

# PAIN MANAGEMENT

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

*This article was prepared by a special Task Force on Pain Management, a group of experts convened by the Catholic Health Association, St. Louis.*

**T**he 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.<sup>1</sup> 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."<sup>2</sup> 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

**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

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.

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."<sup>3</sup>

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<sup>4</sup>
- Fears of hastening the patient's death<sup>5</sup>

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.<sup>6</sup>

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 anal-

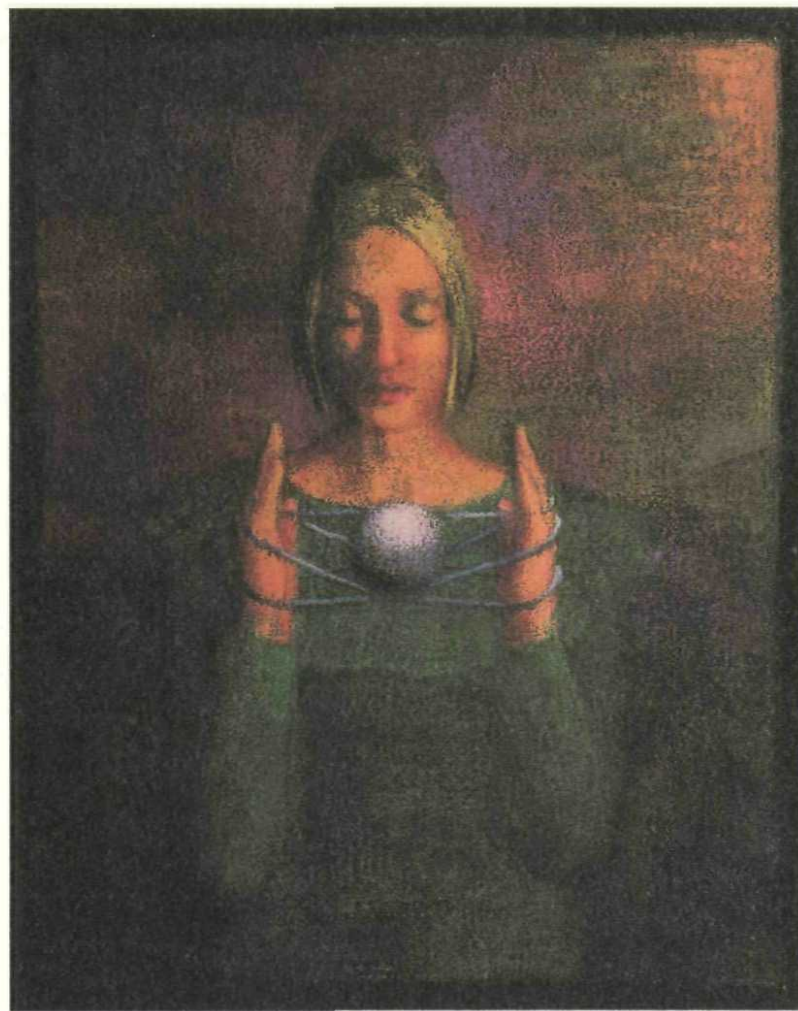
gesics for adequate pain treatment even when such use is clinically indicated. The problem stems from the special license doctors are required to have to prescribe drugs, the severe limitations placed on pharmacies in regard to prescribing drugs in emergencies, and the limitations on the amount of pain 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.<sup>7</sup> 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-



Danuta Jarecka

tom management are not readily available to medical and nursing students. For example, there are no formal education programs in cancer pain management for medical students and house staff. The medical board examinations do not include questions on the subject, and only a few cancer centers or major medical teaching programs have staff experts in pain and symptom management.

Regrettably, the courses that are provided receive mixed reviews. A recent survey of physicians treating cancer patients, for example, revealed that fewer than 11 percent of the respondents thought medical school training in pain management was "excellent" or "good"; only 27 percent thought training in pain management during their residency was either "excellent" or "good."<sup>8</sup>

Practicing physicians and nurses are just as critical about the quality of pain management in their daily work. In the same survey, only 50 percent of those responding said pain management was "good" or "very good" in their clinical setting. In addition, 31 percent of the respondents said they would not prescribe the maximum dosage of pain killers unless the patient had less than six months to live.

Proper pain management hinges on good pain assessment. In clinical practice, however, good pain assessment is not easy to accomplish. Pain is so subjective that the availability of a uniform means of assessing it is probably unlikely. There are, however, practical principles that should direct every pain assessment so it can be disease specific and account for the treatment the patient is receiving. To the extent possible, pain assessment should also be patient specific to account for a personal history of pain, capacity to commu-

nicate the experience of pain, and culturally learned attitudes toward pain and its treatment.

If nothing else, these considerations indicate the serious need for much better medical education in pain and symptom management. Fortunately, practicing pain specialists are convinced, based on their experience, that, with proper education, doctors and nurses can vastly improve their ability to assess and manage their patients' pain.

### INSTITUTIONAL DIMENSIONS

A number of factors, related to the manner in which healthcare is provided today, create additional problems in pain management.

**Acute, Disease-oriented Model** According to the authors of the Wisconsin Cancer Pain Initiative,<sup>9</sup> hospitals operate on the basis of an acute, disease-oriented model. Their overriding goal is to cure. With such a model, they run a high risk of overlooking their accountability for pain management, the central purpose of which is perceived as palliative. This probably explains why pain control is not viewed as a reason for admission to a hospital and why hospitals generally have inadequate provisions for the medical support of pain management, symptom control, and psychological distress caused by pain.<sup>10</sup> Actually, adequate pain relief hastens recovery in acute conditions (e.g., surgery) and helps get patients out of the hospital sooner.

**Patient Transfers** Another area where institutional accountability must be addressed is in coordinating the care of patients as they move between different settings, such as the nursing home, the hospital, and a home-based hospice. With increasing longevity and more effective therapies, patients are more likely to be treated in more than one setting in the course of a painful illness.

**Medical Specialization** Similarly, the treatment of painful diseases like cancer has become highly specialized so that it is common for patients to be treated by several specialists during their illness. Under these circumstances, where the provision of care is so fragmented and patients and families are receiving clinical information from several physicians, proper pain management is easily overlooked.

**Reimbursement** In a broader sense, reimbursement causes serious concern about institutional accountability for adequate pain management. Much of the problem lies with inadequate medical insurance coverage. For example, even though studies show that cancer patients need two routes of drug administration for adequate pain relief before death, there is no reimbursement provision to pay for this. "The high cost of pumps, drugs, and home care supervision on a 24-hour basis makes this care only available to a limited

## RECOMMENDED READINGS FOR DEVELOPING POLICIES

- American Pain Society, *Principles of Analgesic Use in the Treatment of Acute Pain and Chronic Cancer Pain: A Concise Guide to Medical Practice*, Washington, DC, 1989
- M. McCaffery and A. Beebe, *Pain: Clinical Manual for Nursing Practice*, C. V. Mosby, St. Louis, 1989
- N. L. Schechter, A. Altman, and S. Weisman, eds., *Report of the Consensus Conference on the Management of Pain in Childhood Cancer*, American Academy of Pediatrics, vol. 86 (Suppl.), World Health Organization, Geneva, November 1990
- 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."<sup>11</sup>

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

# Adequate pain relief helps get patients out of the hospital sooner.

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.<sup>12</sup>

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."<sup>13</sup> 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."<sup>14</sup>

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."<sup>15</sup> 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."<sup>16</sup>

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."<sup>17</sup> 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.<sup>18</sup> 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 ade-

quate symptomatic relief."<sup>19</sup>

**Suffering** There is a point in critical illness when "hopelessness becomes more intolerable than pain."<sup>20</sup> 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."<sup>21</sup> "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."<sup>22</sup>

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.<sup>23</sup> 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."<sup>24</sup>

In the clinical setting, one of the main dangers in neglecting the differences between pain and

## PAIN MANAGEMENT TASK FORCE

**John H. Burrows, MD**

St. John's Hospital  
Detroit

**Margaret Coloney**

Center for Hope Hospice  
Roselle, NJ

**Marilyn Fisher**

Cope Center for Pain & Stress Management  
Lourdes Hospital  
Binghamton, NY

**Rev. Lawrence T. Reilly, STD**

Sisters of Providence Corporations  
Seattle

**Alice O'Shaughnessy, MD**

Mercy Hospice  
Sea Cliff, NY

**CRITICAL READERS**

**June L. Dahl, PhD**

Wisconsin Cancer Pain Initiative  
Madison

**David E. Joranson**

University of Wisconsin-Madison  
Madison

**Rev. John F. Tuohey, PhD**

Catholic Health Association of the United States  
St. Louis

**PRINCIPAL WRITER**

**T. Patrick Hill**

Choice in Dying  
New York City

**GENERAL EDITOR**

**Sr. Diana Bader, OP, PhD**

Sisters of Providence Health System  
Seattle

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."<sup>25</sup>

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."<sup>26</sup> 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."<sup>27</sup> 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

# Patient self-determination lies at the heart of all good medical care.

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*:

Human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semi-consciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor's advice.<sup>28</sup>

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."<sup>29</sup>

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."<sup>30</sup>

**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-

**PALLIATIVE CARE AND CONTROL OF PAIN**

- I. Mission of the Organization  
(To be formulated by the facility.)
- II. General Guidelines for Pain Assessment and Relief
  - A. Establish a relationship of trust with the patient, accepting the patient's report of pain.
  - B. Instruct the patient about pain—its causes, intensity, when and how it will occur, how to get relief, how to prevent it.
  - C. Emphasize prevention; use pain relief measures before the pain occurs or increases.
  - D. Use a variety of means for pain relief, including what the patient believes is effective.
  - E. Do not abandon the patient.
- III. 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 dying patients.
  - B. 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 in the final stage of life. For patients who lack decision-making capacity, an appropriate surrogate shall be the decision maker.
  - C. It is incumbent on healthcare 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 narcotics. The goal of treatment is to relieve pain and suffering to the fullest extent possible.
  - D. 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 respira-

tions, or altered level of consciousness.

- E. All patients admitted to \_\_\_\_\_ will have access to effective palliative care and pain management regardless of ability to pay.

IV. Implementation

- A. Patient Selection Criteria: Candidates for palliative care prescribed in this policy are:
  - 1. Patients who are experiencing symptoms causing pain, discomfort, or distress for which narcotics are accepted treatment.
  - 2. Ordinarily, patients who have a current do-not-resuscitate order. Exceptions exist when the pain episode is transient.
- B. Protocol for Ordering, Administering, and Documenting *Physician Responsibility*
  - 1. The rationale and goals of narcotic therapy for the dying patient shall be documented in the Progress Notes of the patient's medical record. This shall include a statement that the patient (or appropriate surrogate) agrees with this therapy. This note is written by the attending physician, or by the house officer with the verbal concurrence of the attending or chief resident. The attending shall concur with this note within 24 hours by signing the house officer's Progress Note.
  - 2. The physician's order is written by the attending physician, or by the house officer with the verbal concurrence of the attending or chief resident. In the latter case, the attending shall sign the order within 24 hours.
  - 3. The physician's order shall specify:
    - a. The amount of drug; the amount of diluent.

Adapted from "Administration of Narcotics for the Dying Patient," UCLA Medical Center, Los Angeles, July 1, 1990. See also "Principles of Analgesic Use in the Treatment of Acute Pain and Chronic Pain," American Pain Society, 5700 Old Orchard Road, Skokie, IL 60077-1024.

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 circum-

stances, this does not prevent the carrying out of other religious and moral duties: Yes."<sup>31</sup>

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."<sup>32</sup>

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

## IN THE DYING PATIENT: A SAMPLE POLICY

- 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
- \_\_\_\_\_ approved
- Effective date of policy:  
Revised date:



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."<sup>33</sup>

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.<sup>34</sup>

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."<sup>35</sup>

**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 treat-

# Fear of pain

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related to pain itself

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ed 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

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.<sup>36</sup> 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

allow a patient to experience unbearable pain or suffering is unethical medical practice."<sup>37</sup> (See recommended readings on developing policies in the Box on p. 32.)

**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."<sup>38</sup> 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.<sup>39</sup> 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."<sup>40</sup> 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.<sup>41</sup> □

## NOTES

1. The foundational background for this project is found in *Care of the Dying: A Catholic Perspective*, Catholic Health Association, St. Louis, 1993.
2. David B. Morris, *The Culture of Pain*, University of California Press, Berkeley, 1991, p. 14.
3. Morris, pp. 37-38.
4. "The Cancer Pain Problem: Wisconsin's Response," *Journal of Pain and Symptom Management*, March 1988, p. S3.
5. D. E. Joranson et al., "Opioids for Chronic Cancer and Non-Cancer Pain: A Survey of State Medical Board Members," *Federation Bulletin: Journal of Medical Licensure and Discipline*, June 1992, pp. 15-49.
6. "The Cancer Pain Problem," p. S3.
7. Acute Pain Management Guideline Panel, "Acute Pain Management in Adults: Operative Procedures; Quick Reference Guide for Clinicians," AHCPR Pub. No. 92-0019, Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Rockville, MD, 1992.
8. "Hospitals, Physicians Paying More Attention to Pain Control," *Medical Ethics Advisor*, January 1992, p. 7.
9. "The Cancer Pain Problem," p. F3.
10. Kathleen M. Foley, "The Relationship of Pain and Symptom Management to Patient's Request for Physician-assisted Suicide," *Journal of Pain and Symptom Management*, June 1991, p. 292.
11. Foley, "The Relationship of Pain and Symptom Management," p. 292.
12. "Cancer Pain Relief," World Health Organization, Geneva, 1986, p. 8.
13. John C. Liebeskind and Ronald Melzack, "The International Pain Foundation: Meeting a Need for Education in Pain Management," *Journal of Pain and Symptom Management*, March 1988, pp. 131-132.
14. Rem B. Edwards, "Pain and the Ethics of Pain Management," *Society of Scientific Medicine*, vol. 18, no. 6, 1984, p. 515.
15. Robert G. Twycross, "The Relief of Pain," in Cicely Saunders ed., *The Management of Terminal Malignant Disease*, 2d ed., Edward Arnold, London, 1984, p. 64.
16. Kathleen M. Foley, "The Treatment of Cancer Pain," *New England Journal of Medicine*, July 11, 1985, p. 85.
17. Foley, "The Treatment of Cancer Pain."
18. Cicely Saunders, "The Philosophy of Terminal Care," in Saunders, ed., *The Management of Terminal Malignant Disease*, p. 232.
19. Matthew E. Connolly, "Alternative to Euthanasia: Pain Management," *Issues in Law and Medicine*, Spring 1989, p. 499.

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## DEVELOPING A MODEL FOR TECHNOLOGY ASSESSMENT

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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.

biostimulation, photodynamic therapy, laser diagnostics, and tissue welding.

The task force recommended selecting lasers with multiple applications for start-up programs, monitoring lasers with low volumes for possible discontinuation or replacement, and developing target volume and performance standards as key elements of existing and new laser programs.

Franciscan Health Group-East has applied the model to evaluate linear accelerators. Franciscan Health Services Northwest has also used the model numerous times, applying it to magnetic resonance imaging (MRI), computed tomography (CT), laparoendoscopic procedures, and waste management. Each of these technologies is being considered by one or more of the FHS Northwest hospitals. These studies have resulted in three hospitals sharing MRI service and two hospitals undertaking laparoendoscopic procedures. The CT study, on the other hand, helped convince management that an "ultrafast" CT should not be acquired.

Each study has assessed different issues and tested different outcomes; thus the model has changed each time, but the analytic framework, the work flows identified in the Figure, have remained the same.

### 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. □

## PAIN MANAGEMENT

Continued from page 39

20. T. Patrick Hill and David Shirley, *A Good Death*, Addison-Wesley, Reading, MA, 1992, p. 140.
21. *Care of the Dying*, p. 11.
22. Kathleen M. Foley, "The Cancer Pain Patient," *Journal of Pain and Symptom Management*, January 1988, p. S16.
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24. Hill and Shirley, p. 155.
25. Hill and Shirley, p. 155.
26. Hill and Shirley, p. 155.
27. Callahan, p. 178.
28. Vatican Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, June 26, 1980.
29. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying: A Report by the Hastings Center*, Briarcliff Manor, NY, 1987, p. 73.
30. Daniel C. Stoltzfus and John M. Stamos, "An Appraisal of the Ethical Issues in High Technology Cancer Pain Relief," *Journal of Clinical Ethics*, Summer 1991, p. 114.
31. Pope Pius XII, address of February 24, 1957, AAS 47 (1957), p. 147.
32. "Clinically significant respiratory depression rarely occurs in patients with severe cancer pain, even those taking large doses of morphine because pain is a powerful antagonist to this effect of opioids. Furthermore, tolerance to the respiratory depressant effects of morphine develops rapidly. I know of no evidence that chronic ventilatory failure is either common or severe in patients with severe cancer pain who have been titrated to receive repeated large doses of morphine." June L. Dahl, private correspondence, and D. E. Joranson, in Kathleen M. Foley, ed., *Advances in Pain Research and Therapy*, vol. 16, Raven Press, New York City, 1990.
33. *Declaration on Euthanasia*.
34. *Guidelines*, p. 71.
35. Pope Pius XII, p. 71.
36. Liebeskind and Melzack, p. 132.
37. Sydney H. Wanzer et al., "The Physician's Responsibility toward Hopelessly Ill Patients," *New England Journal of Medicine*, March 30, 1989, p. 847.
38. *Guidelines*, p. 116.
39. Daniel C. Maguire, *Death by Choice*, Doubleday, Garden City, NY, 1984, p. 197.
40. Elizabeth Latimer, "Auditing the Hospital Care of Dying Patients," *Journal of Palliative Care*, vol. 7, no. 1, 1991, p. 13.
41. For a fuller treatment of the theological perspective, see *Care of the Dying*, particularly Part IV.