PAIN MANAGEMENT

Theological and Ethical Principles Governing The Use of Pain Relief for Dying Patients

The management of pain in chronically ill and dying patients is receiving significant attention within the healthcare professions and in many sectors of society that affect and are affected by policies and practices regarding analgesic drugs. Pain management can be an issue through many stages of an illness, not only in terminal stages. Patients have a right to maximal pain relief regardless of the stage of their disease or their life expectancy.

However, medical, ethical, and legal issues related to pain management are of particular concern when it comes to dying patients. Written as part of the Catholic Health Association's project on "Caring for Persons at the End of Life," this article focuses on care of the person who is dying (although the analysis and principles presented here certainly are applicable in any situation in which pain management is at issue).

This article does not attempt to provide a comprehensive clinical study but rather to clarify the theological and ethical considerations, while respecting the clinical realities. Additional reading is suggested in the Box on p. 32.

CHALLENGES AND DEMANDS

Two things are clear about pain in the institutional clinical setting. It is as palpable as it is elusive. "Pain is certainly the result of a biochemical process. But nerve pathways and bodily reflexes do not tell the whole story. Pain is also a subjective experience, perhaps an archetype of subjectivity, felt only within the confines of our individual minds." Although pain has a heavy subjective component, recent research has resulted in enhanced ability to measure the intensity of pain and, on the basis of the intensity and quality of care, frequent transfers, fragmented care, inadequate reimbursement, market forces that drive up costs, and maldistribution of clinical services.

In improving their ability to manage pain, professionals must understand the difference between pain and suffering, acute and chronic pain, and the sensory and emotional aspects of pain. Guiding principles include Church teaching and ethical principles, such as patient self-determination, holistic care, the principle of beneficence, distributive justice, and the common good.

Pain management strategies that will be instrumental in formulating effective responses to these problems include expanding professional and community education, affording pain funding priority, establishing institutional policies and protocols, forming clinical teams, encouraging hospice and home care, and requiring accreditation in pain and symptom management.

Summary

Pain management is a societal problem because of concerns about the use of drugs, the belief that patients are not good judges of the severity of their pain, and an alarming level of ignorance about pain and its treatment among physicians, nurses, and other healthcare providers. The result is that patients suffer pain unnecessarily, even up to the point of their death.

Pain management is also a clinical-practice problem. Courses in pain and symptom management are not readily available to medical and nursing students. And in clinical practice, good pain assessment is not easy to accomplish because pain is so subjective. Fortunately, with education, doctors and nurses can vastly improve their ability to assess and manage patients' pain.

Additional problems in pain management relate to the manner in which healthcare is provided today: an acute disease-oriented model of hospital
pain, to make decisions about appropriate drug or other therapy.

Pain also isolates the person in pain. “Pain seems the quintessential solitary experience. We are probably never more alone than when severe pain invades us. Others appear to go about their business mostly unchanged, thinking that the world is just the same, but we know differently. The isolation of pain is undeniable.”

For both these reasons, pain in its clinical manifestations and the patient in pain present those providing medical care with unexpected challenges to their professional skills and unusual demands on their human sensitivities.

A Societal Problem
Pain management relies heavily on drugs, the clinical use of which can now be wider and more effective because of successful research and development. But it is clear that broad societal concerns about drugs in general can impede the legitimate application of this research. The concerns can be described as:

- Fears of the patient developing a tolerance to narcotic analgesics
- Fears of the patient becoming addicted to narcotic analgesics
- Fears about the side effects of narcotic analgesics
- Fears of hastening the patient’s death

Compounding these fears is a common failure to differentiate between physical dependence on drugs, which is a pharmacological phenomenon, and psychological dependence, which is addiction. In addition, some believe that patients are not good judges of the severity of their pain. Combined, these attitudes and beliefs result in a low priority for pain management.

The reliance on drugs creates risks in pain management, such as suppression of the patient’s respiratory system. Since this complication can lead to death, physicians and nurses naturally worry that they may be morally responsible. The worry is so great that it can seriously inhibit healthcare professionals from managing pain properly.

Further investigation reveals another aspect of the problem of pain management—namely, an alarming ignorance among physicians, nurses, and other healthcare professionals about the nature of pain and its treatment. In the absence of adequate professional training in pain assessment and pain management, they are unable to make full use of the drugs and technologies now available to treat pain successfully.

The law may create a further complication. Even though laws are designed to prevent social misuse of strong opioids such as morphine, they may ultimately inhibit the use of narcotic analgesics for adequate pain treatment even when such use is clinically indicated. The problem stems from the special license doctors are required to have to prescribe drugs, the severe limitations placed on pharmacies in regard to prescribing drugs in emergencies, and the limitations on the amount of pain medication in any one prescription, regardless of the patient’s clinical needs and the pain’s severity.

However, federal law and policy in the United States is supportive of good pain management. State laws may be more restrictive, but even when they are not, physicians’ perceptions or interpretation of the law may be inaccurate and thus impede good practice.

When all these factors come together, the result is that patients suffer pain unnecessarily, even up to the point of their death.

A Clinical Practice Problem
The treatment of pain is a problem for clinical practice because formal courses in pain and symp-
RECOMMENDED READINGS
FOR DEVELOPING POLICIES


M. McCaffery and A. Beebe, Pain: Clinical Manual for Nursing Practice, C. V. Mosby, St. Louis, 1989


World Health Organization, Cancer Pain Relief and Palliative Care, and Palliative Cancer Care: Pain Relief and Management of Other Symptoms, Geneva, 1990
number of patients who have appropriate healthcare coverage.\textsuperscript{11} It is also clear that pain management is not a high priority within the diagnosis-related group (DRG) system. For example, in the case of a cancer patient, where there is a choice between chemotherapy in the very last stages of the disease (when it is useless) and pain treatment, the reimbursement system favors chemotherapy.

And if pain treatment is chosen, a more rigorous standard of justification is required for purposes of reimbursement.

One of the inevitable results of rationing pain management according to ability to pay for it is to force people to consider suicide or assisted suicide as the only alternative to protracted pain inadequately treated.

Market Forces What complicates this situation is the highly competitive and expensive research environment in which the pharmaceutical industry produces the drugs and their application devices used in pain management. The staple drugs used in pain therapy have been available so long that their patents have expired and production costs are not excessive. The real cost is now found in the development and marketing of increasingly effective application devices for use in sophisticated pain therapies.

In the absence of good medical insurance and a more flexible DRG system, few people can afford advanced drug preparations and their accompanying technologies. As a result, accountability for pain management can place Catholic healthcare institutions in a difficult situation as they try to pursue their mission to treat adequately those entrusted to their care and to survive financially in such a market-driven environment.

Maldistribution Finally, pain management can be seriously affected by the uneven distribution of clinical services for the adequate treatment of pain. Depending on where they live, some patients may find certain kinds of pain relief, such as neurosurgical and neurolytic procedures, are not available to them even though they are available to others.

A Worthy Challenge In light of the preceding observations, there can be little doubt that as modern medicine strives to overcome new barriers, it cannot neglect one piece of unfinished business—the ready provision of adequate pain relief to all in need. In a 1986 report, based on 11 studies in so-called developed countries, the World Health Organization concluded that of the nearly 2,000 patients involved, 50 percent to 80 percent failed to receive proper pain treatment.\textsuperscript{13} Untreated or inadequately managed pain has a profound effect on the patient, even to the extent of shortening his or her life or diminishing the person's will to live. Despite this effect, and despite the progress made in understanding and managing pain in terminal illness, the failure to provide adequate medication to keep the patient comfortable continues to be a serious problem for four basic reasons:

- Fear that effective pain treatment necessarily hastens death
- Fear of addiction to narcotic analgesics
- Insufficient education of healthcare professionals in pain and symptom management
- Insufficient public awareness that pain can be effectively controlled

Addressing these deficits will make it possible to realize, 95 percent of the time, the aspiration that "by any reasonable code, freedom from pain should be a basic human right, limited only by our knowledge to achieve it."\textsuperscript{11} The knowledge, the resources, and the technology are readily available. What is lacking is the recognition of the need to take pain seriously, and then the decision, as a matter of sound basic medical practice, to treat it accordingly.

Definitions and Distinctions Pain What too many healthcare professionals do not ask of themselves is what they mean by "pain." "This question is too seldom posed, and I suspect that many patients are being neglected in our medical institutions partly because we attempt to fulfill our professional and personal responsibilities to suffering humanity without a very clear and sufficiently general concept of pain."\textsuperscript{13} Pain has two important features. The first is that it "is a dual phenomenon: one part being the perception of the sensation, and the other the patient's emotional response to it."\textsuperscript{16} The second
feature is that pain can be experienced as either acute, and therefore transient, or as chronic, and therefore persistent. Acute pain is said to have a well-defined time of onset, subjective and objective physical signs, and exaggerated activity of the autonomic nervous system. Chronic pain, in contrast, continues typically beyond a six-month period, with the nervous system accommodating itself accordingly. Objective signs are usually not present in patients with chronic pain even though they exhibit visible changes in their personality, life-style, and functional ability. "Such pain requires an approach that encompasses not only treatment of the causes of the pain but also treatment of its psychological and social consequences." 14

Two other definitions of pain are noteworthy. In 1979 the International Association for the Study of Pain described it as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." With this description as a basis, Dame Cicely Saunders, the founder of hospice, coined the phrase "total pain" in order to embrace something that, in addition to physical pain, included mental, social, and spiritual pain. 18 Considering this enlarged appreciation of pain, one commentator declared, "Failure to remember this complexity is one of the most common reasons why patients fail to achieve adequate symptomatic relief." 19

Suffering There is a point in critical illness when "hopelessness becomes more intolerable than pain." 20 At that point, the difference between pain and suffering becomes apparent. "Not everyone with pain is also suffering. Suffering is a personal matter. It is as much a function of the value of individuals as it is of its physical causes. For example, two people may have the same physical condition, but only one of them may be suffering with it." 21 "The word pain should be used to refer to the perception of a nociceptive [harmful, painful] stimulus in the peripheral or central nervous system and associated with an affective response." 22

Daniel Callahan has defined suffering as the reasonable hopelessness people experience with the prospect of unrelieved pain or when they conclude that their illness is such as to render life devoid of meaning. 23 Suffering is more global than pain and is essentially synonymous with an impaired quality of life. "Serious, and certainly prolonged, illness brings with it social disruptions in the life of the patient, not to mention family crises, financial worries, premonitions of death, and the concerns that arise from the manifestation of new symptoms and their possible significance." 24

In the clinical setting, one of the main dangers in neglecting the differences between pain and
suffering is the tendency to concentrate on the physical symptoms as though they represented the patient’s only distress. That frequently results in patients who are physically more comfortable because of their pain therapy, but whose suffering may continue unabated. “Indeed, there are some patients who suffer serious depression once their pain has been alleviated.”

Moreover, clinical evidence indicates that patients can actually enjoy life more because of, not despite, their pain. One explanation for this counterintuitive finding is that “pain serves to focus and confine anxiety or depression by directing the patient’s attention elsewhere.” From this experience, it does not follow that pain is a good—only that in exceptional cases it may distract attention from a larger, overwhelming suffering.

The distinction between pain and suffering has particular and urgent significance when it comes to managing the pain of dying patients. In the face of the hopelessness that defines suffering, Callahan believes that “a medicine that can only hold out the prospect of prolonging life in order to extend, but not relieve, suffering has come to the end of its resources and purpose.” Failure to observe the distinction between pain and suffering in the treatment of the dying may allow us to continue aggressively with life-sustaining but medically futile treatment in the belief that, as long as pain management protects patients from any physical distress, it protects them from all distress. In other words, the distinction forces us to realize that the availability of pain treatment does not in itself justify the continuation of life-sustaining but medically futile care. The continuation of such care may well cause extreme suffering to those same patients, the majority of whom will be dying patients.

GUIDING PRINCIPLES

Pain management in the care of the dying is clearly a delicate and complex matter, which at all times needs to be informed by the following principles.

Church Teaching: The Church in its formal teaching recognizes the role and the burden of pain and suffering for Christians. Physical pain, while it may serve as a useful warning, often exceeds its own usefulness and causes severe anguish to the patient.

Indeed, for some persons, suffering at the end of life may be experienced as a participation in Christ’s passion and thus as redemptive. Some patients may choose to limit the use of pain medication in order to voluntarily associate their suffering with that of Christ.

In the words of the Vatican Declaration on Euthanasia:

“Indeed, for some persons, suffering at the end of life may be experienced as a participation in Christ’s passion and thus as redemptive. Some patients may choose to limit the use of pain medication in order to voluntarily associate their suffering with that of Christ.”

The document states further that the intensive use of painkillers is permitted even if it is foreseen that their use will shorten life.

Ethical Principles

- Patient self-determination. Patient self-determination, or control of treatment decisions, lies at the heart of all good medical care simply because it is derived from the dignity of the human person and the respect we owe this dignity. In practical terms, respect for patient autonomy is critical to pain treatment if the patient’s own report of pain is going to be taken seriously.

In the case of patients in severe pain, balancing their autonomy with what is clinically judged to be in their best interests is not easy. Adding to the difficulty is that the more high-tech the pain therapy, the greater its complexity. Clinical complexity and patient autonomy are not easily reconciled. “Whenever possible, the patient together with the responsible healthcare professional should determine the degree and type of palliation and pain relief. When the patient cannot do so, the surrogate should make that determination with the professional.”

Informed consent to treatment is an exercise of patient self-determination. To give informed con-
sent to any pain treatment, patients need information about its advantages and disadvantages, as well as any available alternatives. Patients in pain or those being treated for pain with narcotic analgesics may have a seriously compromised capacity to make informed decisions. Under those circumstances, it may be necessary for the surrogate to make decisions on behalf of the patient, guided by appropriate information from the professional care givers.

- **Holistic care.** Holistic care connotes the care not only of the "patient" but also of the person who happens in this situation to be a patient. A holistic approach is critical to pain management in the care of the dying if care givers are to address effectively the patients' suffering, as well as their pain. It is premised on respect for human dignity and the rights of individuals to determine directly, or indirectly through their surrogate, the course of treatment.

When treatment is focused on one diseased organ or system, it is not easy to meet a distinctive clinical challenge presented by proper pain management: whether it is possible "to respect the decision-making ability of a patient in his present capacity, and yet believe, as a healthcare provider, that it is not in the patient's best interest to assign him responsibility for his pain management."

**PRINCIPLES OF PRUDENT ACTION**

**Principle of Double Effect**

One of the perceived risks in pain management is suppression of the respiratory system, leading possibly to the patient's death. The concern is so great that it can serious-
ly inhibit healthcare professionals' willingness to relieve pain.

Traditionally, ethical teaching has offered relief from this worry by applying the principle of double effect. According to this principle, a particular course of action may have outcomes other than the one intended. It is permissible to pursue our intended goal—in this case, the relief of pain—even though, by doing this, we run the risk of an unintended outcome—namely, the patient's death.

This issue was addressed by Pope Pius XII in 1957. Asked by a group of doctors whether it is morally permissible, using narcotic analgesics, to suppress pain and consciousness, even when it is clear their use will shorten life, Pius replied: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes."

However, current medical research raises questions about the need to apply the principle of double effect to pain management. As the chair of the Wisconsin Cancer Pain Initiative stated in correspondence to the Council of Ethical and Judicial Affairs of the American Medical Association, "Death from respiratory depression is exceedingly rare in patients with cancer who chronically receive opioid analgesics for pain. As a person nears death, there is deterioration in respiratory function. However, these respiratory changes should not be confused with the effects of opioids."

Consciousness The principle of double effect can also be helpful in addressing the question of bal-

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| b. The time interval and amount of drug in mg/hour for incremental dose increase. |
| c. That incremental dose increases are to be based on pain or symptom assessment and not vital sign parameters, except in patients without DNR order. |
| d. A maximum or "cap" dose is not required. |
| e. The conditions under which he/she wishes to be notified. |
| 4. The narcotic order shall be renewed every 72 hours. |
| 5. Telephone and/or verbal orders are not acceptable when initiating or changing the order. |
| 6. The physician is advised to assess the efficacy of narcotic treatment on a frequent basis. |

**Nursing Responsibility**

1. Only staff RNs who have passed a pharmacology certification exam may administer narcotics.
2. If IV/SQ continuous infusion narcotics are ordered, they shall always be administered via an infusion pump. The IV tubing proximal to the infusion device shall be clearly identified signifying that this line is infusing a narcotic.
3. An administrative nurse, clinical nurse specialist, or other designee shall cosign the order.
4. The pharmacy is to be notified at least one hour before the next bag of narcotic infusion is needed to allow for drug preparation.
5. The nurse administering the narcotic shall:
   a. Increase the medication by the amount specified in mg/hour within the given time increments should the patient continue to experience pain or other distressing symptoms.
   b. Assess the efficacy of treatment on a frequent basis and inform the physician when pain or other distressing symptoms are not relieved.
   c. Alert the physician when the maximum dose of the narcotic specified above (B, 3) has been given.
   d. Not discontinue the narcotic in the event the narcotic order is not renewed in 72 hours according to policy, but rather notify the physician immediately so that a renewal order may be written at once.
   e. Discontinue the narcotic only upon the physician's order.
   f. Document the initiation or titration of the IV infusion on the Continuous Narcotic Administration Record, on the Nurses Notes, and on the Controlled Substance Audit Sheet.
6. Two nurses shall co-sign any wastage of unused narcotic solution on the Controlled Substance Administration Record per Nursing Service Policy. Any narcotic being returned to pharmacy shall also be documented on this record.
7. Vital signs may be obtained to assess the patient's status in the dying process, but should not influence decisions about administering narcotics in the presence of continued pain or other distressing symptoms for which the narcotic is an accepted treatment. Exceptions are patients who request no DNR order. Parameters of vital signs shall limit the administration of narcotics, to be determined by the physician.
8. The narcotics administered by continuous infusion may include but are not limited to:
   a. Morphine sulphate
   b. Hydromorphone (Dilaudid)
   c. Methadone
   d. Fentanyl

Effective date of policy: [Approved Date]
Revised date: [Revised Date]
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Fear of pain is not so much related to pain itself as to its neglect. And the love of one’s neighbor should become a priority for institutional policy.

Pain Management Strategies

So far this article has reviewed the problems of pain management in the care of the dying and the principles that should guide institutional responses to these problems. It remains now to discuss some key strategies that will be instrumental in formulating effective responses.

Education

Promote professional education about pain and its assessment and treatment for medical, nursing, and pharmacy students; and continuing education for practicing professionals, including physicians, nurses, pharmacists, and social workers. Through community education programs, promote public education about pain, pain treatments, drug addiction, and ways to discuss pain with healthcare professionals for patients, their families, and the general public.

Funding Priority

While establishing pain control as an educational priority for students and practitioners, facilities must also make pain control a priority for funding and budgetary purposes. As John C. Liebeskind and Ronald Melzack have pointed out, ideas for educational programs in pain management are plentiful, but the money to implement them is lacking. It will continue to be lacking until pain management is accorded the priority it deserves.

Policies and Protocols

Develop institutional policies and protocols for pain management that include the right of the patient or surrogate to participate in treatment decisions; establish the clinical parameters of pain treatment, including an operational definition of pain, standards of pain prescription, and methods of assessment; and the justification of pain relief as an end in itself, for which healthcare professionals have a moral and professional responsibility to their patients. "To

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ance between pain and consciousness. Any person experiencing severe pain will be so distracted that fruitful use of consciousness is impossible. Yet, "It is not right," Pius XII declared, "to deprive the dying person of consciousness without a serious reason."

Sometimes the dose needed to manage pain is sufficient to cause the loss of consciousness. However, the use of small amounts of amphetamines to reverse loss of consciousness has become accepted medical practice.

If one’s intent is to manage pain and the dose given is sufficient for and directed to that end, there need not be a moral concern. A serious moral problem arises only if dosages are prescribed with the intent of making the patient unconscious or if insufficient care is taken in the determination and maintenance of the required dose. Often, when a person becomes somnolent, the dose can be reduced slightly without affecting comfort. If medication is carefully prescribed to manage pain, loss of consciousness, like respiratory depression, is not a moral problem. Medical staff, therefore, need not inadequately respond to pain out of a fear the patient will become unconscious.

Principle of Beneficence

The principle of beneficence—doing what is good for the patient—has particular relevance to pain management. To be applied effectively, this principle requires unusual moral and clinical sensitivity on the part of healthcare professionals. As the Hastings Center guidelines point out, the particular situation of individual patients must be considered carefully in providing pain relief and in securing the level of function they desire in the process of dying.

In its most sensitive application to pain management in the care of dying patients, the principle of beneficence means "that professionals will listen attentively to them and provide emotional reassurance, physical contact and social support."

Distributive Justice

In mobilizing our resources to provide pain management for dying persons, distributive justice, or the comparative treatment of individuals according to need, is central. Given that the universal fear of pain is not so much related to pain itself as to its neglect by care givers, the assurance that individuals will be treated according to need should be recognized as a matter of the common good.

In a similar vein, the understanding that the provision of pain treatment is justified and motivated by love of neighbor, a principle central to the Christian mission of our institutions, reflects the priority pain management deserves.

Finally, the provision of something so central to the common good

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allow a patient to experience unbearable pain or suffering is unethical medical practice.  

Clinical Teams  Establish internal or institutional mechanisms for pain and symptom management, such as clinical teams. Clinical teams can address two critical needs in pain management in the institutional and interinstitutional setting. The first is the need for accountability; the second is the need to compensate for the increased fragmentation of care. Cancer patients, for instance, are likely to deal with as many as 10 consultants or to move from one setting to another, such as a hospital to a nursing home. Clinical teams are an effective antidote to fragmentation, while also promoting accountability.

Hospice and Home Care  Encourage hospice and home healthcare. "Hospice care provides not only attention to the physical pain and suffering of a dying person, but also to emotional and spiritual pain and suffering." Moreover, the close involvement of hospices with hospitals has made the hospice concept of terminal and palliative care better known and accepted.

Regarding home healthcare and pain management, two points should be made. One, the increasing use of subcutaneous, intravenous, epidural, and intrathecal routes for the administration of drugs for pain relief has meant that patients can be discharged from hospital and continue their treatment at home. Two, hospice care programs are available in the home setting.

Accreditation  Require accreditation in pain and symptom management to promote an institutional and professional standard of care and thereby establish credibility in this area. This, in turn, provides the criteria for quality assurance in the provision of pain relief.

Transcendence of Pain

There is nothing good in pain and suffering, as such. Both are an assault on the human body and mind, or symptoms of an assault that may eventually be fatal. Patients, their families, and healthcare professionals should not, therefore, pursue pain as a good, even when it is unavoidable.

But in describing suffering as "a manifestation of the incompleteness of creation," theologian Daniel C. Maguire suggests that scientists and clinicians working to heal it are like co-redeemers. The patient frequently reaches a point where pain and suffering are without meaning, inexplicable. One way to deal with the inexplicable is to transcend it. This is what theology permits us to do, providing the intellectual and psychological justification for understanding pain differently and converting it to a wholesome purpose.

Applied practically to healthcare professionals, the theology of suffering is analogous to palliative care, defined as "the active and compassionate care of the sick person at a time when the goals of cure and prolongation of life are no longer possible or most important." Used by the suffering patient, it allows him or her to move beyond the physical destructiveness of pain and embrace it as an opportunity to enjoy the providence of a God who loves personally.

NOTES

1. The foundational background for this project is found in Care of the Dying: A Catholic Perspective, Catholic Health Association, St. Louis, 1993.
17. Foley, "The Treatment of Cancer Pain."

Continued on page 65
The steering committee’s long-term goal is to help each FHS organization make well-informed technology decisions that meet community needs, conform with physicians’ priorities, and improve the quality of patient care.

IMPLEMENTATION

The Technology Task Force’s conclusions and recommendations were presented at the 1992 FHS Futures Forum, an annual meeting for the system’s senior leaders that focuses on emerging issues and trends. These recommendations included designation of a technology steering committee with a budget of less than $50,000 for fiscal year 1993. The funding request included monies for consultative services by technology experts, access to data bases and literature search files, and a system technology conference. System and hospital leaders adopted the recommendations and are now implementing them.

Beginning in July 1992, steering committee members were selected, and they held their first meeting in October. The committee is drafting a vision statement, revising the technology priority list, and selecting technology studies. It is also working to integrate the hospitals’ technology purchases and to provide better information about current and future technologies. Its long-term goal is to help each FHS organization make well-informed technology decisions that meet community needs, conform with physicians’ priorities, and improve the quality of patient care.