Ethics and Professionalism in Pain Medicine

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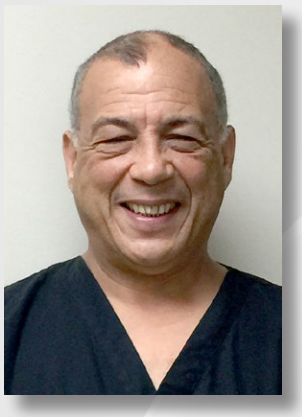
"There is another difficulty in trusting to the honor and conscience of a doctor. Doctors are just like other Englishmen: most of them have no honor and no conscience: what they commonly mistake for these is sentimentality and an intense dread of doing anything that everybody else does not do, or omitting to do anything that everybody else does. This of course does amount to a sort of working or rule-of-thumb conscience; but it means that you will do anything, good or bad, provided you get enough people to keep you in countenance by doing it also."

– George Bernard Shaw, "Doctor's Consciences" (*The Doctor's Dilemma*, 1909)

Managing pain is one of the most challenging disciplines of medicine, a subjective measure frequently met with disbelief, but where the patient should always have the benefit of the doubt. Unfortunately, Mr. Shaw's impression of some doctors has not changed in a century; just consult some online reviews, if you doubt. The Merriam-Webster definition of ethics is "a system of moral standard" and professionalism "the skill, good judgment and polite behavior that is expected from a person who is trained to do a job well. In 2002, the American Board of Internal Medicine (ABIM) Foundation described professionalism as: "improving access to high quality healthcare, advocating for just and cost effective distribution of finite resources, maintaining trust by managing conflicts of interest."

There are four principles of health care ethics, excerpted from Beauchamp and Childress (2008): *principle of respect for autonomy, principle of nonmaleficence, principle of beneficence and principle of justice. Respect for autonomy* means the patient has the capacity to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act. From this principle is derived the principle of "informed consent." Chronic pain patients could be vulnerable and physicians should remain objective while explaining the risks, benefits and alternatives to the patient before signing an informed consent for a specific procedure. Physicians should be well aware of the patient's decision-making capacity, especially for older patients who suffer from dementia or other groups much as mentally challenged individuals. *Nonmaleficence* requires providers to "not



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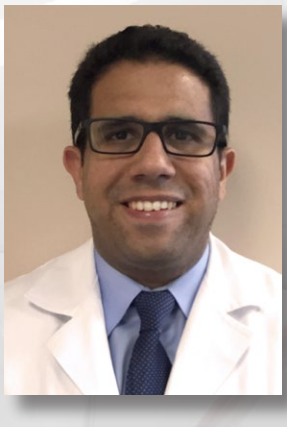

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intentionally create a harm or injury to the patient, either through acts of commission or omission." Chronic pain physicians should have the competence to avoid any unnecessary interventions that can cause harm to the patient. Although medical mistakes happen, it is our obligation as physicians to protect patients from harm. Overly aggressive interventions that have little chance of providing adequate relief could expose patients to a higher chance for complications and is considered an example of non-adherence to non-maleficense. *Beneficence* implies that providers have a duty to take positive steps to benefit the patient, as well as to prevent and remove any harm. Simply refraining from harmful acts is not enough. Chronic pain patients could suffer from untreated pain, and failure to establish an adequate plan to benefit those patients is considered a breach of this principle. *Justice* implies that physicians have the obligation to treat patients regardless of their race, gender or socio-economic status. Racial disparities in managing both opioid prescribing and monitoring have been seen. The implementation of guidelines is inconsistent at best. Unfortunately, racial minorities are still subjected to more prejudicial and punitive measures.

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The business of health care is evolving. Managing change to help reduce costs while remaining profitable is a challenge for pain physicians who have productivity expectations from their employers. Quality of care and evidence-based medicine should remain the main focus for physicians. Heath care institutions as well as providers are rated by patients using instruments such as Press Ganey surveys. While those surveys are important in helping to improve quality of care and ensure patient satisfaction, pain physicians are specifically challenged by the issue of pain satisfaction. Making patients" satisfied" might actually be harmful to the patient. Proper communication, empathy and compassion make the patient more engaged in the treatment plan. Employed physicians face pressures to see a high number of patients at the clinic to increase productivity. Physicians should be efficient while not compromising the time spent with the patients that is required to address concerns and questions. Private practice is also not immune to these issues due to the increasing cost of practice and decrease in reimbursement.

Pain relief has been recognized as a right by entities such as the World Health Organization (WHO) and International Association for the Study of Pain (IASP). Primary care physicians and pain specialists face challenges such as opioid diversion, misuse or abuse. Most pain clinics and opioid prescribers have opioid agreements, and patients require frequent urine screens and office visits to comply with regulations. This can create distrust between the physician and the patient. Continuing education is essential for pain and primary care physicians to avoid becoming naïve, rigid and cynical. The role of trust between the clinician and the patient is important for maintaining professionalism. The efficacy of opioid medications for long-term treatment of chronic non-cancer pain has been debated. A discussion with the patient about the treatment plan and expectations should be started with the initial consult. Most patients see their primary care physician before being referred to pain specialists. Strong communication between pain specialists and primary care is important for unifying the message to patients and creating a common goal.

A multimodal interdisciplinary program consisting of interventional pain specialists, psychiatrists and psychologists, physiatrists, neurologists and physical therapists is a good ethical, professional way to begin. Creating a pain medicine residency has been suggested, which would allow more years of dedicated multidisciplinary training to residents. Substance use disorders should be evaluated and treated. The primary goal of the treatment should be functional restoration, together with pain relief. Outcomes and expected improvement in function should be used as the treatment starts. Interventional procedures can be very helpful as part of the treatment plan, which can include other modalities such as physical therapy, medications, biofeedback and cognitive behavioral therapy. Pain rehabilitation and functional restoration programs have been established in some institutions across the country. Measuring improved outcomes using such models of care helps stabilize reimbursements.

In summary, pain physicians should follow the code of ethics for treatment of their patients. Physicians should provide high-quality care for all patients irrespective of their race, ethnicity, financial means or social standard. Financial pressures seen in the "heath care business" represent an ethical challenge to pain physicians. Chronic pain patients are an especially vulnerable group. A multimodal approach should be used, and outcome measures should be established. Pain specialists should collaborate with all referring physicians to maintain a focus on the health care highway, crossing lanes to ethically practice the standard of care. Ethics and professionalism should be the compass that guides pain medicine physicians to check their moral thermostats with a self-evaluating eye.