Ethics in Pain Medicine: Good for Our Health, Good for the Public Health

This issue of *Pain Medicine* is devoted to examining ethical challenges posed by the practice and research of pain. We are indebted to our colleagues from New York University Medical Center—Dr. Allen Lebovits, who so capably guided the papers in this issue, and Dr. Michel Dubois, Editor of the Ethics Forum, for their leadership in bringing these matters before us.

Ethics affect our daily clinical behavior in many obvious ways, such as when society encodes ethical values into laws that regulate our behavior as clinicians, or when our personal values or economics unduly influence clinical or research decisions. We are challenged by the papers herein to bring ethics into the mainstream conversations of our clinics, teaching rounds, and research in accordance with its importance to the quality and outcomes of our work and to our personal satisfaction with our work.

The editors hope that this volume will serve as a “primer” of medical ethics for clinicians and investigators in the pain field, and for those interested in exploring the uniquely human dimensions of the encounter between a doctor and a person suffering in pain. One desired result would be heightened interest in ethics as a formal course of study and training. Many of us take business courses to learn how to cope with the current environment. We should consider carefully the benefits from formal ethics training as well. Training may provide tools for solving some of the hidden and more obvious professional dilemmas that we accumulate daily, unresolved. If we are lucky, occasionally we have the opportunity to share these problems with others, which may give us courage to do the “right thing,” or insight about practical solutions to moral dilemmas. However, this is a “hit or miss” proposition. I suspect that training in how to maintain a continuing ethics dialogue in practice, much like our discussions of new medications or diagnoses, might provide an emotional return and peace of mind that would buffer our professional stress considerably.

These papers suggest that we should study the distribution of ethical concerns within our professions and the effects of ethics training, much as we study the effects of other educational endeavors. Will ethics training help us solve practice dilemmas, help us manage the daily emotional burden of treating pain and suffering, and give us the skills and courage to fight for the rights of our patients and for our rights to treat them with all of our tools? If we are depleted or demoralized by the cumulative burden of practice, can ethics help us restore our energy and rekindle our spirit? What can we learn from those among us who never waver in their pursuit of high quality medicine and scholarship? These questions reflect dilemmas about the very nature of the caregiver and the process of care giving—is the ability to give care like a bottomless well, available on demand? Sociobiology might argue that ethics derive from biologically determined attributes such as altruism, which are genetic in our species and in all social animals. In their view, our capacity for altruism might be distributed normally, so that some of us have far more than others. Do (or should!) health care providers have a capacity for “caring” that, within a population distribution for altruism, is on the opposite end of the spectrum from sociopathy? Is this a vessel that continuously fills as it empties, by receiving in the giving? How much care-giving is restorative? When is it depleting?

Edward O. Wilson’s consideration of Kohlberg’s stages of moral reasoning, through which most humans evolve during their development, is illuminating in this context [1]. Kohlberg Stages (one can conjure up their clinical analogues pretty easily) include: 1) Simple obedience to social rules and authority to avoid punishment; 2) Conformity to group behavior to obtain rewards and exchange favors; 3) Good-boy orientations, conformity to avoid dislike and rejection of others; 4) Duty orientation, conformity to avoid censure by authority, disruption of social order, and resulting guilt. This Fourth Stage is usually attained by baboon and chimpanzee troops, and considered essential for the survival of our “hunter-gatherer” forbears; 5) Legalistic orientation, recognizing the value of contracts; 6) Conscience or principle orientation, primary allegiance to principles of choice, which can over-rule law in cases where the law is judged to do more harm than good. Wilson maintains that Kohlberg’s Sixth Stage is the most non-biological, and most susceptible to hyper-trophy from cultural and social influences, such as...
training. Traditionally, the effects of long and intensive training from medical school through residency and fellowship have imbued us with an ecumenical, professional value system that endured the fluctuations in societal values about clinical medicine.

The papers in this volume suggest that our basic training no longer sufficiently strengthens our values for the more complex moral issues of modern medicine. Where is training available to help us develop these tools? There is growing recognition that teaching values is both a need and a responsibility of the university, and that daily teaching in the classroom, while teaching other subjects, is the correct forum [2]. Professional education is an extension of this challenge—whether in the classroom, at the bedside or in the clinic, we should be discussing our professional values daily, much as we do our diagnoses, because of the salience of values for our decisions and the outcomes of our practices. We must work with medical school curriculum committees and residency review committees of various specialties. We must seek educational funding from the industries that inundate us with continuing medical education about pain conditions and their treatments. These same industries should provide funding for continuing education that enables us to exchange our personal and intellectual reflections on the moral and ethical challenges of our practices.

We work at a time when moral and scientific authority is constantly challenged by the public and the courts, and the pressure to do more, to work longer hours, and to acquire more resources, often appears to consume our spirit. The daily challenge of responding appropriately to the ethical dilemmas of practice may require that we schedule more frequent collegial meetings, perhaps supported by industry, to share our troubles and concerns. We must discover which forums will effectively provide the restorative pleasures and strength of professional and personal association. How many colleagues meet regularly or even periodically during the year to enjoy each other’s company and to work on issues of common local or state interest? Several years ago, when Hu Rosomoff was President of the AAPM, we decided to develop regional activities for the AAPM, so that a year would not pass between professional associations. State chapters of AAPM are now developing, for example in California and Texas, and regional chapters of the APS flourish. We hope that these will facilitate successful collective efforts, such as the cooperation between the ABPM and our diplomate physicians in the states of Florida, Texas, and California, which achieved recognition of our specialty and ABPM Board Certification by State Medical Practice Boards. Working with our most powerful allies, our patients and the public, can empower us to achieve success. The National Pain Foundation (www.painconnection.org) and the American Chronic Pain Association (www.theacpa.org) are organizations that aim to empower patients through knowledge, support, and links to resources. The strength and coping abilities that we hope to instill in our patients struggling with illness can also empower them to help us achieve our goals of recognition and support for the work of our specialty. Our community of colleagues and patients can empower our profession, and from it we can derive the strength for personal and professional renewal.

As we celebrate our new scientific knowledge and therapeutic tools, let’s discover how ethical reasoning can become integrated with our practices, in the service of taking the best care of our patients but also ourselves. The formation of standing ethics committees of the APS and AAPM will provide ongoing attention to this matter, and I would encourage regional or state chapters to pursue these discussions as well. The ethics committees suggested by Dr. Sulmasy [3] and Ms. Christopher [4] should be available in every hospital, and credentialing for leaders of these committees is important. However, we are challenged to find a way to bring these discussions into our everyday practice. Perhaps we can look to our own colleagues for this help. As Dr. Hamaty has discovered in his workshops [5], the collective experience and wisdom of pain practitioners can form the basis for an ethics curriculum in pain management. His success in this model suggests that we should seek this wisdom from our own colleagues, who daily struggle with their values in the practice of the profession.

One vehicle for collegial discussion is suggested to this editor by his former experience in primary care. Many years ago, when funded by an NIH grant to develop model biopsychosocial primary care programs at the University of Vermont, I developed a means for accomplishing this level of communication by starting “Practice Management Groups”[6] in which we discussed “problem patients.” These evolved from a longitudinal pharmacology training program I had established for primary care physicians in rural New England [9] and the work of an English psychiatrist, Michael Balint, who met with groups of general practitioners to discuss their difficult cases. The pharmacology seminar program was successful, not because of the pharmacology content which was available in books and journals, but because the value the practitioners
placed on the process of discussing challenging cases, which led them to sharing and understanding their personal reactions to the cases and eventually to a sense of a supportive community. In the Practice Management Groups, resident and attending physicians met weekly with a facilitator-teacher to discuss difficult patients and practice dilemmas. Ethical concerns were often at the core of these conundrums. The groups were highly valued by the physicians; eventually we trained several primary care faculty as facilitators, and they continued in those roles following the completion of the grant program. Many of our cases were problems of chronic pain, a focus that eventually resulted in my own research and clinical work in pain and eventually to a career change. Many pain practices have weekly rounds. Pain doctors would do well to consider using this and other forums as opportunities to combine clinical and administrative problem solving with the tools of ethical analysis, in the service of improving both practice performance as well as career satisfaction.

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References

Note from the Editor:

The American Academy of Pain Medicine Ethics Committee, chaired by Dr. Michel Dubois, invites AAPM members to actively participate in its activities. Members of the committee include Drs. Melvin Gitlin, Daniel Hamaty, Phil Lippe, and Peter Wilson. Specifically, challenging ethical cases are requested for the ethics column that appears regularly in Pain Medicine. Please send your cases to Colleen Healy at ch53@EXCHANGE1.DREXEL.EDU The committee has been evaluating the need for a code of ethics for AAPM. Its first step has been to examine other organizations’ ethical guidelines.