

Alternative to Euthanasia: Pain Management

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Euthanasia is increasingly being touted as a beguilingly simple solution to the tragedy of a badly managed terminal illness. However, critical examination reveals that, far from being any kind of worthwhile solution, euthanasia turns out to be a Pandora's Box of woes far worse than those which now confront us.

It should be emphasized that opposition to euthanasia does not mean that one is committed to maintaining existence to the last possible gasp, nor that one is obligated to apply every available form of life support to those who are clearly dying. Providing therapy aimed at alleviation rather than cure while a disease runs its inevitable course is *not* the same as wilfully ending a life. The intention of such palliative care is not to bring about the death of the patient. Consequently, to call such treatment "passive euthanasia" is to brandish an oxymoron of the most unhelpful kind.

The call for euthanasia is often based upon the notion that the terminally ill are bound to suffer horribly, and that this suffering can only be relieved by death itself. Like all lies and half truths, this is in danger of being believed, if for no other reason than because it is so often and so loudly trumpeted by misinformed persons in the proeuthanasia lobby. It cannot be stated firmly enough that this is a false premise.

It is false in the sense that it does not have to be so, for there is already much

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that can be done which will effectively alleviate suffering. The purpose of this article is to demonstrate that pain management provides the basis for a valid alternative to euthanasia.

The questions that must be addressed are these: What is our duty to persons who are terminally ill? Should all persons who are terminally ill receive pain management? Where can pain management be provided? What is the consequence if pain management is not provided?

What is Our Duty to Persons Who are Terminally Ill?

Considering first our duty to persons who are terminally ill, it is of supreme irony that while terminal care has always been a major concern of physicians through the centuries, the explosive triumph of medical knowledge in this generation has served to focus attention in directions that have largely excluded the dying.¹ Such care as is offered means, in the popular mind, a hospice in the form of a gloomy building hidden behind high walls where hushed attendants wait, impotent and silent, until death releases their charges from further pain and suffering.

The genius of the contribution of Dr. Cicely Saunders has not been the re-creation of the hospice as a less oppressive place for terminal care. The credit for that lies with the nuns of Ireland under the leadership of Mother Mary Aikenhead.² Rather it was to reclaim scientific medicine for the care of pain, to show that academic excellence, critical research, and teaching all belong to the care of the whole person in his final days every bit as much as they do in any other phase of the fight against

¹Mount, *Hospice Care*, 73 J. ROYAL SOC. MED. 471, 471 (1980).

²R. TWYLCROSS & S. LACK, THERAPEUTICS IN TERMINAL CARE 9 (1984).

disease.³

Such has been the magnitude of her contribution that the stage has been reached where care for persons who are terminally ill rests on a solid bedrock of scientific observation, and terminal care is at last resuming its rightful place in mainstream medicine. No longer a field reserved for retired and moribund physicians, it is attracting an ever-increasing flow of young and academically orientated physicians.

In meeting the challenge of care for persons who are terminally ill, it must never be said or even thought that nothing more can be done. Cure or no cure, patients are entitled to the assurance that everything possible continues to be done. A patient dying of cancer may present a constellation of symptoms, and the goal must be to gain control of them all so that the patient and his family can employ to the fullest extent whatever time remains.

Pain looms large in the thoughts of most people at the very mention of cancer, and looms even larger in the arguments of those who would have others adopt euthanasia. However, at least a third of all patients dying of malignant disease suffer no pain at any time.⁴ Even though pain is not the most common symptom, this article will consider pain as an illustrative example of what is possible to offer the terminally ill in lieu of euthanasia, and of how much can be done to make the life that remains worth living.

The approach to an incurable patient in pain is no different from the approach to any other person in distress. A physician well trained in this area needs to first take a

³Mount, *supra* note 1, at 471.

⁴R. TWYLCROSS & S. LACK, *supra* note 2, at 9.

Careful history and to conduct a thorough examination. From the observations of Dr. Saunders,⁵ it is clear that pain is more than just a disagreeable physical sensation. "Total pain" is comprised of mental, social, spiritual, and physical pain. Failure to remember this complexity is one of the most common reasons why patients fail to achieve adequate symptomatic relief.⁶

Mental Pain

Mental pain is prevalent when dying, especially in the minds of those who die young and face the distress of leaving behind small children. This distress expresses itself differently at different times, and although few patients follow the sequence described by Elizabeth Kubler-Ross,⁷ the elements of denial, anger, bargaining, depression, and acceptance are commonly encountered. When there is little that can be done about the patient's impending death, just standing by them means more than one realizes. At St. Christopher's Hospice, each patient is assured that they will never be alone, and that promise is honored.

Social Pain

Social pain may arise as a patient contemplates his family as it will be when he is no longer there. If he has been the provider, has he done enough? Will there be problems in relation to housing? Helping the patient put his affairs in order, encouraging him to make a will, and planning with his family for the future may ease this distress. Where available, social services can be mobilized. Knowing that the team

⁵C. SAUNDERS, THE MANAGEMENT OF TERMINAL MALIGNANT DISEASE 232 (1984).

⁶R. TWYLCROSS & S. LACK, *supra* note 2.

⁷KUBLER-ROSS, ON DEATH AND DYING (1970).

looking after him will remain in contact with his family after he has died may also provide the patient with much needed reassurance.

Spiritual Pain

Spiritual pain speaks for itself. Many people do not consider the possibility of life after death until it becomes all too apparent that their immediate future is bound up in it. This is not to say that good terminal care is to be regarded as a vehicle for proselytizing. On the contrary, the attitude has to be one of complete tolerance for religious and nonreligious persons alike. Nevertheless, in American society many patients will have roots in either the Jewish or Christian faith, and the caregiver must remain sensitive to those patients who will accept solace from the realm of faith. There must be a readiness to refer the patient to a pastor, priest, or rabbi of the patient's choosing.

Physical Pain

In the management of physical pain, accurate diagnosis is crucial. It has been observed that one out of five cancer patients have only one identifiable source of pain; four out of five have two or more separate causes of pain; and one in three patients have four or more pain producing processes active at any one time.⁸ The need for careful history and examination is clear. There is a need to know, for example:

- a. Is the pain due to invasion of the soft tissues?
- b. Is the pain due to nerve compression?
- c. Is the pain due to distention of the liver by multiple secondaries?
- d. Is the pain due to involvement of the bones, with an actual or threatened

⁸R. TWYLCROSS & S. LACK, *supra* note 2.

pathological fracture?

e. Is the pain due to some nonmalignant complication of the disease, such as abscess formation or some other infection?

f. Is the pain due to some complication of therapy, such as: pain in a surgical incision, pain following radiotherapy, or gastric irritation caused by aspirin?

Having defined the cause or causes of the patient's pain as accurately as possible, the available therapeutic options need to be considered. All too often physicians fail their patients, either through ignorance of the drugs available, or through neglect of the other forms of treatment available.

A wide range of pain relieving drugs is available. It is appropriate to begin with well known mild analgesics such as aspirin or acetaminophen. There is an ever increasing number of other drugs which act in the same way as aspirin. These include indomethacin, ibuprofen, naproxen, and sulindac. They differ in duration of action and side effects, but basically all can provide effective relief of mild-to-moderate pain and are especially effective in providing relief of pain arising from bone and joint.

A more potent analgesic is represented by codeine, an opiate derivative. People often unnecessarily fear codeine because of its minimal ability to cause addiction. Its main problem, like all opiates, is that it may cause constipation. Often combined with acetaminophen it is an effective analgesic of moderate strength.

If more powerful analgesia is needed, and if it has been determined that the pain is likely to be responsive to opiates, there should be no hesitation in prescribing morphine. For relief of severe pain, morphine remains unexcelled although it is shrouded in myths which the medical profession embraces all too often. For example, "I don't want to start

you on morphine now, because if I do, when we really need it, it will have lost its effect;” or “I’m afraid if I start you on morphine I may turn you into a drug addict.”

The fear of drug addiction in terminally ill patients would be laughable if it had not caused so many patients to endure needless pain. It is well documented that if morphine is taken for the relief of pain, habituation does not occur. Unless the disease advances, dosage requirements usually remain remarkably stable for many months, and if some other pain relieving procedure is initiated, such as a nerve block, morphine can be quite rapidly withdrawn without provoking the type of severe withdrawal seen in a true addict.

For patients able to take morphine by mouth, the best approach is to establish the dose which the patient needs to get relief by giving it either as an elixir or as tablets. The drug is of fairly brief duration and so should be given every four hours. It is wrong to give the drug only when the pain has broken through the effect of the previous dose. Once the total daily requirement has been established, the morphine can then be given in the same amount, using sustained release morphine tablets such as MS Contin. This controlled release preparation allows the patient to be dosed only twice a day instead of every four hours. This is a major boon, and if it did no more than allow undisturbed nights it would be an invaluable preparation.

In terms of dose, morphine is a very flexible drug. The rule is that as long as side effects allow it, the dose should be increased until pain relief is achieved. Pain in some way acts as a physiological antagonist to morphine so that respiratory depression does not occur even at very high doses.

For the patients who cannot take morphine by mouth, there are two alternatives.

The first is to use a constant infusion syringe which pumps a morphine solution either into a vein or under the skin. Alternatively, in centers where the necessary skill exists to set it up, morphine can be infused into the space between the membranes surrounding the spinal cord, the epidural space, or directly into the cerebrospinal fluid around the spinal cord. For both the subcutaneous infusion and the spinal cord approach, heroin would be a better agent because of its greater solubility. Since heroin is not legally available in the United States, physicians continue to use morphine, but may need to explore other agents like hydromorphone (Dilaudid).

There exists an entire spectrum of nonopiate approaches to pain that are equally important, and in some situations represent the treatment of choice. A common cause of pain is the development of secondary deposits in the bones. It is important to deal with these quickly, especially if they occur in a strategic position such as the spinal column. Often a small dose of radiotherapy will produce a marked reduction of pain. When deposits occur in long bones, an ever present hazard is the development of a pathological fracture. Here the combination of radiotherapy with the insertion by an orthopedic surgeon of a metal rod along the bone to prevent it from breaking may be the appropriate treatment. Aspirin-like drugs are particularly effective in controlling bone pain.

The skills of the anesthesiologist are of great value in securing a variety of nerve blocks. These may be useful if the pain is emanating from a rather circumscribed area, and may take the form of an intercostal nerve block for relief of chest wall pain, blockade of the celiac plexus for pain arising from a liver full of metastases, or a variety of localized spinal nerve root blocks. Pain caused by nerve entrapment is notoriously

resistant to morphine and can be very severe. Sometimes this may respond to irradiation, but high doses of cortisone-like drugs may also be needed to reduce the swelling, and in addition, a nerve block may also be useful.

Two case histories cited by Dr. Thomas West, now medical director of St. Christopher's Hospice, demonstrate the effectiveness of pain control.⁹

Case #1

I admitted Mrs. O to St. Christopher's from a local hospital on the 19 May 1977. She had an inoperable carcinoma of the pancreas with secondary deposits in the liver. She was in severe pain. The medical student with me was appalled at her suffering.

On the application form was written 'She does not know she has carcinoma.' On questioning she said to me 'When you have pain for a year you start to think!' Of course she knew. She had had a very sad marriage. By listening to her story and observing her carefully a correct assessment was made of the physical and the mental components of her pain and the correct drugs were prescribed. Within a few days she admitted that the pain was under control for the first time for a year. She did not remain completely pain-free. But each Monday she had her hair washed and set, each Thursday she visited our weekly bar, and each Sunday she came to chapel. The ward staff soon learned that meticulous attention to her drugs, and with more meticulous attention to herself, when pain did break through, it could almost always be alleviated.

She was with us just under three months. Her last few days were peaceful and pain-free and she died surrounded by three faithful friends, the ward sister and a nurse. A few days later one of her friends wrote: 'When I visited her in a previous hospital she was like a demented animal-consumed with pain. . . . I was very frightened, not knowing how to cope. . . . I saw her in St. Christopher's restored to the dignity of a calm rational human being . . . from then on I was able to remain with her for hours,

⁹West, *Do We Need a New Offence of "Mercy Killing"?*, 72 J. ROYAL SOC. MED. 461, 462-64 (1979).

instead of minutes . . . discussing things dear to her heart. . . . By so doing I, too, have gained in spiritual strength.’

Mercy killing’ might well have been appropriate for ‘a demented animal.’ It did not even have to be considered for ‘a calm human being.’¹⁰

Case #2

At St. Luke’s Hospital, New York . . . I was asked to see Robert. Arriving on the ward with the team we were greeted by the ward staff with ‘We’ve certainly got problems with him.’ Robert had an osteogenic sarcoma with gross involvement of the left femus and hip. He was 23, black, an ex-Vietnam soldier, with a white girl-friend who was pregnant. His own parents would not visit him. He was on maximum doses of methodone (incorrectly administered), he was sweating with pain, unable to put a foot to the ground, and desperate. I doubt that a doctor had dared to touch him for several weeks. After shaking his hand and examining him I assured him that his pain could be controlled.

By rationalizing his analgesics, and adding phenylbutazone (an aspirin-like drug) for the bony component of his pain, and steroids for the inflammatory component, we enabled Robert to walk in two days. In a week he was able to walk out of the hospital to attend his father’s funeral in North Carolina. He had to be readmitted within a month, and he died a few weeks later. Those who knew him well wrote: ‘Colour, education, class distinctions faded away in the face of courage and humility. There was acceptance at the end—a willingness to have it go either way. His concern was not for himself but for those who were closest to him.’

I saw Robert for twenty minutes. I cannot recall ever seeing anyone for whom mercy killing would have seemed more appropriate. For Robert and those around him how good it was that he lived to the full the life that was left.¹¹

When the terminally ill patient is assured that “everything possible” will be done

¹⁰*Id.*

¹¹*Id.*

for him, this means a very active ongoing and hopefully scientific endeavor on his behalf to control pain.

Should All Persons Who are Terminally Ill Receive Pain Management?

In humanitarian terms, there can be no question that we should offer pain management for all who stand in need. However, not all those in need have the means of providing for the cost involved. Society has to find an answer to this problem. It is unacceptable for a caring society to allow its stricken to die in agony.

Faced with providing medical care for people who are at the end of all their resources, fiscal as well as physical, we are compelled to confront the crushing expense of medical care in this country. No *one* solution can resolve the issue, but the adoption of a more humane and flexible attitude on the part of those governmental and commercial bodies which fund the bulk of the medical costs incurred by patients would be a start. Fund-raising from private sources will always be needed, and new and creative ways of encouraging donations must be explored.

Careful pain management would, for many, make all the difference between an unspeakable death, and a death cloaked in human dignity. The author can state on the basis of first-hand observation that the terminally ill, when properly cared for, simply do not ask for euthanasia.

Where can Pain Management be Provided?

Separate buildings like St. Christopher's Hospice serve as a monument of protest against the shortcomings of modern high-tech medicine,¹² and have had the effect of making people think that the only way of caring for the terminally ill is in such a building. However this is by no means certain and Dr. Saunders argues that "[p]atients should end their lives in the place most appropriate to them and their families."¹³

¹²Twycross, *Hospice Care — Redressing the Balance in Medicine*, 73 J. ROYAL SOC. MED. 475-81 (1980).

¹³C. SAUNDERS, *supra* note 5.

There is much to be said for the patient continuing to receive care in the same hospital in which he began. At the very least this avoids the impression that he is being shunted off out of the way, to a place where he can expire quietly. There is also the advantage of the ready availability of diagnostic services such as the bacteriology laboratory, the anesthesiologist and the radiotherapy department, if such should be needed. A consultation team of doctors, nurses, and social workers, who have been specially trained in various aspects of terminal care, interacting with the patient's primary care physicians is an increasingly common way of providing a hospice type of care in the context of a general hospital.

Many patients are well enough to spend a considerable period of time at home in familiar surroundings with a degree of privacy which no hospital bed could ever afford. A major thrust in terminal care in some quarters of late has been to develop support from visiting nurses and trained volunteers to such a degree that many patients are enabled to live out their days at home. It is well worth the effort.

What is the Consequence if Pain Management is Not Provided?

As an illustration of the consequences of failure to provide pain management is the story of Frank, culled from the literature of the Hemlock Society:¹⁴

For the next sixty-five days [after her stroke she] lay in the hospital, being turned every two hours to prevent bedsores and being fed by the tube. . . .

By the end of this time a hospital social worker began to put pressure on Frank to take his mother out of [the hospital] which is specifically for the care of the acutely sick and injured, and urged him to put her into a nursing home for the aged and infirm. After looking at several nursing homes, however, he came to a single conclusion: 'They're pigsties. The first thing which hit me was that they were old buildings, they stank of urine, the rooms were shabby-looking, and the general appearance of the premises and grounds were decrepit. The attitude of the people was bad. Such things as call lights were ignored.'

¹⁴D. HUMPHRY, LET ME DIE BEFORE I WAKE 36-42 (1984).

The social worker at [the hospital] did her best to guide Frank towards the most suitable homes and, when he failed to find anything — either because the homes were too full or too disgusting for him to tolerate — she admitted, ‘Let’s face it, nobody wants her. She’s too heavy. They prefer little skinny, eighty-pounders. And she can’t go to the bathroom to relieve herself. She needs too much nursing.’

Further pressure came from the hospital. They now advised him that if he did not remove his mother immediately, they would be obliged to charge him \$200 a day for her care. Up to that point, Medicare had been paying all the bills.

Rather hastily, Frank put his mother in a nearby convalescent home, one not at all to his liking. It had the same pervading smell of urine, and although it looked fairly decent from the outside, Frank saw cockroaches in the rooms. On several visits he found his mother’s bell-call apparatus lying on the floor and attendants watching the patients’ television (for which he was paying rental). He also found that his mother would be kept up in a chair for two hours, whereas [the hospital] had only kept her up for fifteen minutes. When he complained that this tired and pained her, the staff replied that they had the right to keep her in a chair for as long as they wished. One day Frank went into the home and found her face was covered with hardened matter which he feared was excrement. He got a washcloth to clean it off and found that it was caked food. It turned out that Irene, forced to feed herself, had been using her one hand to thrust food in her mouth and was so clumsy that she spattered most of it over her face. Disgusted and angry at the appalling care his mother was getting, he decided to complain. Nobody was taking the trouble to feed her or even look after her hygiene in the most fundamental ways. Yet when he vented his anger, he was told by the staff, ‘Don’t complain, Mr. Robinson, or we’ll ask you to take her out of here.’¹⁵

In desperation, he tried to care for her at home, but with inadequate resources, he soon ran into problems, and she had to be rehospitalized. When the hospital threatened

¹⁵*Id.*

to classify her as abandoned, he took her home again and there he eventually shot her.¹⁶

Though details may differ, that type of saga may repeat itself, if that kind of appalling societal neglect is allowed to continue. Others will repeat the same tragic cycle. Necessarily, they will be drawn mostly from the ranks of those who are the most deprived, the poor and the minority groups, though none of us is immune to such tragedy. The obligation rests with society, the family, and those health care professionals who care enough to provide available pain management techniques. If we fail to meet this challenge the clamor for euthanasia will continue.

¹⁶*Id.*