Ethics & Pain: Relationships & Issues

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Outline

• Ethically salient aspects of pain
• Relational aspects
• Specific Issues
  – Substance abusing patient
  – Opiate contracts
Ethically salient aspects of pain

- Foundational
- Subjective/objective
- Moral weight
- Under & Over Treatment
Foundational

• Pain \( \approx \) Suffering
• It is our raison d'être
• Defines healthcare professions
Subjective / objective

• Ultimately subjective
  – What is pain?
  – Intersubjectivity

• Pain as:
  – Feeling
  – Awareness

• Experienced as objective
  – Patient
  – Clinician
Subjective / objective

• Evokes objective phenomenon – Tissue damage
• Can be accurately imputed based on observation, in many cases
  – But not all
• Prioritization of observable, quantifiable phenomena
• Wittgenstein’s beetle in a box
“Disease” is only one cause of symptoms

Pathologically defined disease (e.g., demyelination)

Psychological factors (e.g., Anxiety)

Physiological processes (e.g., physiological tremor)

Social/cultural factors (e.g., poverty)

Symptoms - Observed & Experienced

Changing perception?

• DSM-IV - Pain disorder
  – Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

• DSM-5 - Somatic sx disorder with predominate pain
  – Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
    • Disproportionate and persistent thoughts about the seriousness of one’s symptoms.
    • Persistently high level of anxiety about health or symptoms.
    • Excessive time and energy devoted to these symptoms or health concerns.
Under-treatment

• *Prima facie* unethical
• Relationship
• Trust
• To avoid over-treatment
Over-treatment: Patient requesting “unneeded” treatment

• Respect for autonomy
  – Patient requests v. refusal of treatment

• Clinician’s assessment
  – “If I don’t see it; it isn’t real”

• If you are “correct”, the patient is either:
  – Lying,
  – Self-deluding, or
  – Mistaken about the best treatment
Over-treatment: Individual v. public health consequences

Risk assessment

Individual

- Low risk
- Risk assumed by patient
- Error of giving unneeded med
  - Pt gets what they desperately want
- Error of not giving needed med
  - Unnecessary suffering

Public Health

- Risk high enough in aggregate that it creates significant problem
- Respect for autonomy less compelling in public health crisis
Relational aspects of treating pain
The aches of others hang by a hair
- Sancho Panza
• Requires subjective data
• Power imbalance
• Gate-keeper
  – Drugs
  – Sick role
• Legitimate & illegitimate suffering

“Health care ethics deals with transplants and gene therapy, but not with whether I greet you in a friendly enough manner”
Gatekeeper of sick role with access to drugs
[Does] “being sick” constitutes a social role at all - isn't it simply a state of fact, a “condition”? . . . The test is the existence of a set of institutionalised expectations and the corresponding sentiments and sanctions.

*The Social System. 1951, pg. 436*
Parsons’ Sick Role

• “Sanctioned deviance”

• Aspects of sick role
  – Exempt from normal social expectations & responsibilities
  – Not responsible for the condition
  – Requires external assistance
    • Seeks socially sanctioned help
    • Shuns role (despite advantages) and tries to get well
Obligations of the Sick

– Try to get well
– Get help
  • Competent/socially sanctioned help
  • Licensure
– Cooperate with the professionals
  • Compliance
– Don’t enjoy (or take advantage)
Three versions of Parsons’ Sick Role

1. Conditional
   – Temporary, recovery is expected with person’s active participation to end sickness

2. Unconditionally legitimate
   – No recovery expected, nothing the person can do

3. Illegitimate
   – A stigmatizing condition
   – Person is blamed for condition
Legitimacy

- Real & Unreal pain
- Pseudo & real addiction
- “Deserving” opiates
- Potential Bias
  - Self-caused suffering
  - Against pain without demonstrable physical cause
Therapeutic connection is more difficult when patient is held responsible for the problem by the clinician.*

Divergent trends in societal consideration of health behaviors creates confusion of attitudes toward lifestyle related pathology

- Perception of health as determined biologically and/or genetically
  - Increases sympathy for patients with lifestyle related disease

- Perception of health as a moral issue of choice
  - Decreases sympathy for patients with lifestyle related disease
Notes on relationship

- Caring concern for the patient is not part of treatment – it is the reason for treatment.

- Factors affecting the clinical relationship:
  - Patient seen as not responsible for problem\(^1\)
  - Patient communication skills\(^2\)
  - Patients express appreciation for care\(^3\)
  - Patient’s social skills\(^4\)
  - Degree of similarity in values

\(^1\) Morrison, 1990; Olsen, 1997
\(^2\) Podrasky & Sexton, 1988
\(^3\) Kahn & Steeves, 1988
\(^4\) Podrasky & Sexton, 1988
“And remember when you’re out there trying to heal the sick, you must always first forgive them.”

From *Open the door, Homer* by Bob Dylan
Two Related Issues

1. Pain relief in drug abusing patients
2. Opioid contracts
Pain relief in drug abusing patients

- Perception of risk
- Social aspects
- Ethics of treatment
- Harm reduction
The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the “social worker”-judge.

From: Discipline and Punish
People take risks
Clinicians and patients may assess risk differently.
Assessing risk of health behaviors

**Patient factors decreasing perception of risk**
- Sense of control over unhealthy behavior
- Familiarity with unhealthy behavior
- Active involvement
- Discounting the future
- Visceral factors
  - Healthy behavior unpleasant
  - Unhealthy behavior has increased desirability (addiction)

**Clinician factors increasing perception of risk**
- No control over patient behavior
- More familiar with negative consequences
- Not involved
- Future not considered
- No visceral reaction to patient behavior
Evidence and risk perception - 1

- Increased perception of risk increases compliance (Cava, et al., 2005)
- Increased sense of risk predicted smoking cessation (Borelli, et al., 2010)
- Bias that others are more likely than self to get disease (Etchegary, 2009)
  - HIV and AIDS (Raghubir & Menon 1998; Schneider, et al., 1991; Bauman & Siegel 1987; Joseph et al. 1987)
  - Flu (Larwood, 1978)
  - Hepatitis (Menon et al. 2002)
  - Cancer (Lin et al. 2003a, 2003b; Perloff & Fetzer, 1986)
    - Smokers believe they have lower risk of cancer than other smokers (Weinstien, et al., 2005)
  - Mental illness (Drake 1987; Kuiper, &MacDonald 1982; Perloff & Fetzer 1986)
Evidence and risk perception - 2

- Factors influencing risk perception
  - Personality
  - Trust (Aldoory & van Dyke, 2006; Brown & Ping, 2003; S’lachtova’ et al. 1998; Wakefield & Elliott, 2000; Walter et al., 2004)
  - Familiarity - without knowledge? (Hawkes & Rowe, 2008)
  - Emotional state (Cerully & Klein, 2010)
  - Sense of control (Kenen, et al., 2003; Mgalla & Pool, 1997; Miles & Frewer, 2001; Miller, 2005; Rodham et al., 2006; Salazar et al., 2004)

- Sense of risk increased with “contemplation” & “preparation” stages in medically ill smokers (Borelli, et al., 2010)
Frustrations of non-compliance

• We value what is best for patients
• We value shared decision-making
• We value liberty as the right to choose lifestyle

But, at the same time -

• People are responsible to care for themselves
• It's hard to watch patients hurt themselves
  – It’s wrong to “help” patients hurt themselves
  – It can feel like the patient is “wasting” your time
Two duties – One conclusion

Duties

1. Provide optimum treatment
2. Respect patients’ choices

This means:

• Giving the best treatment feasible within constraints created by the patient's life choices.
  – Unless there is compelling justification to override a patient’s decision:
    • Lack of decision making capacity
    • Imminent serious harm to third parties
    • Suicidality
Principles of harm reduction-1*

• People choose harmful behavior, HR seeks to minimize the degree of harm
• Health behavior “is a complex, multi-faceted phenomenon” on a continuum where some behaviors are safer than others
• Quality of life and not compliance are the criteria of successful intervention
• Non-judgmental, non-coercive provision of services to assist patient in reducing risk
Principles of harm reduction-2*

• Patients are the primary agents of reducing harm, HR seeks to empower patients to meet perceived needs in real life conditions

• Poverty, class, racism, and social isolation, affect both people's vulnerability and capacity for effectively dealing with behavioral change

• The real threat of the behavior must not be minimized or exaggerated

Ethics and harm reduction

• Respects patient’s choice
• Action directed toward patient’s well being
• Acts for benefit of others by reducing risk
• Conveys message of caring, concern for patient’s welfare
• Evidence shows HR works in drug abuse and AIDS
Arguments against harm reduction

- HR sends a mixed message
- Fears that HR encourages negative behavior
- HR fails to get patients to stop risky behavior
- Addiction reduces autonomy
  - One of the rationales for tolerating unhealthy behaviors is to value the patient’s choice
- Some behaviors mean risk to third parties
Opioid contracts
“Opium teaches only one thing which is that aside from physical suffering, there is nothing real”
A. Malraux *Man’s Fate*
Typical Contents:
Prohibited behaviors & Points of termination

- General statement about the gravity of opioid treatment
- Compliance monitoring including random drug testing
- General cooperativeness with therapy appointments etc.
- No bad behavior – Selling doses, taking street drugs
- No extra refills
- Consequences – No opioid treatment
Not in opiate contracts

- Goals of care
- Clinician obligations
- Commitment to alleviating patient’s pain
- Criteria for treating with opioid
  - For example - Clinical assessment of more benefit than harm
- Potential alternatives if opioid not in patient’s best interest
Contract puts onus on the patient to demonstrate to clinician that:

1. My pain is real
2. I can be trusted
   –And therefore, I *deserve* an opiate
**Goals of Opiate Contract**

- **Informed consent**

- **Adherence** – Evidence unclear
  - Hariharan, et al. (2007) 60% adherence
    - 17% cancelled for sub. abuse or non-compliance
  - Penko, et al. (2012) 44% unaware of contract

- **Relationship**
  - Creates intimidating adversarial relationship, **OR**
  - Reduces misunderstandings/miscommunication
Recommendations

• Less a “contract” than a message
• Use as a statement of concern
• “I can help alleviate your pain if you are forthright.”
  – Is the clinical encounter a safe place to disclose?
• Holistic treatment
• Consider 3rd party monitoring
• Include:
  – Mutually agreed goals of treatment
  – How pain will be treated if opiates become unsafe or are no longer clinically indicated?
Four Lessons from Investigating Patient Complaints

1. Tell patients what’s going on and what to expect, even if they aren’t going to like it.

2. Pay attention to the process of care

3. Allow patients to feel ambivalent about treatment

4. Relationship
If your model of how pain is produced by brain activity still has a box in it labeled ‘pain,’ you haven't yet begun to explain what pain is. . .”

From *Consciousness explained*. 1991