Pain and America's Culture of Death

Throughout history, people have called for medical practitioners to assist in the deaths of patients suffering from intractable pain as a result of advanced disease. But while many doctors themselves have advocated such assistance, including those of ancient Greece, Western medical practice has generally cleaved to the view of Hippocrates, who argued firmly against physicians' "giving a deadly drug to any patient."

Not that the Hippocratic view has reigned unchallenged. Today in the United States support for mercy killing is widespread and growing both among the general public and health-care professionals. A 1991 collaborative study undertaken by the Boston *Globe* and the Harvard School of Public Health found that 64 percent of its 1,004 respondents believed that physicians should be allowed to give terminally ill patients a lethal injection. And a 1988 survey of physicians in the San Francisco area found that 70 percent believed that the terminally ill should have the option of active euthanasia (left undefined), while 54 percent felt that the physician should administer the lethal dose.

Not surprisingly, attitudes toward this most troubling of subjects vary greatly according to shifts in social conditions and values. As Daniel Callahan shows in his eloquent book, *The Troubled Dream of Life* (1993), support for euthanasia and doctor-assisted dying increases sharply in times when the bonds of community are weak and the insistence upon individual rights is strong. Ours is such a time. And the cry for medically assisted dying grows ever louder under the pressure of conditions peculiar to our age. These include advances in high-technology life-support systems, growing numbers of cancer and AIDS patients struggling under the Damoclean diagnosis of fatal illness, the "graying" of the population, and limitations on health-care resources, particularly for patients with terminal illness.

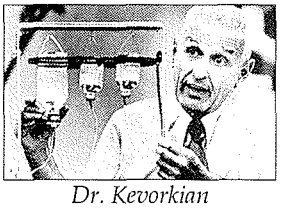
But there is yet another factor that should not be ignored: the inadequate treatment and understanding of pain. Reports of the undertreatment of cancer pain have received considerable press recently, but unfortunately the phenomenon they address is nothing new. The failure to administer appropriate or adequate medication to the terminally ill stems from a number of causes. To begin with, physicians are generally undertrained in the area of pain management. (Significantly, research shows that those health-care professionals who perceive themselves to be less competent at managing pain are more likely to endorse assisted suicide or euthanasia.) In addition, many physicians, like many nonphysicians, bring to the use of opioids and sedatives attitudes highly colored by subjective opinions and cultural beliefs, attitudes which often dispose the physician to undertreat even the most severe states of pain, on the grounds, for example, that heavy sedation would reduce the patient to a "vegetative" state. Then, too, despite ethical and legal clarification of these matters, many health-care professionals remain uncertain about that region where the use of symptom-control methods blurs with either voluntary active euthanasia or physician-assisted suicide.

Countless studies reveal a wide range of serious physical and psychological symptoms among the terminally ill. Such symptoms, along with social and existential factors, comprise what physician Cecily Saunders calls "total pain" or what Eric Cassell names "global suffering." Unfortunately, most doctors lack both the range of expertise and the time to address the total pain of the patient. This can be tragic in the case of a cancer patient who is suffering from depression. Studies have shown that antidepressants can be strikingly effective in treating depressions among persons with severe physical illnesses; moreover, they can have a direct effect in reducing the chronic pain that may precipitate such depressions. Physicians may also fail to consider other factors affecting the patient's experience of pain, including relations with his family, religious beliefs, and even beliefs about pain itself.

To be sure, it is too much to expect physicians to be all things to all patients—and hubris

to think physicians can cure all suffering. But it is important both for physicians and for the terminally ill to know that the pain is multifaceted and that it can be addressed on a variety of fronts. The social support provided by a hospice may very successfully address the loneliness of an AIDS or cancer patient, for example, and thus help reduce his or her pain. It is certainly one of many means of addressing the total pain of an individual who might otherwise believe that the only relief from suffering and despair is self-inflicted or (if only the physician would agree) doctor-assisted death.

The much-discussed case of Dr. Jack Kevorkian illustrates too grimly the consequences of our ignorance about suffering in general and terminal pain in particular. From June of 1990 to November of 1993, Kevorkian assisted in the deaths of 20 patients, ranging in age from 41 to 73. Twelve were women and eight were men. Ten had a history of cancer, and the others suffered from a variety of chronic medical illnesses, including Alzheimer's disease, multiple sclerosis, chronic obstructive lung disease, and amyotrophic lateral sclerosis. The details of the medical care of all of the 20 patients have not been made fully public, but interviews with some of the patients are available. One had chronic pain with significant psychological complications. This patient had seen a pain specialist but had refused psychiatric care. The only physician-patient aided by Kevorkian was reported to have significant pain as well as "anxiety." He had multiple myeloma with diffuse bone pain. According to limited family interviews and available tapes, approximately 10 patients may have had some pain. While incomplete data precludes authoritative discussion of the role of pain among this group of patients, it should be noted that Kevorkian is a pathologist by speciality, has had no specialized training in the medical and psychiatric care of patients with chronic illness, and appears to have accepted all of his patients' requests without addressing any of the complex factors that might have led to their decision to seek his help. Despite the murk surrounding Kevorkian's practice, many Americans hail him as a pioneer in physician-assisted suicide. But to lionize a doctor who assisted the deaths of people who might have received inadequate physical or psychological treatment for their pain seems, at best, premature.


Dr. Kevorkian

At worst, it reflects unthinking sentimentality and misplaced respect for medical authority, currents of which, unfortunately, are sweeping through this country. Some caution, to say the least, is in order. Studies of legally tolerated euthanasia and doctor-assisted suicide in the Netherlands are complex and tentative, but they should be sobering to Americans eager to see their nation follow suit. At the very least, such studies suggest that Dutch physicians have in many cases committed life-terminating acts without the explicit request of their patients. A slippery slope, indeed.

For the past 20 years, as a neuro-oncologist in a cancer center, I have cared for, or directed the care of, thousands of patients with pain and cancer. I know that the treatment of pain and suffering remains a complex medical problem, but I believe the least we can do is provide patients with treatment that encompasses their own needs as well as those of their families and their health-care providers—and that preserves the moral values of all parties involved.

How, then, as a pain specialist, do I respond to patients' requests for physician-assisted suicide? In the only way I can, by saying that I value their lives and their worth and therefore cannot kill them. I tell them, too, that I will care for them and treat their symptoms, and, if their pain cannot be adequately controlled while they are dying, that I will honor their choice to be sedated. And, last, I assure them that I will never abandon them but will remain to the end a witness to their dying.

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