

Grappling With the Ethics of Practical Pain Management

By James Giordano, PhD



“Champions...know that the best way to forecast the future is to change it...”

—Michael J. Gelb¹

One of the difficulties in discussing medical ethics is that it often tends to be perceived as something “external”—something which must be applied to the internal machinations of the practice of medicine. While this approach is not wholly impossible, it is often inadequate or becomes superficial because it fails to recognize how medical practice gives rise to the moral issues and/or problems that require deliberation and the use of one or more ethical systems for resolution. Moreover, this externalized approach tends to foster a view of ethics as an “after the fact accoutrement”—something akin to an “add-on” to be used when situations get sticky and problems arise—rather than being an essential dimension of medicine as a profession. Yet the “work” of medicine is classically defined as a moral, humanitarian enterprise.² Clearly, when one claims to be a medical professional, it is assumed that s/he can be trusted to be morally and ethically responsible.³

Ethics as Component Knowledge, Skill, and Art

Therefore, it becomes apparent that ethics is vital to the body of knowledge and skills that constitute medical practice. In this way, it is what my former college wrestling and judo coach used to call “grappling legs.” The point was simple, to be a good grappler (in both wrestling and judo) one needs a strong set of legs to remain well-planted, and to provide pivotal and driving force in order to generate the whole-body power to make “...the right moves”—even when down on one or both knees. So it is with ethics. Recalling that ethics is defined as a formal systematized description and analysis of moral decision processes,⁴ then for ethics to have any utility, integrity and/or value, it must be well grounded and be able to function efficiently as a part of the working tools that enable decisively right actions to achieve success in the circumstances at hand. To extend this analogy a bit farther, wrestling and judo are sports of technique, power, and timing that combine skill with a fair bit of finesse. Knowing what techniques to use; how, why, and when to use them; and coupling this technical acumen to balance, strength, situational awareness; and a sense of fair play and adherence to the rules are intrinsic to becoming a champion grappler.

Rollin Gallagher, Editor-in-Chief of the journal *Pain Medicine*, and Director of Pain Management Services at the Philadelphia

VA Medical Center, has called for clinicians to accept the challenge(s) of becoming “champions of pain care” in the spirit of the late John Bonica.⁵ What will it take to become such a champion? While medicine is a skill and art, philosophers Albert Jonson and Steven Toulmin assert that all clinical judgments are a form of moral decision-making.⁶ Based upon this premise, the act of medicine—as the provision of right and good care—cannot be divorced from ethics when grappling with the issues and problems that are inherent to its practice. This being the case, the inseparability of therapeutic and moral agency in clinical decision-making compels having, and using, the right (types of) knowledge to allow situational assessment and the execution of good action(s).⁷ As James Rachels notes, it is “...morality [that] guides one’s conduct by reason...to do what there are the best reasons for doing, while giving equal weight to the interests of each individual who will be affected...”⁸

A Working Ethics of Practical Pain Management

Just as the wrestler needs preparatory training in order to build “grappling legs,” a working medical ethics also requires preparation to establish a firm foundation. This entails an understanding of:

- 1) why and how moral responsibilities are generated by the facts of disease and illness (in this case pain and suffering),
- 2) how the expression of pain, needs of the pain patient, and various (social, financial, and legal) demands and exigencies create issues and problems within the reality of pain medicine, and
- 3) how the strengths and limitations of particular ethical approaches may allow or impede their use in resolving these problems.

This background information is not esoteric; rather it clarifies *that* and *how* ethical issues are woven into the fabric of pain medicine’s practice. Over the past two years, my overarching goal for this column was to establish and inform this background. Instrumentally I’ve tried to accomplish this in three ways: first, I’ve attempted to shed light on how the physiology of pain and the experience of the patient and clinician give rise to the moral obligations of pain medicine.⁹⁻¹⁴ Second, I’ve sought

to define the basis of morality and ethics, and its importance to, and in, practical pain management.^{15,16} Third, I've posed the argument that these obligations are wedded to the core philosophical foundations and premises of medicine,^{17,18} and fourth, I've tried to explain how this philosophical basis (i.e., the knowledge, humanitarian applications and ethics that constitute, bio-psychosocially focused pain care¹⁹⁻²¹) should underscore any and all practice guidelines, health policy, and laws.²²⁻²⁷ Table 1 provides a template for how these papers might be arranged to depict what Pellegrino calls "...ethics from the ground up."²⁸

Given this background preparation, I think it is time to step up to the challenge and wrestle with some of the specific ethical issues in practical pain management. In doing so, I offer that the techniques of an ethics consultation in practice be used. This is a process that is usually formalized into seven steps that involve:

- 1) identification of the relevant facts,
- 2) identification of the agents and their participatory roles in the circumstances;
- 3) identification and framing of particular ethical issues,
- 4) illustration of the problems arising from the intersection of circumstances, agents, and issues;
- 5) identification of potential approaches to resolving the problems using various ethical systems and resources,
- 6) recommendation and/or undertaking of some decision or action to achieve such resolution and
- 7) analysis of outcomes relative to the process and its effects.²⁹

Ethical Issues and Problems

From the discussion offered in this column to date, we are already aware of the facts of pain and pain medicine. From this, it should become clear that many of the focal ethical issues reflect the difficulties in pain care as profession and practice. For example, while research has allowed the development of several new (pharmacological, non-pharmacological, and technological) forms of therapeutics, such studies have not been without challenge(s), and the direct translation to available clinical intervention(s) has been less than robust.³⁰ Economic influences have significantly affected the subsidy of both pain research and provision of treatment, and this has led to a reduction in the diversity, if not appropriateness of pain care. As well, market forces have established the patient as consumer, clinician as provider, and instilled third-party regulations to create a commodified milieu that fosters supply-demand discrepancies, inequitable provision of care, and hegemonious practice management.

These issues spawn an array of problems. Broadly these can be regarded as the under-treatment of pain, (inappropriate) over-treatment of pain, and the tensions (if not frank conflicts) that arise between the agents within the relationship established by the practice of pain medicine. But tension(s) and conflict(s) are not limited to the proximate interactions of the physician and patient. The contemporary medical relationship has been broadened to involve patients' families, and is subject to the influence(s) of patients' employment economics, third-party payer, and legal limitations. These factors can play a role in determin-

CLINICAL BIOETHICS ARTICLES ARRANGED "FROM THE GROUND UP"

I. The Facts of Pain and Pain Medicine

- Understanding pain as disease and illness, Part 1. *PPM* 2006; 6(6):70-73.
- Pain as disease and illness, Part 2: Structure and function of the ethics of pain medicine. *PPM* 2006; 6(7):65-68.
- A big picture: neurogenesis, pain, and the reality and ethics of pain medicine. *PPM* 2007; 7(2):37-52.
- Bioethics and intractable pain. *PPM* 2005; 5(7):72-79.

II. Agency, Ethical Approaches, and the Medical Relationship

- Agents, intentions and actions: moral virtue in pain medicine. *PPM* 2006; 6(4):76-80.
- On knowing: Domains of knowledge and intellectual virtue in practical pain management. *PPM* 2006; 6(3):65-76.
- The "promise" of pain medicine: profession, oaths, and the probity of practice. *PPM* 2007; 7(8):78-80.
- The good patient: responsibilities and obligations of the patient-physician relationship. *PPM* 2007; 7(9):58-61.
- The moral community of the clinical pain medicine encounter. *PPM* 2006; 6(5):60-63
- Invoking the placebo effect. *PPM* 2007; 7(4):30-32.

III. Applications in Practice

- Pain research: The relationship of knowing and doing. *PPM* 2007; 7(5):28-30.
- On the role of primary care within a system of integrative multi-disciplinary pain management. *PPM* 2006; 6(8):66-69.
- Pain medicine, morality and the marketplace; time for a change. *PPM* 2006; 6(1):88-89.
- Pain and psychopathology in military wounded: How etiology, epidemiology sustain an ethics of treatment. *PPM* 2007; 7(6):34-42.
- Rational, emotive, ethical approaches to psychosocial pain care. *PPM* 2007; 7(7):74-78.
- Chronic pain and spirituality. *PPM* 2007; 7(3):64-68.
- Dignity and pain medicine at the end of life. *PPM* 2006; 6(2):68-70.
- Resolutions: Examining the past, present, and future of practical pain management. *PPM* 2007; 7(1):63-67.

TABLE 1. Readings from this column in Practical Pain Management are arranged to establish a step-wise, "from the ground up" understanding of the facts, agents, and circumstances that are the focus of a working ethics of pain care.

ing the scope, tenor, conduct and trajectory of the clinical encounter and, as such, may be a contributory source of ethical issues and problems. Moreover, (pain) medicine is enacted within society, and is therefore affected by what H. J. Blackham refers to as “the permanent problems of human history”—namely the nature of truth, the role of religion, political influence(s), economics, cultural variation, and societal plurality—and how each and all of these impact the nature and viability of moral value(s).³¹

Moral Agency and the Question of Ethical Expertise

Ultimately, we must confront the question of who shall deal with these problems. In this light, it is important to explore the meaning and validity of the concept of “ethical expertise” as relevant to pain medicine.³² While I have argued that the

if pain care continues to move toward the single practitioner model, will it then become incumbent upon every clinician to develop and possess the knowledge and skills that are necessary and sufficient to allow ethical expertise? What are the particular situations and the ethical issues and problems that (not only could, but most likely will) occur in the practice of pain medicine? How will (and/or should) clinicians handle these situations and responsibilities? How can the clinician determine what ethical approach(es) work best when moral consideration becomes the most prominently relevant factor in clinical decision-making?

Toward a Coordinated Plan

Each of these questions, issues, and problems will be dealt with throughout the coming year—not so much with the goal of providing absolute resolutions to the

coordinated effort must not only engage the most current technological advances, but must be equally sensitive to inter-personal and social factors so as to remain ethically responsive and competent—thereby sustaining both the skill and art of pain medicine. My hope is that this column will afford some tools to enable clinicians to prudently wrestle with the ethical issues that arise in clinical practice, for as Hippocrates perceived: “...life is short, and the Art long; the occasion fleeting...and judgment difficult...”⁴⁰ In other words, to paraphrase John Bonica (who was, in fact, a very good wrestler himself!)—pain medicine isn’t easy⁴¹—but neither is being a champion. ■

James Giordano, PhD, is Samuelli-Rockefeller Professor of Palliative Care in the Department of Medicine, and Scholar-in-Residence at the Center for Clinical Bioethics, Georgetown University Medical Center, Washington, DC. He is Director of the Center for Brain, Mind, and Healing Research at the Samuelli Institute, Alexandria, VA, and Visiting Fellow in Medical Philosophy and Neuroethics at Harris Manchester College, University of Oxford, Oxford, UK.

“What are the particular situations and the ethical issues and problems that (not only could, but most likely will) occur in the practice of pain medicine? How will (and/or should) clinicians handle these situations and responsibilities?”

clinician is both therapeutic and moral agent and, as such, is certainly responsible for his/her moral conduct,³³⁻³⁶ we must ask whether the medical professional can be expected to possess and utilize a complete enough knowledge of ethical systems to navigate the issues and problems that are part of the moral sphere of pain practice. Moral agency, while necessary, may not be sufficient for the level of expertise required to navigate the ethical terrain shaped by contemporary society. But given the progressive reduction in multidisciplinary pain centers, decrease in dedicated hospital-based pain management programs, increase in single-clinician pain practices, and the persistently diverse, if not inchoate nature of “pain medicine” as a discipline and/or field, we are left to ponder how such issues will be handled. Will ethics committees become the norm in every pain clinic? But, what will happen if the current trend continues, and large, multi-disciplinary pain care centers are replaced by smaller, single-practice clinics? Will all of these clinics incorporate an ethicist and/or ethics’ advisory board to engage in ad hoc ethics consultation(s)? Or,

problems at hand, but rather in an attempt to allow more complete analyses, and provide guidance and insight to tentative answers that are consonant with our readers’ personal moral compass. And while I have advocated an agent-based, virtue ethics, I re-iterate that virtue(s) must work with and within other ethical systems and approaches. Still, it may be that practical wisdom—what Aristotle referred to as *phronesis*—is what will be needed to select the right approach(es) to address and handle the issues and problems in specific cases.³⁷ But *phronesis* is not static; it requires ongoing re-evaluation of knowledge and information and, in this way, remains reflective, flexible, and dynamic. In other words, it remains practical by being a “working” wisdom.³⁸

In forthcoming columns, I will present an overview of what ethical approaches may be best suited to particular circumstances, address the limitations and delimitations of these approaches and, in so doing, attempt to fortify a practical knowledge of ethics that allows what Benjamin Crue referred to as a “...better coordinated assault on the problems of pain.”³⁹ This

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