ETHICS FORUM

The Pain-Procedure-Insurance Triad: Bonds to Help May Hurt

Michel Y. Dubois, MD—Forum Editor

In Ethics Forum, we will present clinical cases selected on the basis of diagnostic dilemmas and/or difficult therapeutic decisions that occur in the practice of pain medicine. We will ask several pain specialists to help identify the ethical issues raised in these cases and to give their opinions based on their perceptions and experience. Please send or e-mail (ch53@drexel.edu) your comments or remarks to Colleen Healy, Editorial Assistant, Pain Medicine, Pain Center, Graduate Hospital, 1800 Lombard Street, Philadelphia, PA 19146. Also, if you believe you have witnessed a case that presents an interesting ethical dilemma for examination, send it for possible inclusion in the Forum.

Case Study

The patient is a 69-year-old widowed white female with a 10-year history of chronic low back and leg pain. She has had two back surgeries in the past for presumed spinal stenosis. These did not produce significant pain relief. They were followed by multiple interventions to address her pain, including selective nerve root blocks, lumbar epidural steroid injections, facet injections, and rhizotomies. The patient did not experience any lasting pain relief from any of these procedures. The patient's overall functional status has deteriorated steadily since the beginning of treatment. Before her first surgery she played tennis regularly. Now she is essentially bedridden. Insurance coverage of her care is becoming more difficult, leaving more and more out-of-pocket expenses, which the patient can barely meet. The patient has been reading information on the Internet and now requests implantation of an intrathecal pump for opioids. The insurance company is balking at this expense, given her lack of response to other therapies. The patient wonders how they can deny her this last chance at relief.

Comment no. 1: Mark Sullivan, MD, PhD

This case raises a number of ethical issues. One concerns the insurance company's perspective on the case. Another concerns the nature and limits of the physician's duty to relieve patient suffering. But the issue I consider central involves defining the nature of the patient's problem and the nature of appropriate therapy. It is here that we must find a way to respect patient welfare and autonomy.

Therapy to this point has been localized to the spine. It has failed to alleviate pain or improve function. The patient again requests a therapy directed toward the spine. Are we obligated to provide this therapy, or should we broaden the approach and look to other potential contributing factors, such as depression or dementia? Patients often resist these explanations, preferring to focus on the dysfunction of the painful body part; but we now have a patient bedridden with pain. These patients have extremely high rates of major depression. Depression diagnosis and treatment as appropriate are now essential, if not straightforward, parts of treating this patient.

The patient may resist depression diagnosis by refusing to acknowledge dysphoria. If she acknowledges anhedonia (the inability to enjoy any activities), a diagnosis of depression can still be made. She may attribute adhedonia to pain, but this is rarely legitimate according to DSM-IV criteria, where the symptom must be a "direct psychological consequence of a general medical condition" to be excluded from depression diagnosis.

The patient may accept depression diagnosis but resist depression treatment. She may state that her depression is the result, not the cause, of her pain. If her pain could be relieved, her depression would improve. She resists depression treatment because she does not think it gets to the root of her problem. Sometimes this argument can be addressed by talking to the patient about a vicious cycle of pain and depression.

Let us assume that she continues to resist depression treatment and to demand an intrathecal pump. Should she be given the pump or forced to take an antidepressant before the pump is considered? Each option is fraught with problems. Implanting a pump in a seriously depressed patient ig-
nores a life-threatening problem and likely will not relieve her suffering. Forcing antidepressants on an unwilling patient likely will produce intolerable side effects.

Negotiating a mutually acceptable illness model with the patient is the best course of action. Her initial choices may not be well informed and should not be followed slavishly. Often, including family in the illness model negotiation is very helpful: diagnoses of depression or dementia that are not accepted from physicians may be accepted from other family members. If she continues with severe pain after depression has been successfully treated, it may well be reasonable to implant a pump. If successful treatment of her depression is not possible, then pump implantation is a more difficult decision. Would therapy for depression proceed better after pump implantation? We would need to try it to see.

Comment no. 2: Allen Lebovits, PhD
This case delineates several ethical challenges faced by today’s pain practitioner that were not as prevalent several years ago. Foremost is the challenge of third party payors dictating treatment on the basis of reimbursement schedules. Now there is someone else in the treatment room, besides the patient and doctor, who may not have the patient’s best interests in mind. How does the health care provider resolve what seems to be a conflict between the principle of beneficence and earning a living? This case is further complicated, however, by possible violations of the maleficence principle, through overly aggressive treatment that seems to have done more harm than good. Failed back surgery syndrome is increasing in frequency due to overly zealous surgical interventions. But the surgeon alone is not to blame. Why did this patient continue to undergo multiple pain procedures, many of which use largely unproven methods, and each with iatrogenic effects, in light of a progressive deterioration in her functional status? This elderly and widowed patient, like many chronic pain patients, may be desperate to maintain her quality of life, but possibly overwhelmed by the medical system she is caught up in. She is vulnerable to overly aggressive providers who might be driven, to an extent, by economic incentives, as opposed to beneficence. But doctors and insurance companies alone are not to blame, for the patient herself is seeking further aggressive treatment. The explosive growth of the Internet has created a new ethical challenge for providers—patients who form opinions and make treatment demands after reading selected and often biased information on the Internet. What does the provider do in light of the now more educated patient’s right to autonomy? Providers know that if they refuse to perform the procedure, the patient can go down the block and get it done by someone else, who might not be as competent.

Given the patient’s 10-year history of chronic pain, which predicts a poor prognosis for significant pain improvement, the ethically correct approach would be to educate the patient and redirect her attention from additional interventional procedures to an aggressive rehabilitation approach, combined with a psychological intervention, that would improve her functional status. No mention of these two more conservative, yet at times more efficacious approaches are mentioned. One wonders what her functional status would be today if she had been offered these two approaches 10 years ago. What happened to the principle of justice—the right of all patients to equal access to all treatment approaches? This might be a case of pain management providers being overly specialized, narrowly focused, and economically driven. We need to keep in mind that the goal of multidisciplinary pain management is the return of the patient to a more optimal level of functioning.

Comment no. 3: Michel Y. Dubois, MD
Such a protracted case raises multiple ethical issues, although they may not be obvious if, as in this case, information is sparse.

Questions that the physician confronted with this situation should ask are: Were previous treatments medically indicated? Were they based on sound diagnoses? Did they correspond to widely accepted standards of care? Is the new modality of treatment proposed by the patient appropriate? In this case summary, no working diagnosis is stated. Has one ever been established? Even if a diagnosis of failed back surgery syndrome is made, it may encompass different origins, musculoskeletal, neuropathic, or a combination thereof. Therefore, it is essential to reassess the patient’s clinical condition and to carry out a complete physical examination before making any new therapeutic move. This assessment should include comorbidities, which are likely to include depression and anxiety. Previous treatments of this patient’s condition included multiple nerve block interventions. Although these treatments may prove to have scientific merit, with appropriate documentation, there is no mention of alternative treatments such as physical therapy, psychotherapy, or occupational therapy. Before embarking on another intervention it is essential to ascertain that less invasive modalities have been im-
plemented, that this was done correctly, and that the choice of these interventions was not driven by motives other than patient well-being (i.e., financial interest, research, etc.). Another possible ethical issue may be the role of previous treatments in the functional deterioration of the patient. In summary, medical assessment should include the evaluation of past and present treatments according to standard ethical values of beneficence, nonmaleficence, justice, and autonomy.

Before making any new therapeutic decision, especially one involving an intervention such as a pump implant, one must be sure that the patient is well informed on all the different aspects of the treatment and that all his/her concerns have been addressed. Intrathecal pump implantation and maintenance have risks, although in the right hands they are usually limited. There is no guarantee, however, that this particular treatment will significantly improve the function of this patient. Also, long-term intrathecal administration of opioids has side effects, which may further cripple the patient. In order to respect the patient’s autonomy, these issues must be thoroughly discussed.

An additional ethical dimension is the impact of the proposed new treatment on the patient’s quality of life. Following treatment, is the patient expected to resume a life where she can again enjoy family, friends, and environment; and will it allow her to recover some degree of personal activity? Or, on the contrary, is this treatment going to further increase her existing physical, mental, or social stress?

Finally, contextual features must be considered, including legal or economic issues. The growing interference of the third party payor in medical decision-making leads, on some occasions, to the third party payor abandoning the patient. Can this eventuality, obviously highly damaging to the patient’s psychological and physical condition, be countered? Additionally, local problems of allocation of resources may exist for the particular treatment chosen, which may cost in excess of $20,000. Is the patient support system able to maintain such a treatment?

As the patient’s pain history and clinical condition unfold, and as different treatment modalities are thoroughly discussed with the patient, it will become obvious that some of the ethical issues raised were never relevant. Others will dissipate. Still others, however, may become an essential part of the patient’s evaluation. They deserve to be raised, documented, and, whenever difficult to solve (as is frequently the case), shared with experienced colleagues. Recognizing and discussing the problems are part of the solution.