

# ETHICAL IMPLICATIONS OF PAIN MANAGEMENT

## *Can A Formalized Policy Help?*

**T**he effective management of pain is a time-honored goal of medicine. From the time of Hippocrates<sup>1</sup> to the present-day Code of Medical Ethics of the American Medical Association,<sup>2</sup> the assessment and management of a patient's pain has been the primary responsibility of every physician. However, the medical profession has a history of not effectively assessing or managing patient pain. The 1995 SUPPORT study found that 50 percent of patients in the intensive care unit (ICU) had moderate to severe pain during their last days of life. This study also found that pain assessment and management was not an institutional priority in most acute care facilities.<sup>3</sup> Another report showed that 40 percent of all dying patients in the United States die in pain.<sup>4</sup> In 1997, the Institute of Medicine found that from 40 percent to 80 percent of patients with terminal illness reported that treatment of their pain was inadequate and prolonged the very agony of death.<sup>5</sup> Finally, a recent research study on persistent pain in nursing home residents found that after two assessments 14.2 percent of residents were in persistent pain and 41.2 percent of residents in pain at the first assessment were in severe pain 60 to 180 days later.<sup>6</sup> This high rate of persistent pain is consistent with other studies that have shown that pain is not adequately assessed or treated in patients in nursing homes.<sup>7</sup> The result of this undertreatment is impaired mobility, clinical depression, and a diminished quality of life for these patients.<sup>8</sup> These studies only confirm a long series of articles in the medical literature documenting the widespread and significant undertreatment of pain, beginning with a 1973 study of hospital inpatients.<sup>9</sup>

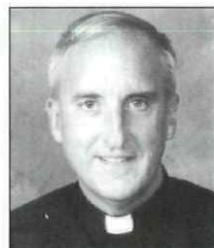
As a result of these studies, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was prompted to issue

revised standards, intent statements, scoring guidelines, and survey process questions so that assessment and treatment of pain is included in all patient populations.<sup>10</sup> The cornerstone of the revised JCAHO standards is that all patients have the right to appropriate assessment and management of pain and that this will be a condition of accreditation. Despite all this concern, the proper assessment and treatment of pain is still lacking in most of our acute care facilities. As a result, patients are pursuing other avenues to deal with the problem, such as litigation and the right to actively seek physician-assisted suicide.

Although the U.S. Supreme Court ruled in June 1997 that there was no federal or fundamental right to commit suicide by having assistance in effecting it,<sup>11</sup> two concurring opinions by Justice O'Connor and Justice Stevens appear to validate legally the medical right to terminal sedation as an efficacious form of palliative treatment for intractable pain.<sup>12</sup> The Supreme Court put the medical profession on notice that it has a responsibility to relieve the pain and suffering of patients to the very best of their ability. If this cannot be done, then there is the distinct possibility that the discussion on physician-assisted suicide could be revisited by the Supreme Court. This warning, along with several recent court cases in which family members successfully sued physicians for not adequately treating a patient's pain,<sup>13</sup> has placed the issue of pain assessment and management as a top priority in most acute care facilities.

However, despite all this attention, some patients still do not have their pain adequately assessed and managed. This is not just a medical and legal issue; it is also an ethical issue. Patients have the ethical right to have their pain managed as part of the basic dignity and respect that is accorded to every human person. This right has a theological underpinning based in the doctrine of

BY FR. PETER A. CLARK, SJ, PhD



*Fr. Clark is John McShain Chair in Ethics, St. Joseph's University, Philadelphia.*

Creation; it also has deep ethical roots in the medical profession. Some ethicists, such as Ben Rich, associate professor of bioethics at the University of California-Davis medical school, believe that the medical profession's failure to recognize the ethical implications of untreated and undertreated pain calls into question whether the majority of practitioners recognize that health care is a moral enterprise.<sup>14</sup>

The purpose of this article is threefold: first, to examine why pain assessment and management have been problematic; second, to give an ethical basis for the duty of health care professionals to assess and manage pain effectively; and third, to recommend ways to implement proper pain assessment and management, including a pain management policy that can serve as a paradigm for other Catholic health care facilities.

**PROBLEMS RELATED TO PAIN ASSESSMENT AND MANAGEMENT**

Pain is an unpleasant sensory and emotional experience.<sup>15</sup> It is recognized as a complex phenomenon derived from sensory stimuli and modified by individual memory, expectations, and emotions.<sup>16</sup> Because pain does not have objective biological markers, the most accurate evidence of pain and its intensity is based on the patient's description and reporting. The dimensions of pain affect every person, from the tiniest neonate to the elderly.<sup>17</sup> Pain can be classified into three types, each of which can be acute or chronic.

**Types** *Nociceptive pain* is generated by somatic or visceral tissue damage. Somatic pain is generated by nociceptors in cutaneous and deeper tissues, such as in the musculoskeletal system, and is described as gnawing, cramping, and throbbing. Visceral pain results from stimulation of the nociceptors in the cardiovascular, gastrointestinal, genitourinary, and respiratory systems. It is described as deep, aching, squeezing, or pressured. It is poorly localized and may spread to cutaneous sites. Second, *neuropathic pain* is usually described as constant, burning, shooting, or stabbing pain (such as in diseases affecting the nerve root). Third, *incidental pain* is pain

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caused by associated conditions (not necessarily cancer), such as positioning or constipation.<sup>18</sup> *Acute pain* is pain that lasts or is anticipated to last a short time, typically less than a month. It is often associated with anxiety and with hyperactivity of the sympathetic nervous system. *Chronic pain* is usually defined broadly and arbitrarily as pain persisting more than a month beyond the res-

olution of an acute tissue injury, pain persisting or recurring for more than three months, or pain associated with tissue injury that is expected to continue or progress. Chronic pain has no adaptive biologic role. (Pain may be broadly classified as somatogenic [organic]—explicable in terms of physiologic mechanism—or psychogenic—occurring without organic pathology sufficient to explain the degree of pain and disability and thought to be related mostly to psychological issues.)<sup>19</sup> Unrelieved pain is one of the greatest fears of people suffering from illnesses, especially terminal illness. Families of the suffering patient can be in great emotional distress as well. Undertreatment of pain and unrelieved pain are also costly for patients, families, institutions, and society as a whole.<sup>20</sup> The reasons that pain has been undertreated or untreated are varied and numerous, but certain well-defined barriers can be identified.

**Barriers** Barriers to effective pain assessment and management fall into four distinct categories. First is the failure of health care professionals to identify pain as a priority in patient care.<sup>21</sup> The failure to treat pain adequately is a result of a remnant of Cartesian dualism that dichotomizes the physical and the mental. Pain is the body's reaction to disease, and suffering is the person's reaction to pain. Bodies are the site of disease, but persons undergo the experience of illness. Suffering is a personal matter. It is as much a function of the value of individuals as it is of its physical causes. Suffering is broader than pain and is synonymous with a reduced quality of life.<sup>22</sup> This dichotomy has allowed medical professionals to claim as their sole responsibility the treatment of the physical and biological domain of illness while surrendering the role of suffering

to clinical psychologists, social workers, or pastoral counselors. The result of separating the objective dimension of disease from the subjective dimension of the person has been that the whole person's response to the experience of illness has suffered.<sup>23</sup>

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Pain management is a priority in the care of every patient and has deep roots in the medical profession. Physicians have the responsibility to treat the patient and the person, which means they assess and manage every patient's pain and suffering; if they fail to do so, they should be held accountable. Likewise, patients have a responsibility to make their physicians aware of the nature, severity, and duration of their pain to the best of their ability. The best way to assess pain is to ask the patient. Because pain cannot be objectively quantified, physicians should believe their patients; patients need to be aware of the fact that they need not suffer because their pain can be and should be managed. This can be done on admission when patients are informed, both orally and in writing, that effective pain relief is an important part of their treatment, that their communication of unrelieved pain is essential, and that health professionals will respond quickly to their reports of pain.<sup>24</sup> Unless patients and their physicians have an open and honest dialogue, the covenant that binds them will be compromised because of a lack of trust.

Second, some clinicians have insufficient knowledge regarding the assessment and management of pain.<sup>25</sup> A major cause of this barrier is the lack of education in medical schools regarding pain evaluation and management. A recent survey reported that the average amount of time spent teaching pain management in American medical schools is one hour; for nursing schools, it is four hours.<sup>26</sup> In addition, students typically take only one course in pharmacology, which cannot properly prepare them for what they will face once they leave the security of medical school. Once these individuals begin their residencies and become attending physicians, their ability to keep abreast of the medical literature regarding pain management is almost nil.

The need for a comprehensive pain curriculum in every medical school is vital.<sup>27</sup> Critics of the medical school curriculum argue that when pain

is addressed, too often it is by a faculty whose knowledge and skills in assessment and management are woefully outdated, resulting in misinformation being passed from one generation of physicians to another, leaving the latter virtually untouched by the remarkable advances of the last quarter century.

This becomes quite evident when one is doing rounds with medical interns and residents. They focus on the clinical problem, which might be a particular wound or the disease itself, but fail to treat the entire patient. While doing teaching rounds a resident will frequently present a case clinically; when he or she has finished, the bioethicist will ask: "What is being done to manage this patient's pain?" A blank stare is often returned with the response: "I didn't think of that." Ben Rich believes this phenomenon might fairly be described as the "cultivation and propagation of ignorance."<sup>29</sup> If interns and residents have not been given the essential clinical competencies in pain management in medical school and fail to receive these clinical competencies while in their residency programs, when will they learn the importance of assessment and management of pain?

One way to bring this issue to the forefront is the regular charting of a patient's pain as the "fifth vital sign." This concept enhances the clinical competency of physicians in pain assessment and management and assures patients that their fear of untreated pain will not become a reality.

Third, there is a fear of regulatory scrutiny of prescribing practices for opioid analgesics.<sup>30</sup> Some physicians are quite open about the fact that they will underprescribe opioid analgesics to avoid regulatory scrutiny. As Rich states:

While the medical literature over the last quarter century is replete with studies demonstrating widespread and significant underuse of opioid analgesics by physicians in their treatment of patients with pain, there is only a single instance in which a state board has disciplined a physician for unprofessional practice for failure to provide adequate pain management in the care of such patients. However, there are many cases in which the courts have criticized the

efforts of state boards to discipline physicians on the grounds that they inappropriately prescribe (i.e., overprescribe) opioid analgesics for patients with pain.<sup>31</sup>

Critics contend that the medical profession has been conscripted into the government's war on drugs. They contend that physicians believe their primary responsibility is to help regulators prevent drug diversion and excessive prescribing of opioid analgesics, not to effectively manage a patient's pain.<sup>32</sup> This fear, which is realistic, has had the potential to coerce physicians into failing to act in the best interest of their patients. As a result, the covenant between physician and patient can be fractured as basic trust dissolves. Both the state medical licensing boards and the federal government need to reevaluate and revise their present regulations regarding opioid analgesics. These antiquated regulations are causing patients to suffer needlessly, are raising anxiety levels among those nearing death that the dying process will be cruel and full of excruciating pain, and are leading the American public toward the slippery slope of physician-assisted suicide. Instead of playing into this antiquated system of regulations, medical professionals should take the initiative to advocate comprehensive new regulations.

In addition, economic barriers to proper pain management exist. With the advent of managed care, greater inattention to pain assessment and management has occurred. Lower staffing levels, with fewer nurses having responsibility for a larger number of patients, decrease the likelihood that even a persistent patient will succeed in securing required pain relief. The reluctance of physicians to prescribe and the lack of an adequate staff to monitor and evaluate patients will only lead to further barriers to pain relief.<sup>33</sup>

Fourth, unsound beliefs and unsubstantiated fears about addiction, tolerance, dependence, and adverse side effects of opioid analgesics persist among health care professionals and the public.<sup>34</sup> The major problem is the lack of knowledge concerning the difference between addiction to narcotics and psychological dependence on opioid analgesics for relief of severe and persistent pain. The medical literature confirms that the majority of patients who receive large and extended doses of opioid analgesics for the management of their pain are not, and rarely become, addicts.<sup>35</sup> An abundance of medical literature emphasizes the important difference between the natural, physiological dependence on opioid analgesics that develops and the pathological, psychological dependence that characterizes addiction. It seems

obvious that many physicians and nurses are not being exposed to this important medical information in their training.<sup>36</sup>

Issues of patient tolerance to opioid analgesics are also based on myths and misinformation. The need for higher doses is almost invariably related to a progression of the underlying disease producing the pain. Patients whose disease is stable do not necessarily require an increase in dosage once an effective level of analgesia is achieved and maintained.<sup>37</sup> Finally, the issue of side effects from the sustained use of opioid analgesics has been greatly exaggerated, according to pain management experts. The most common side effects of the drugs recommended for moderate to severe pain that persists are constipation, sedation, and respiratory depression. Prevailing clinical practice guidelines offer a range of effective means of managing these side effects without compromising the goal of pain relief.<sup>38</sup>

There are clear barriers to the assessment and management of pain that are complex and multifaceted; however, they are not insurmountable. These barriers need to be challenged medically and ethically. If medicine is a moral enterprise, then there is an ethical reason, in addition to a medical reason, to challenge these barriers.

### ETHICAL ANALYSIS

Failure to treat a patient's pain has an impact on the deepest ethical roots of the medical profession. The primary responsibility of a physician is to do what is in the best interests of his or her patient. Not to treat the pain and suffering of a patient is to deny the patient basic human dignity. I believe that the failure of physicians to assess and adequately manage pain violates the basic ethical principles of respect for the human person, beneficence, nonmaleficence, and justice.

*Respect for persons* incorporates two ethical convictions: first, that individuals should be treated as autonomous agents; second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.<sup>39</sup> The physician-patient relationship is a covenant that is based on mutual trust. It is a fiduciary relationship that is based on honesty. Ethicists Edmund Pellegrino and David Thomasma, who have written extensively in this area, argue that among the obligations that arise from the physician-patient relationship is technical competence: "The act of the medical professional is inauthentic and a lie unless it fulfills the expectation of technical

competence."<sup>40</sup> This means that patients can expect their physicians to have the technical skills to assess and manage their pain. Unfortunately, most patients believe that the pain medications they receive are all the pain relief that can be safely and effectively administered. Therefore, their continued pain and suffering can be attributed to the inherent limitations of medical science and technology.<sup>41</sup>

This misconception directly relates to the issue of informed consent. Patients have a right to be informed about the advantages and disadvantages of any treatment as well as about any viable alternatives. Patients usually cannot give informed consent because in most cases they have not been given all the options available to manage their pain. One of the basic aspects of the principle of respect for persons is that a person should never be treated simply as a means, but always as an end. To undertreat a patient because of fear of regulatory scrutiny in prescribing opioid analgesics or out of misguided beliefs concerning addiction, dependence, and tolerance is to use patients as a means rather than an end. Because of a basic lack of education, widespread misinformation, and unnecessary fear among physicians, patients are suffering needlessly, their autonomy is compromised, and the basic respect they deserve as human persons is violated because they are allowed to endure pain that can be alleviated.

*Beneficence* involves the obligation to prevent and remove harm to and to promote the good of the person by minimizing possible harm and maximizing possible benefits. Beneficence includes *nonmaleficence*, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim *Primum non nocere*: "Above all do no harm." Allowing a person to endure pain when said pain can be managed and relieved violates the principle of beneficence because one is not preventing pain and therefore not acting in the best interest of the patient. It also violates the principle of nonmaleficence because it is causing harm—and sometimes injury—to the person. Prescribing lower doses of effective analgesics because the physician fears regulatory scrutiny and failing to prescribe adequate doses of opioid analgesics because of misinformation place the patient in a situation in which his or her pain is either undertreated or not treated at all. This comes very close to willfully inflicting pain.

It is true that most pain technologies also have associated side effects. Therefore, the physician must balance the pain relief potential with the potential harm. This can be done through dia-

logue with the patient and/or surrogates. The impact on the caregivers should also be considered in terms of physical and psychological burdens.<sup>42</sup>

Physicians have a moral obligation to do what is good for their patients. Compromising the basic ethical foundations upon which medicine stands is not only destructive for the patient but for society as a whole. Patients do have different pain levels that they can tolerate. It is also true that some people may wish to voluntarily embrace or tolerate suffering for spiritual reasons. For example, Christians believe that suffering can have value and is salvific because the person can thereby experience the love of Christ in a way that recalls Christ's own love as demonstrated in his willing acceptance of death on the cross. Uniting one's suffering with Christ's is perceived as redemptive. However, this notion should never be understood as a glorification of pain and suffering. To endure unnecessary pain and suffering is not only useless, it is also a misrepresentation of the Christian position.<sup>43</sup> The United States Conference of Catholic Bishops, as stated in the *Ethical and Religious Directives for Catholic Health Care Services*, is quite clear that a patient's pain should always be managed effectively. "Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die."<sup>44</sup> In fact, the bishops go so far as to state that "medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death."<sup>45</sup> This is justified under the principle of double effect.<sup>46</sup>

Physicians, as moral agents, have an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately assess and manage pain, for whatever reason, is not in the best interests of the patient. Therefore, if a physician has impediments to his or her reason or free will because of fear or coercion, then that physician has an ethical responsibility to transfer his or her patient to a physician who will do what is demanded by the basic precepts of medicine—that which is for the good of the patient. This may mean having the courage to challenge state medical boards and the federal government to revise their regulations regarding opioid analgesics. Finally, the principle of *justice* recognizes that each person should be treated fairly and equitably and be given his or her due. Every patient has the right to have his or her pain assessed and managed adequately. Ig-

ignorance is not an excuse or a defense because physicians have the responsibility to be adequately trained and up-to-date on medications that will benefit their patients. If that is not possible, then these physicians have an ethical responsibility to consult those in the medical field who are trained to manage pain effectively. To plead ignorance violates the very goals of medicine and the basic duty a physician has to his or her patients.

It has also been reported that two-thirds of pharmacies in minority neighborhoods do not carry adequate medications to treat persons in severe pain. This is a form of racial injustice, according to Sean Morrison, MD, a pain specialist at Mount Sinai School of Medicine in New York. Morrison and his colleagues surveyed New York pharmacies and found that African Americans and Latinos do not get adequate treatment for severe pain when compared with white males. Not only are they less likely to be prescribed painkillers, but when they get a prescription, they may not be able to get it filled at a local pharmacy. In poor neighborhoods pharmacists may decide not to stock opioids because of the risk of being targeted by drug addicts.<sup>47</sup> Pain is color-blind, and all people deserve to have their pain managed. Health care professionals have an ethical obligation to supply medications to their clientele that are needed to manage pain. Justice dictates that similar medical conditions should be treated in a similar manner if at all possible. If there are pain medications that can adequately manage pain for patients and these are prescribed for only some, then failure to do so for all violates the basic tenet of justice.

#### THE NEED FOR REFORM

The issues surrounding pain assessment and management are here to stay. Much has been written about the failure of health care professionals to address this issue, but simple rhetoric without significant reform will accomplish nothing. Immediate changes that will address the issues of pain assessment and management directly and concretely are needed. If health care professionals honestly believe that one of the major goals of

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medicine is the relief of pain and suffering, then untreated and undertreated pain and unnecessary suffering must be alleviated. In addition, if Catholic hospitals believe that patients should be kept free of pain so they can die with dignity and respect, then our failure to address this issue conflicts with the basic core values of the Christian faith. Finally, if we know that our failure to relieve pain

and suffering is causing people to seek other methods, such as physician-assisted suicide, then we must do everything in our power to help our brothers and sisters to deal with their pain and suffering in a way that benefits the good of the whole person. To accomplish this task, I submit the following recommendations.

- Each hospital should formulate a pain management policy that will address the assessment and management of all types of pain. I submit the Pain Management Policy that has been formulated by the Mercy Health System in Philadelphia as a paradigm for other health care facilities (see **Appendix**, p. 27). This policy is grounded in the dignity and respect of every human person and the duty of health care professionals to relieve pain and suffering of patients.

- Each hospital should also form a pain management team. This team would be interdisciplinary and would consist of a physician, nurse, social worker, physical therapist, pharmacist, anesthesiologist, psychiatrist/psychologist, pastoral care member, and someone skilled in alternative therapies. This team would assist physicians who are unable to manage a patient's pain. It would also make health care professionals accountable for pain assessment and management.

- More educational initiatives for health care professionals regarding how pain should be assessed and managed are needed. This begins with medical schools instituting pain assessment and management curricula, residency programs that include practical experience in pain management (hospice, etc.), and the education of attending physicians through continuing medical education courses. This education of medical professionals must include instruction about pain

management, pharmacologic principles, the uses of analgesics, and nonpharmacologic methods.

- More educational initiatives for the public are needed. The public needs to be educated to the fact that it can expect pain to be assessed and managed properly and that they, too, have a role to play in this process. Patients have the responsibility to report the nature, severity, and duration of their pain to their physicians and to expect that their pain be relieved. This can be accomplished by the regular charting of a patient's pain as the "fifth vital sign." It can also be accomplished by the staff instituting a simple assessment tool of a 0 to 10 scale or a "faces" pain rating scale for children and patients who are cognitively impaired.<sup>48</sup>

- Physicians should begin a grassroots movement to challenge the outdated regulations by medical boards and the federal government regarding opioid analgesics. If physicians are required to act in the best interests of their patients, then they will challenge the regulatory agencies that are hostile to effective pain management as both medical professionals and ethical persons.

The issue of pain assessment and management should always be a priority in the medical profession. Reforms are needed from various aspects of society. Health care professionals have the professional and ethical responsibility to see that these reforms are initiated and carried out so that the best interests of patients remain at the forefront of the medical profession. Pain management can be improved if it becomes a priority for all. □

## NOTES

1. Hippocrates, "The Art," reprinted in S. J. Reiser, A. J. Dyck, & W. J. Curran, eds., *Ethics In Medicine*, MIT Press, Cambridge, MA, 1977.
2. American Medical Association, *Code Of Medical Ethics*, Chicago, 1997, p. 20.
3. The SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *Journal of the American Medical Association*, vol. 274, no. 3, 1995, pp. 1591-1598.
4. J. Lynn, J. M. Teno, R. S. Phillips, et al., "Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients," *Annals of Internal Medicine*, vol. 126, no. 2, 1997, pp. 97-106.
5. Institute of Medicine, *Approaching Death: Improving Care at the End of Life*, National Academy Press, Washington, DC, 1997.
6. Joan Teno, Sherry Weitzen, Terrie Wetle, et al., "Research Letter: Persistent Pain in Nursing Home Residents," *Journal of the American Medical Association*, vol. 285, no. 16, 2001, pp. 2081.
7. R. Bernabei, G. Gambassi, K. Lapane, et al., "Management of Pain in Elderly Patients with Cancer," SAGE Study Group: Systematic Assessment of Geriatric Drug Use via Epidemiology, *Journal of the American Medical Association*, vol. 279, no. 23, 1998, pp. 1,877-1,882.
8. B. A. Ferrell, B. R. Ferrell, and L. Rivera, "Pain in Cognitively Impaired Nursing Home Patients," *Journal of Pain Symptom Management*, vol. 10, no. 8, 1995, pp. 591-598. See also E. A. Sengstaken and S. A. King, "The Problems of Pain and Its Detection Among Geriatric Nursing Home Residents," *Journal of the American Geriatric Society*, vol. 41, no. 5, 1993, pp. 541-544.
9. Ben Rich, "An Ethical Analysis of the Barriers to Effective Pain Management," *Cambridge Quarterly of Healthcare Ethics*, vol. 9, 2000, pp. 54-70. See also R. M. Marks and E. J. Sachar, "Undertreatment of Medical Inpatients with Narcotic Analgesics," *Annals of Internal Medicine*, vol. 78, no. 6, 1973, pp. 173-181.
10. Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook, August 1999*, RI.1.2.8. Available at [www.jcaho.org/standard/pm\\_ac.html](http://www.jcaho.org/standard/pm_ac.html).
11. *Washington v. Glucksberg*, 65 U. S. Law Wk. 4669 (1997), 117 S. Ct. 2258; *Vacco v. Quill*, 65 U. S. Law Wk. 4695, 117 S. Ct. 2293 (1997).
12. Justice Sandra Day O'Connor opined that those individuals suffering from a terminal illness accompanied with great pain may presently obtain whatever level of medication determined professionally by a physician will "alleviate that suffering, even to the point of causing unconsciousness and hastening death." See note 19, *Washington v. Glucksberg*, at 4679; *Vacco v. Quill*, at 4700. Justice John Paul Stevens concluded that because palliative care cannot alleviate every degree of pain and suffering for all patients, there may be situations in which a competent person could make an informed judgment or "a rational choice for assisted suicide." See note 19, *Washington v. Glucksberg*, at 4682; *Vacco v. Quill*, at 4703. Also see Marcia Angell, "The Supreme Court and Physician-Assisted Suicide—the Ultimate Right," *New England Journal of Medicine*, vol. 336, 1997, pp. 50-53.
13. The most recent case was that of the family of William Bergman, who sued his physician, Wing Chin, MD, for undertreating Bergman's pain. The family argued that their father was denied proper pain medication during a five-day stay at Eden Medical Center in Castro Valley, CA, where he was admitted in February 1998 for intolerable back pain. During the course of his hospital stay, nurses charted Mr. Bergman's pain levels ranging from 7 to 10 on a scale that awards a 10 to the worst pain imaginable. Mr. Bergman was discharged and died of lung cancer at home three days later under the care of a hospice program. On June 13, 2001, an Alameda County jury awarded \$1.5 million to the family of William Bergman. The jury found Chin guilty of elder abuse and recklessness for failure to give a dying man sufficient medication to relieve his suffering. The jury deadlocked on whether Chin was guilty of malice, oppression, or intentional emotional distress. The family settled its suit against the Eden Medical Center on May 7, 2001, before that trial began. As part of the settlement the hospital has agreed to provide pain management classes to its staff and to physicians who admit patients to the hospital. See

- Maria LaGanga and Terence Monmaney, "Doctor Found Liable in Suit over Pain," *Los Angeles Times*, June 15, 2001, pp. A-1, A-34.
- There have been two previous lawsuits for the undertreatment of pain that have resulted in large damage awards. A North Carolina jury awarded \$15 million in damages in a 1990 lawsuit against a nursing home where a nurse failed to administer prescribed pain medicine to a terminally ill patient. See *Estate of Henry James v. Hillhaven Corp.*, 89 CVS 64 (S.C. Hertford Co., North Carolina, 1991). A judge in a 1997 case in South Carolina awarded \$200,000 in damages for pain and suffering caused by inadequate treatment of a cancer patient's pain. See Susan Okie, "Doctor's Duty to Ease Pain at Issue in California Lawsuit," *Washington Post*, May 7, 2001, p. A-3.
14. Rich, p. 55.
  15. H. Merskey & N. Bogduk, eds., *Classification of Chronic Pain*, 2nd ed., IASP Press, Seattle, 1994, p. xi.
  16. R. A. Sternbach, "Clinical Aspects of Pain," in R. A. Sternbach, ed., *The Psychology of Pain*, Raven Press, New York City, 1978, pp. 15-17.
  17. Recent research suggests that infants may be more vulnerable to the negative effects of pain, which may later affect their neurological development, including the reaction to pain. See B. A. Larsson, "Pain Management in Neonates," *Acta Paediatrica*, vol. 88, 1999, pp. 1,301-1,310.
  18. T. M. Cutson, "Management of Cancer Pain," *Primary Care*, vol. 25, no. 2, 1998, pp. 407-421.
  19. Robert Berkow and Mark Beers, eds., *The Merck Manual of Diagnosis and Therapy*, 17th ed., Merck Research Laboratories, Whitehouse Station, NJ, 1999, p. 1363.
  20. Effective pain management has been shown to shorten hospital stays and reduce costs. For a more detailed analysis, see J. Slack and M. Faut-Callahan, "Pain Management," *Clinical Nursing in North America*, vol. 26, no. 4, 1991, pp. 463-476.
  21. Rich, p. 54.
  22. Catholic Health Association Task Force on Pain Management, "Pain Management: Theological and Ethical Principles Governing the Use of Pain Relief for Dying Patients," *Health Progress*, January-February 1993, pp. 30-39, 65.
  23. Rich, p. 56.
  24. M. I. Donovan and C. Miaskowski, "Striving for A Standard of Pain Relief," *American Journal of Nursing*, vol. 92, no. 3, 1992, pp. 106-107.
  25. Rich, p. 56.
  26. B. A. Rich, "Pain Management: Legal Risks And Ethical Responsibilities," *Journal of Pharmaceutical Care in Pain Symptom Control*, vol. 5, no. 1, 1997, p. 5-20.
  27. For a more detailed analysis of this topic, see R. S. Weiner, "An Interview with John J. Bonica, M.D.," *Pain Practitioner*, vol. 1, 1989, p. 2.
  28. C. S. Hill, "When Will Adequate Pain Treatment Be the Norm?" *Journal of the American Medical Association*, vol. 274, no. 23, 1995, pp. 1,881-1,882.
  29. Rich, p. 59.
  30. Rich, p. 54.
  31. Rich, p. 60. The one state medical board that did discipline a physician for not adequately managing a patient's pain was Oregon. See "Foubister v. Oregon: Doctor Cited for Negligence for Undertreating Pain," *American Medical News*, September 27, 1999, pp. 7, 9.
  32. Rich, p. 60.
  33. Rich, p. 63.
  34. Rich, p. 54.
  35. J. Porter and H. Jick, "Addiction Rare in Patients Treated with Narcotics," *New England Journal of Medicine*, 1980, vol. 320, no. 2, pp. 123.
  36. Rich, p. 64.
  37. Rich, p. 64.
  38. Rich, p. 65. See also Agency of Health Care Policy and Research, *Management of Cancer Pain*, Washington, DC, 1994, pp. 61-65.
  39. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, U. S. Government Printing Office, Washington, DC, 1979, p. B-1.
  40. E. D. Pellegrino and D. C. Thomasma, *A Philosophical Basis of Medical Practice*, Oxford University Press, New York City, 1981, p. 213.
  41. Rich, p. 62.
  42. B. R. Farrell, "Cost Issues Surrounding the Treatment of Cancer Related Pain," *Journal of Pharmaceutical Care for Pain Symptom Control* vol. 1, 1993, p. 9-23.
  43. Illinois Bishops, "Facing the End of Life," *Origins*, June 21, 2001, pp. 106-109.
  44. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, 1995, Directive 61, p. 23.
  45. Directive 61, p. 23.
  46. The principle of double effect supposes that an action produces two effects. One of these effects is something good that may be legitimately intended; the other is an evil that may not be intended. For such an action to be morally acceptable, it must meet four conditions: (1) the action itself is good or indifferent; (2) the good effect is not produced by means of the evil effect; (3) the evil effect is not directly intended; and (4) a proportionate reason supports causing or tolerating the evil effect. For a more detailed analysis see, Gerald Kelly, *Medico-Moral Problems*, The Catholic Hospital Association of the United States and Canada, St. Louis, 1958, pp. 12-16.
  47. Abigail Trafford, "No Pain Relief for Some: Study Points out Inequality in Care," *Philadelphia Inquirer*, September 4, 2000, p. E-3.
  48. A simple 0-10 numeric scale that rates pain from "none" to "worst imaginable" and pain relief from "none" to "total" can be used with most patients older than 7 years of age. Patients should be shown the scale and asked about pain intensity on admission, after each painful procedure, and at least once per shift. With children under 7 years of age and with the cognitively impaired, the same type of scale can be used with representations of human faces instead of numbers.



## APPENDIX: PAIN MANAGEMENT POLICY

### PURPOSE

The purpose of this policy is to state Mercy Health System's commitment to provide a dignified, comprehensive, and collaborative approach to pain management consistent with the *Ethical and Religious Directives for Catholic Health Care*.

### POLICY

Mercy Health System believes that patients have the right to maximal pain relief at all stages of their acute and/or chronic disease processes. We recognize that appropriate pain management is critical in the care of patients and believe that all patients are entitled to a dignified, comprehensive, and collaborative approach to pain management. While we realize that some medicines that alleviate pain in the dying patient may indirectly shorten the patient's life, our goal is to relieve pain and suffering as much as possible.

Although maximal pain relief is the right of all patients, some patients may choose to endure some aspects of their pain as an affirmation of their religious beliefs. The theological foundation of pain management for Christians is rooted in the passion of Christ. "Physical suffering is certainly an unavoidable element of the human condition. According to *Christian teaching, however, suffering, especially during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of painkillers in order to accept voluntarily at least part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (Mt 27:34)."*\*

Respect for the dignity of each patient creates a responsibility for the health care team to respect the free and informed decision by the patient to make medical treatment decisions, including the degree of pain relief. Emphasis of pain management should be on prevention, evaluation, and relief. Comprehensive pain management is a multidisciplinary and collaborative effort that must address physical, psychological, spiritual, and social effects of unrelieved pain.

### PRINCIPLES FOR PAIN MANAGEMENT

- A. The dignity of the human person creates a responsibility for medical professionals to relieve maximally the pain and suffering of patients.
- B. Pain management must be tailored to the specific patient's needs and situation and include a comprehensive assessment of pain and an evaluation of the effectiveness of treatment.
- C. Patients who possess decision-making capacity are the decision-makers for the course of their medical treatment, including the degree of pain relief desired. For patients who lack decision-making capacity, the appropri-

ate surrogate, acting in a compassionate and ethical manner, should be the decision-maker.

- D. Consistent with our policy of informed consent, placebos should not be used to assess or manage pain. Complementary treatment modalities may be used.
- E. All patients will have pain addressed as part of the plan of care and will be taught that pain management is an essential part of treatment.
- F. Discharge instructions will include information about pain as it pertains to the patient's individual situation. This will include the cause(s) of pain, recognizing precipitating and relieving factors, available methods of relief and how to use them (including the importance of safe and effective use of medications), and communication to the physician relating to pain and its management.

### PROCEDURE/GENERAL PAIN MANAGEMENT FOR PATIENTS

- A. Assessment
  1. Each patient will be assessed by the nurse and the health care professional on admission for the presence/absence of pain.
  2. Each patient will be reassessed for the presence/absence of pain prior to, during, and/or following any intervention that may cause pain.
  3. Each patient will be assessed for his/her previous experiences with pain, beliefs about, and preferences for pain assessment.
  4. Every patient will have pain addressed as part of the plan of care.
  5. Every patient will be educated to inform the health care professionals when he/she experiences pain, recognizing that communication of unrelieved pain is essential in helping to manage its relief.
    - Staff will utilize one of the available pain scales in assessing a patient's pain. The scale used will be determined by patient age and cognitive function.
    - Staff will educate patients with regard to prevention of pain or reduction of pain rather than chasing and reducing pain once pain is established.
  6. The patient will be assessed and reassessed for pain. The frequency of assessment and reassessment is based on how well each patient's pain is controlled.
  7. Documentation will reflect assessment, reassessment, education, interventions, and patient outcomes.
- B. Intervention
  1. Response to a patient's complaint of pain will be timely in an attempt to provide quick relief of pain.
  2. If initial interventions are not effective to decrease the pain to a level acceptable to the patient, additional methods of pain relief will be sought. These may include other available pharmacologic methods as well as nonpharmacologic methods.
  3. If relief is suboptimal, the physician will be notified.

\*Congregation for the Doctrine of the Faith, "Declaration of Euthanasia," 1980.

Continued on page 28

## APPENDIX: PAIN MANAGEMENT POLICY (Cont'd.)

- Documentation will reflect additional interventions, reassessments, and patient outcomes.

### C. Pain Management Team Consultation\*

- For hospitalized patients, a Pain Management Consult is recommended in the following situations:
  - For any patient admitted with intractable pain
  - For any patient experiencing increasing pain or decreasing relief of pain by current methods utilized
  - For any patient situation in which the physician desires assistance with pain management for his/her patient

### D. Patient Education

- Patient education is tailored to address the patient's needs, values, abilities, and readiness to learn.
- The goal of patient education is to include the patient in the management of his/her pain.
- Education on pain management includes:
  - A general overview of the causes, a rating scale to communicate pain as well as effectiveness of interventions, and the use of a diary to record occurrences, intensity, treatment, and relief
  - Pharmacological management
  - Nonpharmacological management

### PROCEDURE/GENERAL PAIN MANAGEMENT FOR THE GERIATRIC PATIENT

- The health care professionals caring for the geriatric patient recognize that the geriatric patient:
  - May suffer from multiple, chronic, painful illnesses and may take several medications
  - Is at greater risk for drug-drug and drug-disease interactions
  - Presents unique problems when assessing for pain—these include physiologic, psychological, religious, and cultural changes associated with aging
  - May believe that their pain cannot be relieved and are stoic in reporting their pain, especially the elderly and frail elderly
  - May have cognitive impairment, delirium, and dementia as well as visual and hearing changes
- Health care professionals will adjust their assessments for the geriatric patient to include observations for behavioral cues to pain such as restlessness, agitation, or facial grimacing, recognizing that the absence of behaviors does not negate the presence of pain.
- When appropriate, caregivers or family members will be included when assessment of pain is necessary and will

\* It is suggested that the Pain Management Team consist of a physician, registered nurse, social worker, case manager, physical therapist, pharmacist, a pastoral care member, hospice nurse, anesthesiologist, psychiatrist/psychologist, and someone skilled in alternative therapies.

be asked about pain history, interventions, and outcomes.

### PROCEDURE/GENERAL PAIN MANAGEMENT FOR THE PEDIATRIC PATIENT

- The health care professionals caring for the pediatric patient recognize that the pediatric patient:
  - Determines pain by many factors, including medical/surgical condition, developmental level, emotional and cognitive state, personal concerns, meaning of pain, family issues and attitudes, religion, culture, and environment
  - Requires frequent assessment/reassessment of the presence, amount, intensity, quality, and location of pain
  - Requires prevention or reduction of anticipated pain and, when prevention is not possible, needs prompt alleviation of pain
  - May require the use of a different format for measuring pain, e.g., a "faces" pain rating scale, gestures, quality of cry, or the use of special pain scales
- Health care professionals will adjust their assessments for the pediatric patient to include knowledge of the growth and development level of each individual child.
- The assessment of the child will include a pain history, an evaluation of diagnoses such as infection that could cause the pain or an increase in the pain, evaluation of the pain severity and location, as well as observation of the child and his or her response to the environment.
- When appropriate, patients, caregivers, or other family members will be included when the assessment of a child's pain is necessary.
- All interventions are tailored to the developmental level and personality of the child.

### PROCEDURE/GENERAL PAIN MANAGEMENT FOR THE DYING PATIENT

- Dying patients who possess decision-making capacity are the decision-makers for the course of their medical treatment, including the degree of pain relief desired.
- It is incumbent on health care professionals to make every effort to relieve the pain and suffering of the dying patient even if this requires either intermittent or continued administration of progressively larger doses of opioids. The goal of treatment is to relieve pain and suffering to the fullest extent possible.
- Dying patients should be assured the maximal possible comfort even in the face of impending death as heralded by falling blood pressure, declining rate of respiration, or altered level of consciousness.
- A variety of means for pain relief, including what the patient believes is effective, should be used.
- Establish a relationship of trust with the patient so that the patient will not feel abandoned.

### CONTINUOUS QUALITY IMPROVEMENT

The process of managing pain in our patients and its effectiveness will be monitored, evaluated, and revised to continually improve outcomes.