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THE ETHICS OF PAIN MANAGEMENT IN HOSPICE CARE

Nowadays [...], a model of society appears to be emerging in which the powerful predominate, setting aside and even eliminating the powerless: I am thinking here of unborn children, helpless victims of abortion; the elderly and incurably ill, subjected at times to euthanasia; and the many other people relegated to the margins of society by consumerism and materialism. Nor can I fail to mention the unnecessary recourse to the death penalty... This model of society bears the stamp of the culture of death, and is therefore in opposition to the Gospel message.

J o h n P a u l II, *Post-Synodal Apostolic Exhortation*, „Ecclesia in America”, Chapter V, n. 63

Total denial of the meaning of life and rejection of the truth that death is only passage to life is very prevalent in the today's culture of the post-modern society founded on existentialist thought. The Christian vision of life which is rooted in the risen Christ and the faith that man is created by God, for God, and destined to share with Him infinite happiness of eternal life – is not embraced by modern civilization¹ In consequence it leads to abandoning those who are approaching death and to the refusal of Christian model of ethics, as the responsible behavior of men liberated from the slavery of sin and focused at Easter. The Church teaches: „Even though man's nature is mortal, God had destined him not to die. Death was therefore contrary to the

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¹ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th Edition, Washington, DC: USCCB 2001, *Introduction*, p. 29: „Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death... In the face of death-for many, a time when hope seems lost-the Church witnesses to her belief that God has created each person for eternal life”

plans of God the Creator and entered the world as a consequence of sin”² And one could add that disease and pain and tears entered with death into man’s world.

Today’s contemporary society has forgotten, that in Christ, death and suffering changed its meaning and don’t bring fear or catastrophe, but expectation of participation in the Lord’s work of salvation. St. Paul affirms this mystery and hope: „None of us lives for oneself, and no one dies for oneself. For if we live, we live for the Lord, and if we die, we die for the Lord; so then, whether we live or die, we are the Lord’s” (Rm 14:7-8). In the same spirit the Church is not glorifying physical life, but searching for true dignity of the person and the ethical way of accepting death”: Certainly the life of the body in its earthly state is not an absolute good for the believer, especially as he may be asked to give up his life for a greater good [...]. No one, however, can arbitrarily choose whether to live or die; the absolute master of such a decision is the Creator alone, in whom „we live and move and have our being” (Acts 17:28)”³

The rejection of that fundamental truths leads to psychological isolation of the terminally ill patient in health care facilities. This is why the fear of pain associated with incurable disease, old age and solitude opens the door to euthanasia and assisted suicide seen as a final resolution to the burden of suffering⁴.

I. PAIN AND SUFFERING

There is great fear that the final moments of person’s life will be filled with persistent, agonizing pain. Certainly, the presence of severe pain does make death less than dignified and gracious, yet the treatment of severe pain in hospitalized patients is regularly and systematically inadequate. Physicians

² *Catechism of the Catholic Church*, 2nd Edition, revised in accordance with the official Latin text promulgated by Pope John Paul II, United States Catholic Conference, Inc., Vatican: Libreria Editrice Vaticana 1997, n. 1008, p. 263.

³ J o h n P a u l II, *Encyclical „Evangelium Vitae”*, The Gospel of Life, n. 47.

⁴ Cf.: P. S c h e p e n s, *Cultural Dimensions and Themes of the Pro-euthanasia Movement: the Special Case of Holland*, [In:] *The Dignity of the Dying Person. Proceedings of the Fifth Assembly of the Pontifical Academy for Life*, Ed. J. de Dios Vial Correa, E. Sgreccia, Vatican: Libreria Editrice Vaticana, 2000, p. 63-85; J. L e l k e n s, *Pain Control in Terminally ill Patients*, [In:] *The Dignity*, p. 242-251.

often seem reluctant to prescribe sufficient medicine to elevate quality of life. No dying patient should have to endure intense pain unnecessarily⁵

Palliative care brings remedy to that situation in offering the comprehensive, coordinated, and concentrated relief of both pain and suffering in terminally ill or incurably ill patients⁶ The term comes from the Latin word „palliare” meaning „cloaked” or „protected,” and involves care which seeks to conceal or shield the terminally ill through the alleviation of their pain or disease symptoms without curing⁷

The medical terrain of palliative hospice care is usually the patient’s home where family becomes primary care provider and single unit for care delivery. This gives them a stronger influence on ethical decision making because the care is given „on their turf” The goals are comfort, patient/family control and a „good death”, as defined by the patient/family and not professional caregiver. Sometimes a home care setting can jeopardize patient privacy and control, so disclosure, truth telling, and confidentiality become especially important⁸.

Throughout the world specialist palliative care services have grown, though their distribution is uneven. In 1999 there were over 6560 hospice or palliative care services in 84 countries, with 3600 in North America (in 2003

⁵ A. M a r c i a, *The Quality of Mercy*, „The New England Journal of Medicine”, 306 (1982) (2), p. 98-99.

⁶ L. G o r m a l l y, *Palliative Treatment and Ordinary Care*, [In:] *The Dignity*, p. 252-254. Report of a WHO Expert Committee, *Cancer Pain Relief and Palliative Care*, Geneva: World Health Organization 1990, p. 11: „Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering [...] and treatment of pain and other problems: physical, psychosocial and spiritual. Palliative care: 1) provides relief from pain and other distressing symptoms; 2) affirms life and regards dying as a normal process; 3) intends neither to hasten or postpone death; 4) integrates the psychological and spiritual aspects of patient care; 5) offers a support system to help patients live as actively as possible until death; 6) offers a support system to help the family cope during the patients illness and in their own bereavement; 7) uses a team approach to address the needs of patients and their families [...]; 8) will enhance quality of life, and may also positively influence the course of illness; 9) is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life [...]”, Cf.: *An Explanation of Palliative Care*, National Hospice and Palliative Care Organization, www.nhpco.org (Accessed on Jan. 3, 2005).

⁷ M. J. M c C a b e, *Ethical Issues in Pain Management*, [In:] *Ethics in Hospice Care. Challenges to Hospice Values in a Changing Health Care Environment*, Ed. B. Jennings, New York: The Haworth Press 1997, p. 25.

⁸ J. M. B r e n n e i s, H. C h a p p l e, *Ethical Issues in Hospice Care*, [In:] *Catholic Health Care Ethics: A Manual for Ethics Committees*, Ed. P. J. Cataldo, A. S. Moraczewski, Boston: The National Catholic Bioethics Center 2001, p. 6B/1-6B/3.

there were 3300 estimated hospice programs in the USA), 933 services in the United Kingdom, almost 1200 in the other 36 countries in Europe, and 350 in Australia and New Zealand. Those with diagnosed cancer accounted for almost 50% of hospice admissions in 2003 in the USA (in 1992 only 24%)⁹

In playing a central role in the development of palliative care, the hospice movement has been able to profoundly address the fundamental concerns of the terminally ill: (1) the fear of pain related to the illness, (2) the suffering that results from unrelieved pain and symptoms, (3) the fear of becoming a burden to the family, and (4) the fear of financing the cost of a terminal illness¹⁰.

In the strict use of the term within hospice care, palliative care begins when the following criteria have been established:

- 1) a terminal illness has been diagnosed;
- 2) death is likely or imminent;
- 3) a curative approach to care has been abandoned¹¹

In the past few decades the moral principles of hospice care has been grounded in patient choice, self-determination, and the importance of maintaining the quality of life even during the process of dying. Hospice care seems a far better choice than dying intubated, monitored, poked, „doped up” with no control over dying or on the other end – undermedicated and aggressively resuscitated by strangers in an unfamiliar and uncomfortable environment¹². Consequently a fundamental need in terminal care, and one addressed by the hospice movement, is the reassurance that, for most patients and their families, the balance between adequate pain control and being alert is possible¹³. However better understanding of pain and methods of palliation pose a challenge to the hospice movement, both to remain aware of

⁹ Hospice Information Service, *Hospice and Palliative Care Services Worldwide*, London: Hospice Information Service 1999; National Hospice and Palliative Care Organization, *Hospice Facts and Figures*, www.nhpco.org.

¹⁰ Hospice focuses on caring, not curing and, in most cases care is provided in the patient's home. Hospice care also is provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients of any age, religion, race, or illness. In the United States of America hospice care is covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations.

¹¹ D. J e f f r e y, *There is Nothing More i can do! An Introduction to the Ethics of Palliative Care*, Cornwall: The Patten Press 1993, p. 2.

¹² M. K a l i n o w s k i, *Towarzyszenie w cierpieniu. Postuga Hospicyjna*, Lublin 2002, p. 159-161.

¹³ M c C a b e, op. cit., p. 26.

these developments and to use this knowledge in the education of the medical and nursing profession's care of the dying.

It is very difficult to define, measure, or quantify perception of pain. While pain and suffering are conceptually distinct, for the terminally ill they are combined because the former is often the underlying cause of the latter. For the physiologist, pain is defined as the body's protective mechanisms triggered by a distressful, undesirable sensation or experience ordinarily associated with a physical cause¹⁴. It simply blots everything out at a critical point in a patient's narrative so that he or she cannot think or respond beyond the present moment.

In the suffering experience other components enter, such as memory, presence or absence of distracting stimuli, anxiety, anger, fear. Sometimes suffering is referred to as „pain of soul” and includes such experiences as boredom, depression, and anxiety. This pain of soul can enhance the physical pain a person is experiencing, while conversely localized bodily pain can distract the individual from the more diffuse but no less disagreeable pain of soul¹⁵

Equally important for the proper management of pain and for the ethics of pain control, is the obvious recognition, often overlooked, that it is the pain and suffering of human persons which means that the patient has the right and the obligation to make decisions regarding his life and health¹⁶

II. PAIN MANAGEMENT

Effective pain control is the immediate need for the dying despite some negative effects of pain medication. It is the right of the patient to decide the level of pain relief he needs; he may want to offer up some of his pain for spiritual reasons. To fail to address the pain of the dying is to misunderstand the highly subjective nature of pain and to diminish any choices the terminally ill may wish to make in preparing for their deaths. According to recent studies only 50% of terminally ill patients are receiving adequate pain mana-

¹⁴ D. C a l l a h a n, *The Troubled Dream of Life: Living with Mortality*, New York: Simon and Schuster 1993, p. 91.

¹⁵ A. S. M o r a c z e w s k i, *The Ethics of Pain Management*, [In:] *Catholic Health Care*, p. 14/1.

¹⁶ Given the state of the art of palliative care, pain can be controlled, although, in a few cases, it will be at the price of reduced consciousness, Cf.: *Ibid.*, p. 14/1.

gement and only 12% of physicians characterized their pain management training in school as excellent or good¹⁷

The control of pain centers around three steps:

1) A careful assessment of the patient's condition and determination of the type of pain;

2) A plan of pain management (necessary treatment with attention to changes in surroundings and alteration of movements);

3) A constant evaluation and monitoring (to respond to the new symptoms and adjust doses of medication)¹⁸.

The determination of the cause of pain involves a specific and careful history of the patient. The importance of the case history lies in the fact that, generally speaking, pain is what the patient says it is; not what the doctor believes it ought to be. The patient's perception of pain and emotional response to it are critical factors in its effective relief¹⁹. That is why attention is given not only to tissue damage, but also to the suffering component of the pain because both are integral parts of a patient's experience of pain. Equally, because the pain threshold and the effect of symptoms vary from patient to patient, effective palliation requires constant monitoring and adjustment of the particular drug regimen. Preferably patient should be provided with ade-

¹⁷ The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, New York 2000, p. 43. There are many reasons why people experience physical pain despite the ability of current medicine and treatments to relieve it. U.S. Department of Health and Human Services describes the most common barriers to pain control:

I. Problems related to health care professionals: a) Inadequate knowledge of pain management. b) Poor assessment of pain. c) Concern about regulation of controlled substances. d) Fear of patient addiction. e) Concern about side effects of analgesics. f) Concern about patients becoming tolerant to analgesics.

II. Problems related to patients: a) Reluctance to report pain. 1. Concern about distracting physicians from treatment of underlying disease. 2. Fear that pain means disease is worse. 3. Concern about not being a „good” patient. b) Reluctance to take pain medications. 1. Fear of addiction or of being thought of as an addict. 2. Worries about unmanageable side effects. 3. Concern about becoming tolerant to pain medications.

III. Problems related to the health care system: a) Low priority given to cancer pain treatment. b) Inadequate reimbursement. c) Restrictive regulation of controlled substances. d) Problems of availability of treatment or access to it.

U.S. Department of Health and Human Services, *Management of Cancer Pain: Adults*, „Quick Reference Guide for Clinicians”, Number 9, Agency for Health Care Policy and Research (AHCPR), Publication Number 94-0593, March 1994, Table 1. Barriers to cancer pain management.

¹⁸ Mc C a b e, op. cit., p. 27.

¹⁹ Cf.: Ibid. p. 27.

quate pain relief by employing the least potent effective medication with diligent consideration to other treatments or medications that can compliment the effect of reducing pain. Medication given orally, dissolved under the tongue or applied through skin patches provide adequate pain control to almost 90% of patients. Around 10% of terminally ill patients require invasive techniques – mostly narcotics delivered by a pump intravenously or under the skin. In less than 1% of patients pain medications are delivered directly to into the spinal canal²⁰.

A fundamental principle in palliative care is that continuous pain requires continuous relief. It is very counterproductive to prescribe pain relief, as was done formerly – and sadly still is in many places – solely on an „as needed” (PRN) basis. It is more effective and easier to prevent than relieve intense pain. In terminal care, pain-relieving medication must be given on a regular „around the clock” (ATC) basis together with an „as needed” or „pain rescue” basis²¹ This principle is intrinsically linked with another key factor in the alleviation of pain, namely the fear of additional pain, which can, in fact, exacerbate and increase a patient’s pain²²

Hence, a physician who has the responsibility of managing a patient’s pain, whether cancer-caused, postoperative, from some injury, or from some other condition, is faced with the problem of controlling the patient’s pain to the patient’s satisfaction while minimizing adverse effects of the analgesic. These undesired effects (also sometimes referred to as „side effects”) may include, for example, drowsiness, respiratory depression, constipation, urinary retention, as well as the potential for physiological drug dependency. However, as already noted, physicians who hold the power to prescribe the painkiller, particularly the narcotic analgesics, and the nurses who are the persons who ordinarily actually give out the pain medication, are often reluctant to provide the necessary pain relief for fear that the patient will become „addicted”

Occasionally, it is the nurse or other staff member who creates a problem for the patient. The physician may have properly prescribed the pain relief

²⁰ R. Ryan, *Palliative Care and Terminal Illness*, „The National Catholic Bioethics Quarterly”, 1(2001) (3), p. 315-316.

²¹ Mc Cabe, op. cit., p. 27.

²² „The fear of pain increases pain itself by geometric proportions. When severe pain is experienced and is expected to continue indefinitely, even to get worse, the patient enters into a world of horror and hopelessness that for many treated by conventional methods only ends in death”. S. Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying*, New York: Basic Books 1983, p. 20.

medication, but when the patient requests it at the designated time, the nurse (or other care giver) may purposefully delay or even berate the patient, telling him that he really does not need it. Such a response from the nurse or other care giver – even a family member – is not necessarily a sign of negligence or a sign of a sadistic trait. Rather it may be that the nurse or other have failed to appreciate individual differences in pain perception and tolerance as well as differences in the priority of values relative to the experience of pain²³

Once a patient's pain symptoms are under control there can be renewed awareness of his or her dignity and worth as a person as well as the „freedom” to address other causes of their distress and suffering. Because physical, emotional, and spiritual symptoms are closely interwoven, the emphasis is on holistic care²⁴ It would be facile indeed to suggest that all pain is related to a troubled spirit, but equally, one is unwise to ignore the concerns of the inner world and the power of memory as very real factors in addressing the pain and distress of the terminally ill. For this reason, Cicely Saunders developed the term „total pain” to describe this holistic and comprehensive approach to suffering. This term recognizes the broad reality of pain whether it is „a consequence of loneliness, spiritual distress, inappropriate diet, or tumor growth”²⁵ Just as effective management of pain cannot be achieved without reference to a patient's inner world; neither can it be achieved without reference to a patient's family. The family is best served when hospice workers remain objective and respect the fact that they are only witnessing a „brief snapshot” in this particular patient-family narrative.

²³ R. B. E d w a r d s, *Pain and the Ethics of Pain Management*, „Social Science Medicine”, 18 (1984) (6), p. 518: „Furthermore, a common area of patient abuse consists in staff activities designed to generate pains of soul. Challenging the patient's claim concerning the degree of his suffering and/or his need for help definitely and gravely affects his moral standing in the hospital and broader human community [...] once the proper degradation ceremony has been performed, staff members then feel morally justified in stereotyping and humiliating the patient, disregarding his pain professions and pleas for help, avoiding his room, ignoring his buzzer, and generally ostracizing him from the community of human moral agents”

²⁴ M. K a l i n o w s k i, *Duszpasterstwo hospicyjne. Studium pastoralne na podstawie badań wybranych ośrodków hospicyjnych w Polsce*, Lublin 2000, p. 58.

²⁵ Cf.: C. S i e b o l d, *The Hospice Movement: Easing Death's Pains*, New York: Twayne Publishers 1992, p. 96.

III. THE RISK OF HASTENING DEATH

The moral and ethical question of whether or not palliative care hastens death is, in the light of recent medical literature, an open question. Several writers argue that effective palliation using the opioids does not hasten death and neither does it cause respiratory depression and may, in fact, have the ability to prolong life²⁶ Because of the patient's ability to develop tolerance for repeated doses of opioid drugs, respiratory depression is limited in effective palliative care. While there is a deterioration in respiratory function as a person nears death, this occurs as a result of the presence of an underlying pathology, and should not be confused with respiratory distress²⁷

A physician in a modern medical setting has the means of relieving pain but his or her responsibility to relieve patient's pain is limited by the means which are realistically and morally available for the relief of that patient's pain²⁸ It is both medically and ethically obligatory upon the physician to

²⁶ Some people mistakenly believe that the toxic side effects of the opioids shorten the lives of cancer patients. No one questions that opioids have side effects. However, with skilful management of opioid analgesics, including anticipation of possible adverse side effects, no evidence exists that these drugs shorten life. Cf.: D. C u n d i f f, *Euthanasia is Not the Answer: A Hospice Physician's View*, New Jersey: Humana Press, 1992, p. 118.

²⁷ Kathleen Foley argues: „In fact, respiratory depression is not a significant limiting factor in the management of patients with pain because with repeated doses, tolerance develops to this effect, allowing for adequate treatment of patients with escalating doses without respiratory compromise” K. M. F o l e y, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, „Journal of Pain and Symptom Management”, 6 (1991), p. 291-292. Similarly, David Outerbridge and Alan Hersh state that: „Medical studies have shown [...] that the increasing tolerance to the medication is normally accompanied by a similar tolerance to adverse side effects” (D. O u t e r b r i d g e, A. H e r s h, *Easing the Passage*, New York: Harper Perennial 1991, p. 119). See also: J. Z i m m e r m a n, *Hospice: Complete Care for the Terminally Ill*, Baltimore: Urban and Schwarzenberg 1986; T. R y n d e s, *Psychosocial Principles of Pain Management in the Terminally Ill*, [In:] *Quality of Care for the Terminally Ill: An Examination of the Issues*, Ed. K. Gardner, Chicago: Joint Commission on Accreditation of Hospitals 1985, p. 51; M. C o n o l l y, *Alternative to Euthanasia: Pain Management*, „Issues in Law & Medicine”, 4 (1989), p. 501; C. S a u n d e r s, *The Evolution of Hospices*, „Free Enquiry” (Winter), 1991-1992, p. 19-23.

²⁸ The Supreme Court reasserted a distinction which many courts had recognized before and which the *American Medical Association* currently is promoting, namely, the difference between the death of a patient, caused, say by an overdose of morphine or other drug, and the death of a patient following the removal of life support. In the latter the case is brought about by the underlying pathology, which required the use of life support in the first place.

acquire the skill and knowledge necessary to control pain satisfactorily²⁹ In addition the patient assumes that the physician has the willingness to minimize the pain in a manner and to the degree compatible with other treatment concurrently being given.

With regard to the use of pain medication, the opinion of the Court delivered by Chief Justice Rehnquist refers with approval to a report of the New York Task Force On Life and the Law: „It is widely recognized that the provision of pain medications is ethically and professionally acceptable even when the treatment may hasten the patient’s death if the medication is intended to alleviate pain and severe discomfort, not to cause death”³⁰.

What is critical is that there is no intention on part of the patient and physician to bring about death by means of the pain medication. What is sought directly is relief from severe pain, not death. This distinction seems to be lost on some people. They look only at the end result of both – death. There is a vast moral difference between directly willing and intending the death of the individual and foreseeing and permitting death as almost certain.

In current development and reform of Health Care system in the United States there is visible movement to pass legislation permitting physician-assisted suicide³¹. These shifts in public policy have cast a pall over the historical ethos of hospice and thus over the requisite trust. The negative liberty to refuse medical treatment is rapidly being joined with the positive right to an entitlement to help in dying in American law. The ethos of hospice, where hastening death, hurrying death, or assisting in death had no place in hospice treatment is now in jeopardy³².

²⁹ In 1997 K. Foley cited an *American Medical Association* report that found that „only 5 of 126 medical schools in the United States require a separate course in the care of the dying”. K. M. Foley, *Competent Care for the Dying Instead of Physician Assisted Suicide*, „The New England Journal of Medicine”, 336 (1997), (1), p. 55.

³⁰ Quote from: Moraczewski, *The Ethics*, p. 14/3. Cf. The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, New York 2000, Chapter 8: „Caring for Severely Ill Patients”, p. 153-181.

³¹ Moraczewski, *The Ethics*, p.14/3: „Oregon currently is the only state that has a law. The United States Supreme Court handed down the ruling on June 26, 1997 that there is no constitutional *right to die*. However, it did permit the individual states to pass legislation that could permit physician-assisted suicide, but they could not base it on an alleged constitutional *right to die*”.

³² A. L. Caplan, *Will Assisted Suicide Kill Hospice?*, [In:] *Ethics in Hospice Care, Challenges to Hospice Values in a Changing Health Care Environment*, Ed. B. Jennings, New York: The Haworth Press 1997, p. 22: „It is very unlikely that assistance in dying is something that will long be restricted to the terminally ill. For too many Americans, the issue of when

IV. CATHOLIC TEACHING

The fundamental intent of palliation for the terminally ill is the relief of suffering through effective pain relief and symptom control. Ethicists and theologians have traditionally argued that the inherent risk in palliative care – the suppression of the respiratory system – can be justified from the perspective of the intention of the caregiver³³

„Intention” distinguishes what one does in an action from what one allows to happen as the result of that action. The intention in administering narcotics for the terminally ill is to relieve pain. Consequently, palliative care is ethically acceptable because any unintended effects are physical and not moral. The *Declaration on Euthanasia* states: „In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine”³⁴. This distinction between the direct and indirect intention is known within the Catholic moral tradition and in medical ethics generally as the *Principle of Double Effect*³⁵. More positively, this principle is not a „legalistic formula” but provides an aid for discerning the ethical and moral validity of an action³⁶

to die involves neither terminal illness nor pain. It involves the loss of a sense of personal identity, the loss of dignity and the loss of an acceptable quality of life. This is the group that poses the greatest challenge to the tradition of hospice since many of those who fit these categories are not now and have not been candidates for eligibility for hospice, yet they are strong candidates for requesting help in dying”.

³³ Cf.: Mc C a b e, *Ethical Issues*, p. 29.

³⁴ The Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), [In:] *Catholic Health Care Ethics: A Manual for Ethics Committees*, Ed. P. J. Cataldo, A. S. Moraczewski, Boston: The National Catholic Bioethics Center 2001, Chapter III, p. A/25.

³⁵ The literature on this principle is considerable. See, for example, *Double Effect: Theoretical Function and Bioethical Implications*, Ed. T. J. Boyle, „The Journal of Medicine and Philosophy” (16 October), 1991, p. 467-585; J. F. K e e n a n, *The Function of The Principle of Double Effect*, „Theological Studies”, 54(1993), p. 294-315; T. B e a u c h a m p, J. C h i l d r e s s, *Principles of Biomedical Ethics*, New York: Oxford University Press 1989, p. 127-134; R. G u l a, *Reason Informed by Faith*, New York: Paulist Press 1989, p. 270-279; B. A s h l e y, K. O’R o u r k e, *Healthcare Ethics: A Theological Analysis*, St. Louis: The Catholic Health Association 1989, p. 184-190; J. W r ó b e l, *Człowiek i medycyna, Teologicznomoralne podstawy ingerencji medycznych*, Kraków 1999, p. 331-354; J. M a n g a n, *An Historical Analysis of the Principle of Double Effect*, „Theological Studies”, 10(1949), p. 41-61.

³⁶ B. A s h l e y, K. O’R o u r k e, *Healthcare Ethics: A Theological Analysis*, St. Louis: The Catholic Health Association 1989, p. 187.

Richard McCormick summarizes the fourfold conditions of the principle that must be present if the necessary good is to be achieved:

1. *The Nature of the Act.* The action from which harm results is good or indifferent in itself – it is not morally wrong.

2. *The Agent's Intention.* The intention of the agent is to achieve the beneficial effects, that is, the harmful effect is sincerely not intended.

3. *The Distinction between Means and Effects.* The beneficial effects must follow from the action at least as immediately as do the harmful effects, for otherwise the harmful effects would be a means to the good effect and would be intended.

4. *Proportionality between the Good Effect and Bad Effect.* The foreseen beneficial effects must be equal to or greater than the foreseen harmful effects³⁷

When these conditions are present, any resultant „harm” that occurs is referred to as an „unintended by-product” of the action. The harm is only indirectly voluntary, and it is justified by the presence of a proportionately serious reason, specifically, the imperative to relieve unbearable pain for the terminally ill³⁸

The Church has officially addressed the issue of pain medication. The question of pain relief was addressed by Pope Pius XII in response to question put to him at an international meeting of anesthesiologists: „To sum up, you ask Us: „Is the removal of pain and consciousness by means of narcotics (when medical reasons demand it) permitted by religion and morality to both doctor and patient even at the approach of death and if one foresees that the use of narcotics will shorten life?” The answer must be: „Yes – provided that no other means exist and if, in the given circumstances, that action does not prevent the carrying out of other moral and religious duties”³⁹

More recently the same teaching is contained in Pope John Paul II's encyclical *The Gospel of Life*⁴⁰ and in the document from the National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (n. 61):

³⁷ R. Mc C o r m i c k, *How Brave a New World? Dilemmas in Bioethics*, Washington: Georgetown University Press 1981, p. 413.

³⁸ Medical practice provides many examples of an action that has more than one effect, such as the surgical excision of a tumor that may both save life and disable the patient.

³⁹ P i u s XII, *An Address of Pius XII to a Symposium of the Italian Society of Anesthesiology* „Anesthesia: Three Moral Questions” (February 24, 1957), „The Pope Speaks” (Summer), 4(1957), (1), p. 48.

⁴⁰ J o h n P a u l II, *Encyclical „Evangelium Vitae”* (March 25, 1995).

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since, a person has the right to prepare for his or her death while fully conscious; he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering⁴¹

The respiratory depression associated with the use of high doses of morphine and similar compounds, as already noted above, require special care by the physician or nurse. The dose of medication should be adjusted to bring about the degree of pain relief the patient desires, which may mean the retention of some level of pain. If the level of pain is so severe that the patient may be rendered unconscious, it is important for the patient to be aware of this possibility before the administration of such high doses. The patient should be given the opportunity to take care of spiritual matters such as receiving the sacraments of Reconciliation and Viaticum as well as settling unfinished personal and business matters.

As Bishop McGann says in his pastoral letter on death and dying *Comfort My People*, assisted suicide or euthanasia are not the answer to the relief „[...] from physical pain, relief from depression, relief from the social pain caused by isolation and relief from spiritual suffering” McGann urges: „Sometimes [...] we abandon dying people to too much treatment and technology [...]. Other people are abandoned to too little medical care, especially those who are poor, those immigrants who are denied access to health services and increasing number of the middle class who are underinsured or who have no health insurance” He commends „[...] the middle ground: a letting go with the true dignity that comes with adequate treatment of the physical, emotional, social and spiritual suffering of the dying person. This very wide middle ground avoids the extremes: Death is not directly caused and dying is not unnecessarily prolonged”⁴².

⁴¹ United States Conference of Catholic Bishops: *Ethical and Religious Directives for Catholic Health Care Services*, 4th Edition 2001, [In:] *Catholic Health Care Ethics: A Manual for Ethics Committees*, Ed. P. J. Cataldo, A. S. Moraczewski, Boston: The National Catholic Bioethics Center 2001, p. A/116.

⁴² J. R. McGann, *Pastoral Letter on Death and Dying: Comfort my People* (February 19), „Origins”, 26(1997), (39), p. 640-648.

To die with dignity and gracefully, means at the very least, to be free from the fear of death and dying; to be free from pain; to be able to communicate with family and other loved persons; and to be at peace with God, having received the sacraments of consolation.

V. CLOSING REMARKS

In light of the above, the physician and others having the medical or nursing care of patients with severe pain need to recognize the complexity of pain management. They are to serve the patient, helping them recover their health if possible or allowing them approach death as smoothly as possible. Throughout any disease and/or dying stages, the physician is there to control pain to the extent the patient desires, in order that he or she may live his present life (whatever remains of it) in a humane way.

Thus the hallmark of hospice care, palliative care, is a practical application of the moral virtues of medicine because it seeks to alleviate pain and promote healing, in the broadest sense of both terms, through the judicious use of narcotics. Ethical palliative care helps to provide a dignified death for the terminally ill hospice patient in a way that allows for greater resolution of the complexities within the human narrative-complexities which are especially highlighted in the care of the dying.

There is a fine line of moral and ethical conduct to protect the seriously ill and dying against euthanasia/suicide and aggressive medical treatment in a society that has lost value in the human person and life. Culture of death with its utilitarian ethic based on the cost-benefit relationship and tendency to limit medical treatment to terminally ill require strong oppositions not only in public opinions debates or through political activities and voting, but also by providing proper and dignified care for the dying.

In the face of ever visible manifestation of today's humanism closed to the Transcendent⁴³, the Holy Father writes: „a unique responsibility belongs to health-care personnel: doctors, pharmacists, nurses, chaplains, men and women religious, administrators and volunteers [...] to be guardians and servants of human life” (*Evangelium Vitae*, n. 89). Accompany Christian and non-Christians in the dramatic moments of death help them to understand

⁴³ J. L. B a r r a g a n, *The Physician and Bioethical Challenges: The New Paradigm*, „Algologia”, 22(2003), Special Number, p. 22.

mystery of greatness and dignity of the human person, meaning of life and suffering, and help them to embrace the fullness of life everlasting⁴⁴

Man's journey to God is plagued by disease, injuries, and pain. Yet God has given human beings a variety of means – to be sure, gradually revealed/ discovered by man over the ages – which enabled man to cope with these adversities. God has revealed, and the Church provides us, moral teachings which guide us in making right decisions in the midst of the complexities of the modern world so that our pilgrimage to God will not be impeded. Each moral decision rightly made brings us closer to God so that eventually we will be totally immersed – without losing, but enhancing our individual identities – in the Creator in whom is our eternal delight!

„Comfort, give comfort to my people, says your God”⁴⁵

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⁴⁴ K. Masłowski, *Zespół Hospicyjny w opiece duchowej*, „Nowa Medycyna”, 11(2004), (2), z. 124, p. 100.

⁴⁵ Is. 40:1.

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ETYKA POSTĘPOWANIA Z BÓLEM W OPIECE HOSPICYJNEJ

S t r e s z c z e n i e

Cechą charakteryzującą współczesną kulturę jest kwestionowanie przez nią bezwzględnej wartości ludzkiego życia i istnienia wieczności, na krawędzi której staje człowiek w chwili śmierci. Ta postmodernistyczna tendencja w nurtach myślowych prowadzi w konsekwencji do odrzucenia założeń etyki chrześcijańskiej dotyczącej sensowności przeżywania cierpienia, troskliwej opieki hospicyjnej czy właściwego stosowania środków uśmierzających ból. Racjonalizm kultury współczesnego świata, który odrzuca objawianą w chrześcijaństwie prawdę o naturze ludzkiej obciążonej grzechem i znamieniem śmiertelności, ale odkupionej śmiercią i zmartwychwstaniem Chrystusa, nie jest w stanie znaleźć uzasadnienia dla wartości cierpienia, godnego umierania i ofiarnego towarzyszenia umierającym. Ujawniając się w postawach i zachowaniach personelu medycznego, ten sposób myślenia może prowadzić do psychicznej izolacji terminalnie chorych. W konsekwencji lęk towarzyszący chorobom nieuleczalnym i doświadczenie samotności mogą potęgować uległość pacjenta wobec iluzji sugerującej, iż eutanazja jest najlepszym rozwiązaniem problemu choroby terminalnej. W tym kontekście troska paliatywna oparta na chrześcijańskiej wizji człowieka jest zbawienną alternatywą.

Część artykułu poświęcona zagadnieniu bólu i cierpienia ukazuje opiekę paliatywną, jako spójny, skoordynowany i właściwie ukierunkowany zestaw zabiegów, który jest adekwatną odpowiedzią na potrzeby terminalnie chorych. Charakterystyka ta wyznacza trzy kryteria, które decydują o tym, kiedy można mówić o opiece paliatywnej:

1. Choroba terminalna została zdiagnozowana.
2. Ryzyko śmierci jest bardzo wysokie lub nieodległe w czasie.
3. Zabiegi lecznicze nastawione na przywrócenie zdrowia zostały wstrzymane.

W takiej sytuacji postępa paliatywna koncentruje się na zapobieganiu następstwom: (1) lęku przed bólem związanym z chorobą; (2) cierpienia, które jest rezultatem nieukojonego bólu i jego przejawów; (3) lęku przed stanieniem się ciężarem dla rodziny; (4) niepokoju o finansowe obciążenia związane z chorobą terminalną.

Zasady moralne, jakie dotychczas wyznaczały kryteria słuszności działania w obrębie zabiegów hospicyjnych, za główny punkt odniesienia przyjmowały decyzję pacjenta i potrzebę utrzymania odpowiedniej jakości życia. Obok tych słusznych założeń istotne jest także takie spojrzenie na problematykę opieki paliatywnej, by uwzględniało ono nowy zakres wiedzy, jaki na temat bólu i cierpienia wnoszą współczesna psychologia, nauki biologiczne i medyczne. Najnowsze badania wykazują, iż na tym polu pozostaje wiele do zrobienia. Według aktualnych statystyk jedynie 50% pacjentów terminalnie chorych jest poddawanych adekwatnym zabiegom łagodzącym ból, a tylko 12% personelu medycznego określa swoje teoretyczne przygotowanie do takich zabiegów, jako dobre i bardzo dobre. W związku z tym istotne wydaje się postawienie akcentu na wypracowanie lepszych standardów stosowania metod i środków znieczulających. Rozwiązanie tej kwestii winno uwzględniać: (1) staranną ocenę stanu pacjenta i rodzaju bólu, jakiego doświadcza; (2) stworzenie takiego planu zabiegów łagodzących ból, który uwzględniałby wszystkie uwarunkowania; (3) nieustanne monitorowanie i ocenianie stanu pacjenta wraz z dostosowywaniem środków zapobiegawczych.

Na uwagę zasługuje założenie, iż najbardziej adekwatną opinię o bólu i cierpieniu wydaje pacjent, który ich doświadcza. Wynika to w dużej mierze z faktu, iż każdy człowiek – w wymiarze ciała i ducha – w osobliwy sposób interpretuje daną chorobę i związane z nimi odczucia. Ten fakt jest wyzwaniem dla personelu medycznego, który musi określić właściwą równo-

wagę między najefektywniejszym łagodzeniem bólu nazwanego przez pacjenta a ryzykiem negatywnych następstw stosowania środków znieczulających.

Problemem moralnym pozostaje fakt, iż działanie środków przeciwbólowych może także przyspieszać moment śmierci. Wydaje się, że słuszną odpowiedź na tę wątpliwość daje raport *New York Task Force on Life and the Law*, gdy pisze: „Przyjmuje się powszechnie, iż podawanie środków znieczulających jest, z punktu widzenia etyki i profesji lekarskiej, uzasadnione nawet wtedy, gdy takie zabiegi mogą przyspieszyć śmierć pacjenta, jeśli tylko leki te są podawane z intencją uśmierzenia bólu i usunięcia poważnego dyskomfortu, a nie z zamysłem przyspieszenia śmierci” Kluczowym zatem kryterium pozostaje fachowa ocena sytuacji i właściwa intencja.

W tym kontekście wydaje się bardzo istotne to, by personel medyczny, budując zawodowy etos, pogłębiał zarówno znajomość nowych sposobów łagodzenia bólu, potrzeb ludzi chcących umierać z godnością, jak i nadziei, jaką w życiu wiecznym mogą pokładać umierający. Jest to nieodzowne, jeśli służba zdrowia ma pozostać wierna pełnieniu swojej misji, a nie odwoływać się do eutanazji, która jest zaprzeczeniem etosu pracowników opieki medycznej.

Szczególnie współcześnie, w obliczu każdej formy humanizmu zamkniętego na wymiar transcendentny, istnieje głęboka potrzeba uświadomienia, że personel medyczny jest, jak naucza Jan Paweł II, szczególnym strażnikiem i sługą ludzkiego życia (por. EV 89). Towarzystwo człowieka w przeżywanym przezeń dramacie umierania, bez względu na wyznawaną religię, wszystkim zaangażowanym osobom pomaga zrozumieć tajemnicę godności człowieka i niegasnącej nadziei na życie.

Streścił ks. Włodzimierz Wieczorek

Key words: pain management, hospice, palliative care, terminally ill, ethics, chronic pain, death and dying.

Słowa kluczowe: ból, hospicjum, opieka paliatywna, chorzy terminalnie, chroniczny ból, śmierć i umieranie.