain relief does not suffer from any serious deficiencies in its workability but must be subject to resource considerations.

A *Is a right to pain relief unworkable?*

The primary issue with a right to pain relief is the difficulty of defining its scope: what is the extent of the physician’s duty to manage pain? Because pain is ordinarily secondary to another injury or illness,¹³¹ does a right to pain relief include treatment of the underlying cause? For example, will a right to pain relief entail joint replacement surgery for a patient with osteoarthritis or will it simply be enough to provide a patient with osteoarthritis with pharmacological options to minimise the pain? And, what treatments for relief of pain can

123 At [109].

124 Health and Disability Commissioner *Commissioner’s Opinion—Case 99HDC12423* (31 May 2001) at 35.

125 At 36.

126 Health and Disability Commissioner *Opinion 03HDC17242* (16 November 2004).

127 At 22.

128 At 23.

129 At 25.

130 Health and Disability Commissioner *Opinion 02HDC15234* (19 April 2005) at 5.

131 Gill and Taylor, above n 5, at 1.

reasonably be expected? For example, does a patient with neuropathic pain have a right to neuromodulation treatment with Spinal Cord Stimulators—at a cost of \$35,000—if this would relieve their pain?¹³² In addition, if pain relief were a basic human right, who would an affirmative injunction compelling pain relief be issued against?¹³³ And of course the definitional problem remains: how will it be decided when pain management has been appropriate and enough treatment has been provided? Is this simply based on a clinical judgement that it is not practicable to manage the pain better?

The extent of the physician's duty to manage pain may be found in the current test for negligence. As Manning notes, it is well settled that the Court has the ultimate responsibility to determine the standard of care required.¹³⁴ In this context, the Court will likely be strongly guided by the *Bolam* test. However, if practitioners have a duty to provide pain relief to the extent allowed by current knowledge, the question is very much a clinical one. The scope of the duty will require a practitioner to exhaust all clinically viable options. This is an inquiry the courts are well equipped to make. Taking a step back, it must also be seen that part of the answer to this question lies in excellent patient-doctor communication. A patient is most likely to accept the treatment plan and relief offered by a doctor when they feel they are being listened to and are understood. Therefore, adequate communication will go some way in preventing claims by disgruntled patients who feel their right to adequate pain relief has been breached.

Short work can also be made of the argument that the right is unworkable because it lacks a bright line test for physicians. If a right could not exist except where there was a bright line, then the right to be fully informed or the right to health would also be unworkable. Yet, both these rights exist happily in domestic and international legislation, relying as they do on the practitioner's common sense.

The real difficulty, perhaps, lies in whether a right to pain relief entails a right to treatment of the cause also. Montgomery notes that a more expansive concept of health law would include protection from disease and accidents, but surely this is not a realistic proposition.¹³⁵ Indeed, there is room for "considerable disagreement" about what the government can legitimately be expected to do.¹³⁶ As John K Hall and Mark V Boswell suggest, these facts make "the argument that pain management is a basic human right ... less defensible".¹³⁷ Ultimately, the question is not capable of being answered in a concrete way. The particular situation of the patient will dictate what is required for them. There is no apparent reason why treatment of the underlying condition would not be appropriate where this would provide the patient with pain relief. The right to pain relief should not be concerned with *how* pain is relieved, but instead the key consideration is whether the pain relief provided is appropriate. Decisions of resource allocation may well dictate the degree to which this is achieved by targeting the underlying cause of the pain or merely effectively masking the symptoms.

Finally, resource limitations are a necessary, pragmatic consideration. The Accident Compensation Act 2001 specifically provides that treatment injuries do not include injury

132 Peter Larking *Effectiveness of Spinal Cord Stimulation for the Management of Neuropathic Pain* (Accident Compensation Corporation, August 2009) at 13.

133 Hall and Boswell, above n 55, at 504.

134 Manning, above n 50, at 110.

135 Jonathan Montgomery *Health Care Law* (2nd ed, Oxford University Press, Oxford, 2002) at 5.

136 Jean McHale, Marie Fox and John Murphy *Health Care Law: Text, Cases and Materials* (Sweet & Maxwell, London, 1997) at 7.

137 Hall and Boswell, above n 55, at 505.

that is solely attributable to a resource allocation decision.¹³⁸ Clause 3(3) of the Code also protects practitioners, whose actions were reasonable in their clinical circumstances, including resource constraints. Thus, a failure to “treat or delay in treatment because of resource decisions”, even where treatment is possible and would be beneficial, is likely to be viewed as a legally justified breach of the patient’s right to pain relief.¹³⁹ So, the answer to the question whether a patient with neuropathic pain has a right to neuromodulation treatment with Spinal Cord Stimulators—at a cost of \$35,000—will turn on the availability of resources. Rationing is an infamous but necessary concept in health care, and is explicitly recognised in s 3(2) of the Public Health and Disability Act 2000.¹⁴⁰

VI Concluding Remarks

This article first outlined how an ethics-based approach to pain relief obliges physicians to provide adequate relief of pain and suffering. I found that there are good grounds for recognising a prima facie ethical right to pain relief.

Secondly, I noted that this ethical right is supplemented in New Zealand and overseas by statute. A notable shortcoming—which begs to be remedied by Parliament—is the absence of any explicit recognition of a right to pain relief in domestic legislation. But international and professional instruments clearly acknowledge a right to have pain alleviated, and it has been shown that the Code can be read to include this right by pronouncing a right to receive appropriate care. Although the *right* is often framed as a *duty* to provide pain relief, the existence of a duty deductively indicates the existence of a right. So, a statutory responsibility to provide adequate pain relief implies a statutory right to receive it.

Thirdly, the way in which case law and other relevant decisions support this interpretation was considered. Importantly, I showed how the issue has barely been considered. Nonetheless, looking at decisions in Canada, the United States, Australia and the United Kingdom, a right to receive pain relief is capable of recognition. Decisions of the Health and Disability Commissioner make it plain that a patient in New Zealand is entitled to adequate relief of pain.

And at the end of this article, I charted practical problems with a right to pain relief. While accepting that there are legitimate practical issues with a right to pain relief, these are not insurmountable. I sounded a note of optimism in suggesting that courts are more than equipped to interpret the right where required.

Ultimately, if one remembers the story of Lillian Boyes and recognises the cold reality of severe pain, it is hard to envisage a situation where it would be appropriate to deny a person adequate pain relief. I would like to say that a legal right to adequate pain relief is self-evident. It is not, although there are powerful grounds for arguing its existence. Practitioners cannot have the duty to relieve pain placed squarely on them, however, and any right to pain relief must be careful to acknowledge the patient’s role in relieving pain and suffering. Additionally, a right to pain relief must be limited to the practical realities of

138 Accident Compensation Act, s 32(2)(b).

139 Joanna Manning “Treatment Injury and Medical Misadventure” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 679 at 714.

140 The section states that the purposes of the Act are to be pursued to the extent that they are reasonably achievable within the funding provided.

current medical knowledge. This does not mean we should accept severe pain as something that is as certain as death and taxes, but practitioners and patients must continually seek to provide and receive adequate pain relief. This is a humanitarian obligation.