Ethics

An Ethical Analysis of Crisis in Chronic Pain Care: Facts, Issues and Problems in Pain Medicine; Part I

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We posit that in order to realistically, fully, and most positively affect the capability of implementing a more comprehensive paradigm of pain care it is necessary to: 1) recognize the complexity of chronic pain; 2) account for economic factors imposed upon the health-care system, and 3) enable articulation of any paradigmatic revision within the contemporary medico-legal environment.

Three primary ethical problems arise from the interaction(s) of these contingencies — namely 1) the under-treatment of pain, 2) the inappropriate over-utilization of pharmacologic agents and techniques, and 3) tensions and conflicts that develop within the relationships of pain medicine. All can lead to a failure of technically apt and ethically sound pain care.

This essay — the first in a 3-part series — employs the method of ethical analysis to approach the circumstances, issues, questions, and problems of contemporary practice of pain medicine, to allow insight(s) to the facts, define the agents involved, appreciate how problems are generated, and develop more thorough evaluation and articulation of potential resolutions. We contend that resolution of these problems must offer practical responses to the circumstances and issues. Such practicality entails affording “good” in ways that are grounded to the facts and realities of situations, and are not merely theoretical or conceptual.

Determining the “good” is the work of ethics — as systems and analyses of the moral decisional process. Ethics establishes norms and articulates their use in practice, and we opine that the distinction between the normative and applied is more of a continuum that is dependent upon case and circumstance(s). Given the variety of circumstances in the practice of pain medicine, no single ethical system would be totally adequate, and we believe a discursive approach to be most effective.

Subsequent papers in this series will describe the systems, structure, and function of a putative ethical infrastructure of pain medicine, and will attempt to illustrate how these could be articulated within an integrative paradigm of pain care.

Key words: Pain medicine, crisis, ethics, philosophy, sociology, humanities, chronic pain

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Mayerfeld (1) has argued that there exists a general moral obligation to prevent or relieve human suffering. The original Code of Ethics published by the American Medical Association in 1847 states: "...from the age of Hippocrates to the present time, the annals of every civilized people contain abundant evidences of the devotedness of medical men to the relief of their fellow-creatures from pain and disease..." (2).

While some may question the universality of this obligation, few would argue the ethical responsibility of the pain physician to manage patients' pain and relieve suffering. Edwards (3) has suggested that, "...there is the duty to do all that can be done within the limits of current medical knowledge and available resources to relieve all the pain and suffering which can be alleviated" .

Yet, in this age of technophilic orientations to solving many if not all medical problems, an over-reliance on technology or purely objective assessment(s) can likely result in ineffective attempts to treat a patient's pain (4). In many ways, this reflects a dissonance, if not frank reluctance to confront the limitations and inadequacies borne of the technocentric, disease-based healthcare paradigm. Chronic pain frequently does not neatly "fit" into this model, but rather is more characteristic of phenomenal illness. As such, a more encompassing approach may be required that goes beyond simple focus upon the symptom or disease of pain, and entails evaluating and treating the person who suffers from pain.

We contend that in order to fully and most positively affect the capability (if not reality) of implementing a more comprehensive paradigm of pain care it is necessary to: 1) recognize the complexity of chronic pain, 2) account for economic factors imposed upon the healthcare system, and 3) enable articulation of any paradigmatic revision within the contemporary medico-legal environment.

A Crisis in Pain Care: Time for Change

Three primary ethical problems arise from the interaction(s) of these contingencies — namely 1) the under-treatment of pain (i.e., defensive practice), 2) the inappropriate over-utilization of various pharmacologic agents and techniques, and 3) the tensions and conflicts that develop within the proximate (i.e., patient and clinician) and second- and third-order relationships of pain medicine (i.e., between clinician, patient, and third party payer(s), attorneys, medical

governing bodies, and state and federal agencies). All can lead to a failure of technically apt and ethically sound pain care. These problems are evidenced by a generalized lack of interest in chronic pain management among many physicians (5,6), concerns regarding professional sanctions and legal action relating to the prescription of opioid analgesics (7-9), and a decrease in viable pain management programs due to the insurance industry's and hospital administrations' concerns with cost-containment and profitability when confronting long-term pain management (10,11). As a result, pain care has become increasingly disjunct, broadly affecting pain medicine as a social good, with particular groups of patients — such as the poor (12,13), certain racial and ethnic minorities (14-17), children (18-22), and older patients (23-26) — being at even greater risk for underservice and undertreatment.

Thus, while Congress has declared this to be the "Decade of Pain Control and Research" (H.R. 3244), and there has been increased interest in pain research, there is little compelling evidence to suggest that 1) federal funding priorities for basic and translational pain research have improved, 2) translational research applications are being articulated within an economically supportive healthcare system, 3) medico-legal guidelines and policies have been enacted to thoroughly address the issues and resolve the problems inherent to the practice of pain medicine, and 4) chronic pain is any less prevalent than 8 years ago (27,28). In fact, some have suggested that the problem(s) of chronic pain are actually becoming worse (29). Given the capacity of technology to longitudinally manage chronic diseases, and the increased potential (if not likelihood) for patients who have these diseases to have an extended lifespan with durable chronic pain, medicine in general — and pain medicine more specifically — must ardently address the nature, multi-fold individual effects, and social, economic, and legal impact of intractable pain, and must confront the question of how to heal what cannot be cured. In this light, Ben Rich (30) has noted that "...the silence...of caregivers to adequately address pain in the clinical setting has been deafening." Taken together, these factors have led to what we consider to be a "crisis" — literally a "point at which change must come" — in chronic pain care in the United States.

If we are to develop a voice that calls for, and defines change in the practical and ethical conduct of pain medicine, then it becomes important to approach

these problems with a sense of measure and purpose. In this essay, we employ the method of an ethical analysis to approach the circumstances, issues, questions, and problems that are drawn against the contemporary practice of pain medicine. This approach allows insight(s) to the facts that both underlie the circumstances and which help to define the agents involved, appreciation of how problems are generated at the intersection of agents in circumstance(s), and sustains a more thorough evaluation (and ultimate articulation) of potential resolution(s) of such problems.

THE ANALYSIS

1. The “Facts”

Pain as biological process

Any analysis of an issue must begin with, and be built upon a recognition of facts (and perhaps a realization that such facts may be contingent and mutable) that are pertinent to the situation and relationships of involved agents. Thus, we posit that knowledge of pain — as symptom, disease, and/or illness — must be the basis for any and all constructs of pain medicine (31,32). We have proposed that chronic pain may represent a spectrum disorder that entails co-morbid neuropsychological manifestations (33,34). The expression of this pathologic spectrum is dependent upon genetic, environmental, and experiential interactions throughout the lifespan, and establishes individually unique patterns of physiological, cognitive, emotional, and behavioral responses to (pain as) disease and illness. Often, such co-morbidity presents as frank psychiatric disorder(s) (35), and we have posed that it is important to regard the underlying mechanisms of this spectrum disorder in order to appreciate the pre-disposition to, and co-presentation of, anxiety, mood, and substance abuse disorders in the chronic pain patient (36).

The pathologic process(es) of chronic pain may involve functional and structural activation and remodeling of neural networks involved in affect, cognition, and emotion. As well, changes in peripheral and central nociceptive and analgesic neuraxes can lead to changing thresholds and tolerance to pain. In this way, pathologic down-regulation of pain modulatory substrates would induce both altered patterns of pain and pain modulation (e.g., central sensitization, hyperpathia, allodynia, etc.), as well as diminished pharmacologic sensitivity to analgesic drugs, and could enhance the need for escalating doses of opioids and/or

psychotropics. These mechanisms would elicit effects (e.g., rightward shifted opioid dose-response), and behaviors (e.g., apparent early-phase tolerance, rapid dose-escalation, drug seeking) that would appear to reflect non-responsiveness to treatment, non-compliance, and/or addiction (36-38).

The “self” in pain

This change in the neural basis of multiple domains of neural functions (e.g., sensation, perception, cognition, emotion, and perhaps more expansively, the basis of conscious processes that evoke the definable “self”) contributes to the embodied person who is the patient in pain, defines the uniqueness of their suffering, its impact and expression, and their needs (39,40). As Nuala Kenny (41) notes “...suffering is an experience of persons...we must know persons...to come to some appreciation of their suffering. We cannot predict the source or severity of an individual’s suffering from their diagnosis.” In claiming that the responsibility of pain medicine as a practice is enacted within the relationship of circumstance(s), persons, actions and consequences, we have argued that the pain physician must not only understand pain, but must regard the effects that pain can incur on persons, and appreciate how pain manifests effects in a given patient (42). It is this contextualization that establishes the therapeutic and moral probity of the clinical encounter, and which provides the foundation for the trajectory of any and all care.

2. Agents in Interaction

The pain patient

Knowledge of the complexity of pain (as neural mechanism, symptom, disease, and illness) affords the clinician insight to how pain affects cognition, emotion, and behavior, and provides a “conceptual template” upon which specific patients’ actual presentation of signs and symptoms can be based and evaluated. But ultimately, the reality of the clinical encounter must address the identity and agency of the person in pain. In other words we must ask: Who is this pain patient? How does pain affect this person, and how is it manifest and expressed?

Obviously, pain is defined by its noxiousness, and the adversity of hurting is the most fundamentally negative experience of pain. Yet, for many patients, an equally deleterious aspect of the chronic pain experience is the loss of function, which as Pullman (43) states “...can rob persons of ...capacity to pursue

meaning-conferring endeavors” and purloin their capacity for activities, roles and relationships, independence, and for many, diminish the sense of personal agency and attributive dignity (44,45). Undoubtedly, when an individual has historically been independent across multiple dimensions of functioning (including, but not limited to, activities of daily living, transportation, vocation, finances, etc.), the psychological and social consequences of such physical and economic dependence are likely to be profound. This change (or loss) of agency is compounded by the co-morbidities that frequently are expressed within the pain spectrum. Not only can psychological dysfunction (e.g., anxiety, depressive, and somatic characteristics and/or frank disorders) and substance misuse/abuse elicit increasingly greater subjective “hurt” and suffering (46,47), but these co-morbidities often incur negative stigmatization that may become implicitly (or explicitly) apparent even within the medical relationship.

The pain clinician

The pain clinician’s claim to be a specialist invites the trust and reliance of the pain patient. In making this claim, the clinician not only declares a specific level of knowledge, and skill, but also affirms that this knowledge and capability will be used in ways that uphold the “good” of each and every (prospective) patient. We have opined that the pain clinician must utilize differing domains of knowledge in distinct ways and with appropriate balance to comprehend pain and discern its effects and expressions in the patient (48). While a mechanistic knowledge of pain can be objectively acquired, the effects of pain on the life world of a given patient require subjective insight. It is the combination of objective and subjective information that allow the clinician to 1) determine “the good” relative and relevant to a particular patient’s (biomedical, psychological, and social) needs, values, and goals, and 2) direct the best (i.e., most technically right, and morally sound) course of care.

But the pain clinician is a person in her own right, with values, and dispositions that dictate her moral compass. How will she use her specialized knowledge? How will she enact the promise of profession in practice? In many ways, this speaks to what it means to “be” a pain physician. At the fore is a responsibility to both acknowledge the enigmatic nature of pain and its effects, and realize that the pain patient often co-presents with psychological and/or substance use

issues that can complicate diagnosis and treatment. These complications heighten the vulnerability of the pain patient, and deepen the therapeutic and moral obligations of the clinician.

Clearly, unconditional positive regard is essential to any clinical practice (49), but even so, it is important to acknowledge that socio-cultural experiences can, and frequently do, shape the values and expectations of clinicians (50). We have stated previously, and reiterate here that “...the physician who enters the field of pain medicine does so by choice” (51). Thus, on an elementary level, we contend that the values of the pain clinician must be consistent with attending to the exigencies of the pain patient (e.g., psychological co-morbidity, potential for substance misuse/abuse).

The community of patient and clinician

That needn’t mean that the values of clinician and patient must concur, but rather that clinician and patient should develop and work toward realistic goals that the patient has identified, and which are based upon the premise of shared intentionality of pain relief and/or effective management and healing (52-54). Nor does this create any undue assumptions about what is required of the pain patient, who, in his/her state of vulnerability, might not be expected to be responsible for anything more than respect, and a commitment to the construct, goals, and ends of the medical relationship (54,55).

The patient is driven to the clinician out of need, while the clinician freely enters the practice of pain care because of an intellectual and emotional identification with, and dedication to, helping and healing persons in pain. This fiduciary establishes the patient and clinician *de communitas* — “in community” (56, 57). Such sense of community is based upon the shared identification of “good” that is achievable within the relationship, and in this way the relationship is both therapeutic and moral — the clinician must seek to provide biomedical good in ways that allow equal appreciation for patients’ values, goals, and choices, and which convey respect for the patient as a person (57). In the ideal, the “healing agency” of the clinician engenders the restored personal agency of the patient.

But the medical relationship is not enacted in a vacuum, and so even the most aligned values and interactive agency of patient and clinician are subject to the intentions and acts of agents and forces external to the clinical encounter. To be sure, the values and

relative power of patient and clinician are asymmetrical to begin with, and given that pain medicine exists within a social environment, socio-economic and socio-legal factors frequently become the source and/or instigation of ethical issues and problems within clinical practice. Thus, if we are to catalyze change, we must look to the practice of pain medicine — writ large as a social good, and small as the individual good(s) rendered within the clinical encounter — to identify the issues and problems that impede progress, elucidate the causes and consequences of these issues and problems, and develop resolutions that are most well-informed, practical, and morally sound.

3. The Nature of the Issues and Problems

The ethical, economic, and legal boundaries of these issues and problems are not clearly demarcated. Instead, these domains tend to be reciprocally influential. A number of convergent forces have created the social environment, and set the stage for the ethical problems of contemporary medical practice, including 1) the progressive rise in market values and the business ethic as a consequence of the second industrial revolution; 2) fortification of market incentives of time-restriction and cost-efficiency fostered by an increasing reliance upon technology and technocentric mindset; 3) a renewed interest in patient autonomy that has been spawned, at least partly, by legal response to socio-medical misconduct in the twentieth century (e.g., medical crimes against humanity, resulting in the Nuremberg Code, Belmont Report, etc.), and a strongly libertarian anti-paternalistic sentiment, and 4) an increasingly litigious social climate, that ultimately relegates medicine to business conduct, and imposes contractual regulations upon medical practice(s) (58).

That economic influences have significantly affected the subsidy, and conduct of pain medicine (i.e., both research and practice) is undeniable, and despite the congressional incentive for "Pain Control and Research," the diversity (and perhaps appropriateness) of pain care has not been meaningfully enhanced. In many ways, this is a reflection of how market effects (e.g., short-term vs long-term cost and benefit analyses, prohibitive third-party payer regulations, etc.) that have negatively impacted the provision and availability of viable resources for treating and managing chronic pain. Diminishing resources coupled to an increasing need and demand for pain-related services

have commodified the practice of pain medicine (a trend also seen in medical practice, at large) and have established the clinician as "provider" and patient as "client" (59).

This has hobbled professional responsibility and capacity in 3 ways: First, it has led to a somewhat bastardized conceptualization of patient autonomy to be construed as "the right of unrestricted free choice," rather than the dignity of independent action and agency and/or (albeit somewhat more narrowly defined) the negative right to refuse care that is offered. Second, the primacy of the patients' best interests is often subordinated to an economically-driven decisional process that has created supply-demand discrepancies; and third, these factors have prompted increasingly contractual, if not litigious, undertones that have progressively affected the scope, type, and nature of pain care.

In the main, this has led to the notion of "patient as consumer," that has created a direct tension between the expert knowledge and actions of the clinician, and the choices and behaviors of the patient. The medical relationship is based upon the definable medical needs of the patient, and the clinician's abilities to assess these needs and provide proper, safe, and sound treatment(s). Consumerism has resulted in an escalating pressure to provide treatments that patients view as being of "greatest value" (viz., facilitating the greatest "return" — i.e., perceived subjective effect — in light of investment of time and cost incurred by delays in receiving care, non-appropriation of benefits, etc.). Often the "high value" treatments requested/demanded are opioids and/or excessive interventional techniques (including surgery). This can lead to an overutilization of agents and procedures in an attempt to accommodate patient demands (i.e., acquiescent care, in which patient "autonomy" trumps that of the clinician to exercise prudent expert use of knowledge and skill). Characteristically this is prompted by patients' fears of escalating pain, diminishing resources, and availability of care, and by clinician's fears of legal retribution by "unsatisfied" patients (58,59).

As well, underutilization/provision of agents and procedures is equally prevalent and none the less problematic. In this case, restricted treatment can result from 1) diminishing or non-available (fiscal and/or clinical) resources; 2) inadequate third-party coverage schemes; 3) clinicians' fears of medico-legal sanction

and prosecution, 4) clinicians' mistrust of patients' capacities to abuse "autonomy," and/or 5) clinicians' discomfort of losing control of the medical situation (60-62).

4. Toward Resolution: The Need for Practical Ethics

At least part of the problem stems from a lack of cohesion in pain medicine, ranging from practice models and settings to inadequate policy and economic support for research and clinical care. Resolution of these problems must offer practical responses to the circumstances and issues. By definition, such practicality entails affording "good" in ways that are grounded to the facts and realities of situations and that are not merely theoretical, conceptual, or implausible. In this way, any attempt at resolving these problems must acknowledge technological advances, their applications, limitations, and effects, and must equally exhibit sensitivity to the social and personal factors that characterize pain medicine (60,62). Determining what is "good" is the work of ethics — as systems and analyses of the moral decisional process. Ethics both establishes norms and articulates their use in practice, and thus the distinction between the normative and applied is nominal at best (63), and as matter of fact is more of a continuum of expression that is dependent upon case and circumstance(s). Given the variety of

circumstances in the clinical practice of pain medicine, no single ethical system would be totally adequate, and a discursive approach is likely to be most useful and effective. It may be that what is actually needed is a meta-ethics of pain medicine, despite the onerous nature of such an undertaking. But for a meta-ethics to have any applied value and validity, it must be equally committed to the facts, realities, and contingencies of pain medicine as profession and practice, and therefore must incorporate an ethical "infrastructure and function" that engages ethical systems and approaches in ways that support and sustain the good to be provided on individual and public levels (64,65). Subsequent papers in this series will describe the systems, structure, and function of this ethical infrastructure of pain medicine, and will attempt to illustrate how these approaches could be articulated within an integrative paradigm of pain care.

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