

Focus: current issues in medical ethics

The hospital as a place of pain

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This paper was first presented at the London Medical Group's Annual Conference entitled Death: the last taboo held in February 1980. Dr Vere comments on the evidence of research done by him and his colleagues on the pain and discomfort suffered by patients who are dying and are in hospital. He contrasts this with the situation in hospices, analyses the differences, and attributes much of the unnecessary pain suffered in hospitals to attitudes of staff, as well as to a reluctance by relatives to allow patients with terminal pain to die at home. He deprecates the tendency in hospitals to separate 'curing' and 'caring' and suggests that sometimes the best help involves 'doing' less, not more.

The embarrassment of this paper is its paucity of ordered fact; its justification is the importance of the subject. But one fact seems beyond doubt; whereas the pains and discomforts of disease and dying are well relieved in hospices, they are not in hospitals, at least in sufficient numbers of cases to evoke great disquiet.^{1 2} Why?

These comments are based on considerable evidence. They owe much to the patient efforts of Jennifer Hunt and Jennifer Raiman, research nurses in our hospital and department, and my colleague David Littlejohns³ though the opinions are mine. Besides long experience in general medicine, which persuaded us to research in this field, but also warned of the danger of the 'sore thumb' exaggeration of single events, we have made a pilot study of the problem,⁴ followed by a much larger study which now nears completion. We are also impressed by the opinions of colleagues in the same field.⁵ All of this evidence points in the same direction. Though the final quantitative analysis is incomplete, we are sadly unaware of any evidence which casts doubt on the main message in hospital environments which we have been able to study. What is the diagnosis?

This would be my taxonomy of the features noted so far:

- a) Factors which arise from staff – junior staff, senior staff, communication
- b) Factors which arise from the nature of general hospital work
- c) Facilities
- d) Patients' homes and relatives

Factors related to staff

In the nature of things, and it could not be otherwise, 'house' staff and student nurses are the people nearest to the patient in the busy general ward. Of course they are young, and immature in the sense only of experience. (Young people nowadays are not socially unaware, as many older staff were when they were young and they are highly motivated to care for others.) They have little experience of pain relief, and so lack confidence that it can be relieved or to attempt to relieve it. So they may lack the 'self-worth' appreciation of an experienced member of a caring team. Their term will only last for from two to six months.

Their education may well have contained information about pain and other symptom control, but it is likely that this will always have been a secondary topic. Symptom relief usually takes second place to controlling disease processes, and treatment to diagnosis. And, however much they may be taught, they seem to have remarkable difficulty in learning the management of opiate drugs.

Senior staff also contribute to the problems. They often seem to relegate symptom control as a routine matter to juniors, unless something goes wrong. After all, they are properly preoccupied with weightier matters than their juniors, and tend to lay down routines to be followed by them for the less portentous issues. These routines can lead to a remarkable inflexibility in opiate prescription, for example. Again and again, we have seen drugs not used when they are needed, or even used when not needed, in ways which bear little or no relationship to the patient's needs, which of course vary all the time so that a routine approach becomes useless and damaging (as, for example, using 'a required' analgesics for constant pain). This problem is redoubled by increasing specialism, where someone may know an awful lot about x but makes mistakes about y, or fails to recognise y or consult a y-ologist when this is necessary. After all if you do not know much about y you are unlikely to recognise it. On at least two occasions we have encountered senior nurses amongst whose patients pain does not occur. This seemed all the more remarkable when, on their translation to other work, pain seemed to break out in the eyes of other observers amongst the very patients for whom they had cared. Acceptance of inadequate pain relief is a more frequent sign of a related attitude. It is remarkable, when one considers how subjective symptomatic must be, that the word of A is so often taken for B's comfort, without considering B's view of his own

symptom alongside A's view of the situation. This happens most when meetings occur in the office, rather than at the bedside.

Communication problems complete this part of the diagnosis. It is often very difficult to ascertain pain unless one uses careful cross-checked methods such as a pain chart completed by different observers (including the patient). But these problems are strongly compounded nowadays by the junior staff shifts and off-periods. It is very difficult to 'hand over' a symptom-control problem to someone who does not know the patient, and will only be in charge for one or two days, though it can be far easier to pass on a technical problem like electrolyte balance, for example. The person who takes over may be a student, or agency staff, or an overseas doctor who is reticent about cultural differences even if he or she is very competent at the technical level. There is also an interaction with the nature of the work; if a neurosurgical house surgeon is in the theatre all day, how can he respond meaningfully to a difficult problem of symptom control? And when the house staff are in theatre, and the nurses are in the ward for most of the time a major inter-professional barrier can arise. The time lag from recognition of a problem to effective action can in such circumstances be as long as a week. A week is a convenient interval between rounds, but a very long time to suffer a severe pain. And do patients know that an 'as required' drug must be requested, and do they know whether the aim is to *abolish* pain or make it tolerable, and that drug dependence is not a problem in the last few months of life?

The nature of the work

This is also most important, and much has been written about the difference between those two modes or (to be theological) 'intentions', of hospital work, 'care' and 'cure'.^{2,6} This is particularly sad when one recollects that in 1750 those words would have meant much the same thing. In 1980 they are often widely dissociated, as in other ways, are diagnosis and treatment. The problem, in modern jargon, seems to be 'primary task orientation', *ie* people are trying to do one thing and do it well. This is fine if patients can be categorised accurately and do not change or multiply their categories. But this is seldom true; patients who are 'curable' become 'incurable', or may develop symptoms which have little relevance to whether or not they can be 'cured'. To make this matter worse, there is a nasty statistical aspect to it. For every patient who seems 'incurable', there is a real chance that he might be cured, however small that chance may be. And, if the doctor changes therapy from the 'cure' mode to the 'care' mode, or vice versa, there is a real chance, however small, that he was wrong, and there is no possibility of making the experiment both ways in the same patient to discover the truth. It is therefore hardly surprising that doctors differ, or that some cling to pointless attempts to 'cure' for longer than others think they should. And, if symptoms are reasonably endured during a few days of the 'curing' process, it is very easy

to set them aside during longer episodes of meddling or mechanical medicine. It is easy to spot meddling medicine after the patient has died, but less easy to diagnose it in the enactment. No wonder that many who long to care end up as frustrated curers, almost in spite of themselves. To try to cure is never negligent, for negligence is a *negative* thing. To fail to care cannot readily be defined as negligence either. So the law unwittingly adds its little impetus to our patients' sorrows. I want to emphasise that I do not see 'care' and 'cure' as mutually exclusive categories. They are two complementary forms of medical activity, which can and should co-exist.

Lastly, there are other differences between hospice and hospital which augment the problems. Hospital work is more variegated than that in a hospice, and the whole tempo of work is geared to throughput at a pace which ill suits the dying or infirm. Routine therapies, reasonably suited to replicable problems like coronary care or hernia surgery, cannot deal effectively with problems where the patient's personality is the prime determinant. So there are confused roles and contradictory attitudes.

The facilities

These are a small part of the problem, as David Littlejohns has pointed out³; all that is needed is in fact available in abundance in a busy general hospital. It just tends to be diverted into main stream tasks, while the dying and infirm drift like bits of wood to the side of the stream, sometimes getting in the way. There is no lack of water, it just travels too fast and in one direction, as it were. The milieu is inappropriate; it has been described as 'two standards of care on the same ward', or as 'the lack of hospitality in hospital'. And do not want anything that I have said to be construed to mean that severe pain *cannot* be relieved in the busy general wards. We have shown that it can, and should be relieved and that if anything the facilities for this are available in plenty. All that is needed is a flexibility of attitudes and skills; there really is not anything very difficult about it.

Relatives

The relatives often have certain stereotyped reactions, arising perhaps from our teaching in part, and from their own aims and guilt feelings as well. These amount to saying that the proper place for the sick is hospital whatever the nature or stage of an illness may be. Certainly, the work and material pressures on male and female relatives alike today inhibit the care and comforts of a patient's home. It is so difficult to help them to see that, once the initial diagnostic phase is past, it may be better for the patient to be cared for at home than for them to be thrown again and again against an unyielding failure to cure in hospital. Sending the patient home looks so like a heartless attempt to empty a bed, for which they feel they have paid at least as much as the next person. And, even if relatives want

patients to die in hospital, the evidence is that patients want to die at home.

One of my character building experiences as a student was to hear that very compassionate lady, Professor Dorothy Russell, say as the houseman ended his history over a post mortem, 'Ah well, we can certainly say that everything possible was done'. Whether the *double* (or treble!) *entendre* was intended or unconscious I do not know, but it is certain that her meaning would have been both penetrating and kind. Perhaps in doing well, we failed to see that there was one more thing we could have done – to stop doing *things*, reconsider the patient, and go all out to help in other ways even if it needed courage, risked misunderstanding, and seemed dangerously original. One can collect dangerously original, but highly appropriate ideas together in a hospice; they tend to die from competition in a hospital.

References

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the terminally ill cancer patient as seen by surviving spouses. *Journal of the Royal College of General Practitioners*, 28, pp 19–30.

²Saunders, C M (1978a) Patient care: an introduction. In *Topics in Therapeutics*. pp 72–74. Tunbridge Wells: Royal College of Physicians of London and Pitman Medical. (1978b) The management of terminal disease pp 1–2 London, Edward Arnold.

³Littlejohns, D W (1979) Paper read to the Section of Epidemiology and Preventive Medicine, Royal Society of Medicine.

⁴Hunt, J M, Stoller, T D, Littlejohns, D W, Twycross, R and Vere, D W (1977) Patients with protracted pain. *Journal of medical ethics*, 3, 61–73.

⁵Melzack, R (1979) Remarks reported in 'Pain topics' December from a conference at New Orleans, Mount Sinai Medical Centre, on evidence published in Melzack, R, Ofesh, J G and Mount, B M (1976) *Canadian medical association journal*, 115, 125–128.

⁶Mount, B M (1978) Palliative care of the terminally ill. *Journal of the Royal College of Physicians and Surgeons of Canada*, July pp 201–208.

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