Healthcare ethics and pain management

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I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
—From the Hippocratic Oath, 4th Century BC [Miles, 2004]

I will consider the welfare of humanity and relief of human suffering my primary concern.
—From the Oath of a Pharmacist, 1994 [Fink, 2007]

Introduction

One might begin a discussion about the ethical dilemmas which physicians, pharmacists, and others confront in healthcare, pain management, and palliative medicine with a rhetorical question: would any reasonable person challenge the proposition that there is a moral obligation to help patients suffering with pain? The response is certain to be: “No.” How might anyone dispute—or even question—the accepted belief that physicians and pharmacists have an ethical obligation to assist in relieving pain? Moreover, one might observe that in giving this answer, the respondent is simultaneously asserting—as an assumed element of the reply—that it is universally held among physicians and pharmacists generally, and the entire community of patients and society itself, that physicians and pharmacists have an ethical duty or professional responsibility, to help relieve patients’ pain. Thus, without realizing it, or maybe quite fully understanding it, the individual who answers the question states and accepts a professional ethical norm. That is, in giving the response, one recognizes that it is normative ethical conduct or behavior for a physician or pharmacist to act in ways to help patients suffering with pain symptoms. Concurrently then, one acknowledges an ethical standard in medical and pharmacy practice.

Meeting ethical obligations—or more simply, ethics—is about “right” conduct; conduct that is accepted to be right—or at least, believed to be the most appropriate action or choice given the circumstances—by an individual actor, and hopefully by the individual’s peers and the individual’s community [Morris, 1999]. Ethics is a field or sub-set of philosophy and encompasses not only the study of right conduct, but also how an ethical person might determine which actions or behaviors are right, and the decision-making processes that ethical persons use to make better rather than worse decisions when confronting a moral dilemma within a specific context [Ingram and Parks, 2002]. Healthcare ethics deals with dilemmas and decisions impacting the care of patients.

The phrase professional ethics is used to describe more accurately the study of the right conduct of professionals (such as physicians and pharmacists) and the critical examination of how professional persons might determine which professional acts or behaviors are ethical or right. Professional ethics is a branch of applied ethics; the analysis of how one applies ethical theory or learned philosophical concepts or recognized ethics principles to everyday practices [Ingram and Parks, 2002]. Similarly, healthcare ethics and bioethics are broad terms that encompass much more than professional ethics. Bioethics implies decision making about life, much broader than just healthcare, the life sciences, or even quality of life. However, as healthcare professionals, the decisions made by physicians and pharmacists clearly impact the healthcare of patients, individually and collectively. In fact, there is no better example of how compassion, good decision making, and right conduct are intertwined than in the provision of
adequate pain control to palliative care patients. If anything, palliative medicine is about appropriately managing pain and other symptoms, discussing the need for advance planning, and dealing with psycho-social issues, all toward improving quality of life [Jadad & Bowman, 1995].

**Concepts and contexts: obligations and choices**

Effective pain management has been an ethical obligation of physicians and pharmacists since the professions were first recognized. Few ancient or modern references are necessary to support this idea and acknowledged professional commitment. Hippocrates (460 BC to 380 BC)—the Father of Western Medicine—prescribed willow bark and leaves to women during childbirth to help relieve pain [Chapman and Gavrin, 1996]. Scribonius, a court physician or pharmacist to the Roman Emperor Claudius in 47 AD, wrote one of the first pharmacopoeias or formularies; its pages included prescriptions for pain medicines [Pellegrino, 2002]. (Incidentally, one should note that this same early manuscript is believed to be the first historical record identified thus far to use the word profession in reference to those who practice the healing arts. In this brief work, the author defined profession as “a commitment or compassion or clemency in the relief of suffering.” In the few leaves surviving, Scribonius made the argument that the proper use of medicines was consistent with the Hippocratic injunction to help and heal the patient).

Of course, pain control and relief are just as important in the practice of medicine and pharmacy today as in previous centuries. Albert R. Jonsen, Mark Siegler, and William J. Winslade, in their book Clinical Ethics, list “relief of symptoms, pain, and suffering” second only to “promotion of health and prevention of disease” when describing broad practice objectives, or the “goals of medicine” [Jonsen et al., 2002]. This essential conviction about professional ethical obligation is easily supported by empirical evidence (AP analysis finds U.S. pain medicine use has skyrocketed 88 percent, 2007):

- "People in the United States are living in a world of pain and they are popping pills at an alarming rate to cope with it";
- "The amount of five major prescription painkillers sold at retail establishments rose 88 percent between 1997 and 2005, according to an Associated Press analysis of statistics from the Drug Enforcement Administration";
- "More than 200,000 pounds (90,720 kilograms) of codeine, morphine, oxycodone, hydrocodone and meperidine were purchased at retail stores during the most recent year represented in the data. That total is enough to give more than 300 milligrams of [prescription] painkillers to every person in the country";

- "Oxycodone, the chemical used in OXYCONTIN® (Purdue Pharma L.P.), is responsible for most of the increase. Oxycodone use jumped nearly six-fold between 1997 and 2005".

Although the word pain is not mentioned specifically in either the American Medical Association’s (AMA’s) [American Medical Association, 2001] or the American Pharmacists Association’s (APhA’s) [Fink, 2007] most recent codes of ethics, one may reasonably infer that pain control and relief are subsumed in the applicable passages which read: "a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights"; "a pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner"; and "a pharmacist respects the autonomy and dignity of each patient". Moreover, in documents expounding on the scope of the relevant AMA code section, the association’s Ethical and Judicial Council states specifically, in reference to patients near the end of life, that "physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care" [American Medical Association Council on Ethical and Judicial Affairs, 2002]. Similarly, in recent APhA publications discussing pharmacists’ duties and pain management, one will find these statements [Singh and Wyant, 2003; American Pharmacists Association, 2005]:

- "In a curricular review of 28 pharmacy schools, the topic of pain management was included as a part of the coursework of all 28 schools";
- "Participants (in a study of pharmacy faculty who teach pain therapy topics) generally thought that pharmacy students must understand that they are in a unique position to act as patient advocate for appropriate pain management, particularly with regard to chronic pain at the end of life";
- "Pharmacists, regardless of their specialty, are in a pivotal position within the health care team to influence and monitor the success of pain management in patient care";
- "Goals of pharmacist pain management should include both reducing pain levels and preventing pain from recurring";
• “The imperative to provide appropriate medications to patients with pain must be balanced with the imperative to prevent inappropriate dispensing of opioids”. (One should readily note that the last statement immediately above highlights the difficult ethical “balance” that physicians and pharmacists share in prescribing and dispensing the “right” medicine, in the “right” dose, and at the “right” time in helping patients with acute and chronic pain. Too much pain medicine might lead to overuse and abuse and addiction; too little to continued suffering with the patient’s pain untreated or undertreated. Professionals and patients and regulators would alike soundly condemn either extreme of the spectrum as inappropriate—outside the expected professional norm—or unethical.) [American Pharmacists Association, 2005]

In addition to the codes and standards established by medicine and pharmacy practitioners themselves, one should remember that the community through its authorized representatives—through statutes, regulations, quasi-regulatory mandates, and the courts—has established parallel behavioral norms in enforceable legal standards, for example:

• model guidelines regarding the use of controlled substances for the treatment of pain—adopted as regulation or policy by several state medical boards—have been endorsed by the Federation of State Medical Boards since 1998 [Federation of State Medical Boards of the United States, Inc., 2004];

• standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JC) in 2001 recognized pain symptoms as the “fifth vital sign” and required accredited organizations to establish measures to assure quality pain management for symptomatic patients [Landis, 2001]; and

• a number of jury and appellate court cases, such as Bergman v. Chin [Okie, 2001] and U.S. v. Hayes [U.S. v. Hayes, 1979], illustrate that providing too little pain medicine in a terminal situation and knowingly filling controlled substances prescriptions with no “legitimate medical purpose” may lead to civil or criminal liability.

One might observe that, even with statements of recognized normative ethical conduct, as from the AMA and APhA codes and the other expository materials, it is still difficult at times to determine what a right decision or course of action is because of the particular circumstances of the cases. It may be of value to assert that doing “good” and avoiding “harm” and “caring” and “compassionate” and “autonomy” and “dignity” and “justice”—to use the exact words in the Hippocratic Oath and the AMA and APhA codes of ethics—are important in making choices about what is the right thing to do, but it may be a very different matter at the pharmacy counter or patient’s bedside given the complexities of a specific situation. One must be able to move beyond mere words and aspirational platitudes to “doing good” in practice and taking defensible ethical action.

These difficulties in interpreting words and phrases and actually putting the words into action are not new. Philosophical sages throughout the millennia have attempted to offer advice and counsel to those facing ethical dilemmas. An important few include:

• Aristotle (384 to 322 BC, Greece) who suggested that virtuous people or people with “good character” would make virtuous or “right” decisions when confronting moral choices. His is known for describing virtue-based ethics, or showing that making good decisions in life is a tension or struggle to maintain a mean or moderate character between opposites of noble and ignoble traits [Aristotle, 1987]. Applying Aristotle’s teachings, one might conclude that virtuous or good physicians and pharmacists will make good decisions;

• St. Thomas Aquinas (1225 to 1274, Italy) who wrote that by understanding the immutable laws of nature and Nature’s God, one could reason through to a correct resolution or universal standard of conduct. His ideas were instrumental in developing what theologians and ethicists term natural law theory [Pence, 2004]. Applying St. Thomas’ teachings, one might conclude that physicians and pharmacists when faced with a moral dilemma will be able to reason and come to a better conclusion about proper conduct;

• Immanuel Kant (1724 to 1804, Germany) who believed that a person confronting a moral dilemma needs only to determine one’s duty in the given circumstances and a resolution will surely present. Kant regarded duties as obligations that must be met; he felt duty was at the core of ethics. (His work promotes what supporters call duty-based or deontological ethics, from the Greek deon meaning “obligation” or “duty.”) [Kant, 1964]. Applying Kant’s teachings, one might conclude that a physician or a pharmacist facing a moral crisis just needs to identify the correct “duty” or “duties” required to meet a particular ethical obligation or set of obligations;

• John Stuart Mill (1806 to 1873, Great Britain) who
expanded the utilitarian or consequentialist theories of Jeremy Bentham (1748 to 1832, Great Britain) to explain that one should always consider the possible outcomes of making one ethical choice versus any other in order to maximize beneficial results for the greatest number impacted by the decision [Pence, 2004]. (End results or consequences of actions in this context have to do with aims and goals; philosophically this is a teleological view from the Greek *telos*, or “target.”) Applying Bentham and Mill’s teachings, one might conclude that a physician or a pharmacist should always consider the possible consequences or outcomes of various decisions when resolving moral problems and act to help as many as practical.

- **John Rawls (1921 to 2002, United States)** who contributed that individuated decision making may not be enough if society is to be truly just or fair (justice-based ethics). Rawls noted that within a “just” community equal opportunity means minimizing the impact of luck (the accidental privileges of birth and intellect), permitting a more fair distribution of collective benefits based on merit and need [Pence, 2004]. Applying Rawls’ teachings, one might conclude that physicians and pharmacists should take into account concepts of fairness and justice to the degree achievable in solving ethical dilemmas.

(But it may be observed that philosophical thought through the ages may not add that much more to healthcare professionals’ ability to resolve real-life moral problems than the words and platitudes found in codes of ethics, but perspective and historical analysis are certainly helpful for more complete reflection and consideration.)

Contributing to the codes and theoretical ethical frameworks for determining good conduct and making better rather than worse decisions are more recent ethical decision-making approaches or doctrines, including:

- **Principality**—the notion that resolving ethical dilemmas results from identifying competing principles and weighing or prioritizing each to give precedence to the one that may be more important or critical [Beauchamp and Childress, 2001]. The four principles identified by Tom Beauchamp and James Childress in their seminal volume *Principles of Biomedical Ethics* are:
  - **Beneficence**—that one should strive to “do good” (from the Latin *bene*, “well” or “to do good”; embodied in the Hippocratic Oath);
  - **Nonmaleficence**—that one should try to “avoid harm” (from the Latin *non*, “do no”; and *maleficentia*, “evil doing”; “do no harm”; recall the similar Latin injunction to doctors *primum non nocere*, “first, do no harm”; again embodied in the Hippocratic Oath);
  - **Autonomy**—that one should respect the self-determination of each individual (transliterated from the Greek *autos*, “self,” and *nomos*, “law”; or “self law”; embodied in the AMA and APhA codes of ethics); and
  - **Justice**—that one should resolve dilemmas in a way that is just or fair for the individual and community (again found in the AMA and APhA codes of ethics and strengthened by Rawls’ teachings).

One of the difficulties with balancing competing principles is that physicians and pharmacists cannot always make the best choice between two: to “do good” without risking some harm as a by-product (for example, almost every drug has unfortunate and deleterious side effects that are unavoidable).

- **Casuistry** (case-based ethics)—the belief that each ethics dilemma is unique (in the same way that each patient is unique, each patient’s anatomy and physiology and drug absorption and metabolism are different, each person’s psychosocial milieu is dissimilar from those of every other individual) and that one problem should not necessarily be resolved relying on previous similar cases or application of principles [Jonsen et al., 2002]. However, using a case-by-case analysis to resolve ethical dilemmas leaves many bewildered or confused because it opens decision makers to the charge of being relativistic, ungrounded in changeless truths;

- **Narrative ethics**—a system of reflection that offers those confronting an ethical dilemma opportunity to work through a problem in much the same way as a narrator tells a story, filling in as many important details as necessary for the plot or resolution to unfold [Nelson, 1997]. Regardless of how issues or facts are identified or cataloged or considered, one must still make a decision; narrative ethics may perhaps offer a better way to teach about ethics than resolve dilemmas;

- **“An ethic of care”** (as suggested from feminist ethics)—a view that ethics should focus more on community and wider connectedness or relationships in providing care rather than on individuals (and autonomy) [Sherwin, 1997]. One would hope that rejection of
absolutist, coldly objective, or callously impartial approaches to ethics might be an element of most
good decisions which emphasize the higher moral
good of inclusiveness and caring for (and about) others
without being critical of best intentions to resolve
problems in better rather than worse ways;
• Pragmatism—a bottom line acceptance or realization
that after appropriate analysis and reflection, one
must make a decision just to get it over with and move
on, recognizing that there may be untoward fallout
to deal with afterwards [McGee, 2003]. Regrettably,
in haste and without cue regard for values, codes,
community standards, philosophical contemplation,
or contemporary opinion, one may not make as good
a decision as possible if too pragmatic about issues or
processes.

Apart from using various techniques or schemas to
think about ethics, one must also have a method or process
to come finally to a resolution or decision. David Bruce
Ingram and Jennifer A. Parks have written: “An ethical
dilemma forces us to choose in a way that involves breaking
some ethical norm or contradicting some ethics values”
[Ingram and Parks, 2002]. One might characterize an
ethical dilemma then as one in which a decision which
involves conflict between two or more “right” actions must
be made with results possibly compromising treasured
values, principles, or deeply-held beliefs [White, 2007].

Robert A. Buerki and Louis D. Vottero, in their
pharmacy ethics textbook, Ethical Responsibility in Pharmacy
Practice, offer a systematic decision-making outline for those
facing an ethical dilemma [Buerki and Vottero, 2002]. Their
modified question sequence s offered below from the way
it is presented in the casebook, Drugs, Ethics, and Quality of
Life [White, 2007]:

(I) Identify the problem(s).
   (i) Identify technical facts;
   (ii) Identify moral parameters;
   (iii) Identify moral constraints;
   (iv) Identify legal constraints;
   (v) Identify relevant human values.

(II) Develop alternative courses of action.
   (i) Identify relevant ethical principles for each alternative;
   (ii) Recognize ethical assumptions for each alternative;
   (iii) Assess additional emerging ethical problems.

(III) Select the one best course of action that permits the
decision maker to have the greatest peace of mind
or that which satisfies the demands of conscience.
   (i) Justify the selection;
   (ii) Defend the choice upon ethical grounds.

(IV) Anticipate logical, rational objections to the selected
course of action.
   (i) Be prepared to defend the selection against
objections arising from factual errors;
   (ii) Be prepared to defend the selection against
objections arising from faulty reasoning;
   (iii) Be prepared to defend the selection against
objections arising from conflicting values.”

Commentary and clarification: difficult cases
and hard decisions

Unfortunately or fortunately, a physician or pharmacist—
in any particular instance—may not find codes of policy
statements, or sagacious ethical opinion, or modern
biomedical ethics thought as helpful or as determinative
as one would like or hope in resolving dilemmas involving
effective pain management and good patient care; but
still one is left with identifying ethical concerns and then
attempting to make better rather than worse decisions
given the options. Four hypothetical cases dealing with pain
management may offer opportunity for practice ethics issue
identification and analysis.

Hypothetical case 1

Ms. Jones is a 17-year-old African-American teenager who
has suffered with sickle cell disease all of her life. She lives
with her mother and one-year-old child; she is a senior in
high school. She was diagnosed with clinical depression
about six months ago and is taking an antidepressant daily.
About every six- to nine-months for the last several years,
she has been hospitalized for severe sickle cell vaso-occlusive
or pain crises. Quite often, each crisis has been triggered
by a viral illness or a streptococcal throat infection; that Ms.
Jones contracts from a sick contact at school. Each crisis has
had a relatively predictable course that resolves over three
to five days with intravenous hydration, oxygen, narcotics
and non-steroidal-anti-inflammatory drugs (NSAIDs), and
bed rest. Typically, when the patient leaves the hospital,
she receives prescriptions for oral medicines, including
VICODIN® (hydrocodone and paracetamol, Abbott
Laboratories) and TYLENOL® No. 3 (acetaminophen
and codeine, Ortho McNeil Pharmaceuticals) tablets.
Regrettably, since the last crisis about three months ago, the
doses of narcotics required for adequate pain control have
been escalating remarkably, more that might be expected
given her control for the last several years. The amount of narcotics now required are so unusually high that both her long-standing hematologist and pharmacist worry that she may be physiologically and psychologically habituated and may require intervention now for a narcotic addiction.

In the case, involved physicians and pharmacists are probably worried about adequately controlling any true—ethically, "real"; legally, "legitimate"—pain symptoms, but not making the situation worse by providing too much pain medicine that the patient may misuse or abuse. From the facts of the case, there may be reasonable suspicion that the patient is diverting legally prescribed and dispensed narcotics from a legitimate medical purpose (to control sickle cell disease pain) to a non-legitimate purpose (to support an addiction). It may be this concern or this tension between the beneficence principle (doing good, controlling the pain) and the nonmaleficence principle (avoiding harm, contributing to habituation and diversion of controlled substances, violating the law) that receives the most attention when pharmacists and physicians think about ethical considerations in pain management cases [White, 2007]. Noted commentators—such as pharmacist-attorney-teacher David B. Brushwood—have spoken and written much on this topic [Smith & Brushwood, 2012].

Involved physicians and pharmacists in this case should act on their reasonable suspicions in the best interests of the patient. It is not permissible for physicians and pharmacists to violate recognized legal and ethical norms; improper action would not be fair or just (the justice principle) to other patients or the rest of society. There may be a number of appropriate actions that the physician or pharmacist might take here: observe the patient when presently experiencing pain symptoms and when comfortable without pain (monitoring for appearance or physical state or changes in heart rate, respirations, blood pressure, inability to focus or concentrate) to understand the extent of the problem better; have appropriate conversations with caregivers and peers and compare observations and views; ask the patient about the escalating use of narcotics; reflect about the change in the amount of medicine now required to relieve the pain; learn more about the risks of addiction for patients with chronic acute pain; reassess the need for narcotics and the level of the patient's pain; investigate mitigating circumstances (for example, the patient's depression or perhaps stressful family situation or medication tolerance or possible drug interactions); institute a "contract" with the patient about the proper use of medicines; set boundaries for the amount of medicines to be prescribed or dispensed; advise the patient about risks and the established legal standards; report any illegal diversion to the authorities; and document any actions properly. If it is determined that the patient is habituated to a controlled substance and diverting use from a "legitimate medical purpose," then the primary physician's and pharmacist's relationship with the patient shifts to one now controlled by legal norms rather than ethical norms because of the legal standards that now apply. Drug Enforcement Administration (DEA) regulations have sections that deal directly on point with these changed conditions [White, 2007]. (One might say that the recognized legal norm dictates the commonly accepted ethical course of action in such cases; or that the ethical norm is merged in the legal norm).

One may query why a physician or pharmacist might take other action(s) as well, such as ignoring the dilemma, telling the patient that they cannot prescribe or dispense the narcotic any more, simply not being available for continued care, or not stocking the narcotic in the pharmacy. One of these options (not being available or abandoning the patient) may bear civil or malpractice risk [White, 2007]; more particularly, a physician should terminate a physician-patient relationship ethically and legally by advising the patient of the unilateral decision and assisting the patient to the degree possible in finding alternative sources of care (for example, providing a written 30 day notice of future non-availability and a list of other competent practitioners in the area that treat sickle cell patients). Also, perhaps one should note that with these alternative option(s), the physician and pharmacist might be resolving the key ethical issues in their own best interests (for example, simply avoiding the patient altogether or acting to minimize or avoid legal hassles), rather than in the patient's best interests. (This may be a very good and practical example of a conflict of interest in ethical decision-making).

Edmund D. Pellegrino has written that should physicians or pharmacists do this, then they do not strictly meet the historical definition of a professional as he understands it: professionals are those who suppress self-interest when the welfare of those they serve—or profess to serve—requires it [Pellegrino, 2007].

Additionally, there is at least one other ethical issue in this case that needs to be addressed: the patient's status as a minor and the recognition that consent and ascent are different [O'Rourke, 2000]. Recall that the patient is 17-year-old, legally a minor and thus technically incompetent (legally incapacitated) to give informed consent for medical treatment [White, 2007]. (Note: that
just because the patient has given birth to a child typically does not automatically emancipate her from her legal status as a minor and her inability to consent or refuse medical treatment). However, a number of states have relaxed the purely technical legal definition of competency; in favor of a more ethically sound view of obtaining informed consent for those who have clinical decision making capacity (some legal scholars and judges refer to this as the "mature minor doctrine") [Moore, 2006]. This rule is an extension of the autonomy principle in ethics that promotes allowing individuals with decision-making capacity to make their own decision because they have power for self-determination. The idea of the informed consent process may be described as follows:

"In order to obtain informed consent, the practitioner should be assured that the patient fully comprehends and understands the nature of the proposed encounter; the diagnosis (diagnoses); the prognosis (prognoses); and the available, reasonable evaluation and treatment options and the benefits and risks of each (including the possibility of forgoing any treatment at all) [White, 2007]."

The 17-year-old patient as described in the case certainly appears to have autonomous capacity. However, even if the patient is incompetent legally to give consent because of age, it may be ethically appropriate and beneficial to obtain the patient's assent (or agreement) to treatment before proceeding.

Hypothetical case 2

Ms. Smith is 28 years old; she is pregnant with her first child. The mother and father have planned for a "natural childbirth"; they have attended Lamaze classes and have arranged to be followed and delivered by a nurse midwife. The nine-month pregnancy went well; she received excellent prenatal care. Ms. Smith went to the hospital when her "water broke" (the membranes ruptured and leaked amniotic fluid); however, Ms. Smith experienced very few and relatively weak contractions. In the hospital's birthing suite, with stronger contractions, Ms. Smith began complaining of severe discomfort (more severe than might be usually anticipated by the delivery team). After an hour of increasing dis-ease, Ms. Smith demanded medicines to relieve the pain. Mr. Smith and the nurse midwife were quite surprised and somewhat frustrated by her repeated requests given what they both knew (or believed they knew) about her wishes from prior conversations and actions. After she refused to be swayed from her increasingly hostile demands for pain medicines, the nurse midwife ordered VISTARIL® (hydroxyzine, Pfizer Inc.) 50 mg IV for anxiety and mild analgesia. However, there was only minor relief for Ms. Smith and after a few minutes, the patient demanded more drugs (again, a somewhat unusual response for a patient to have so little relief as compared to other similar deliveries). Moreover, the cervix was only dilated to about 4 cm and the delivery appeared to be progressing was quite slowly. The nurse midwife elected to wait a little longer before administering more medicines, but after 30 minutes Ms. Smith was concentrating less and less on the impending delivery and more and more on the unrelieved pain. At this point, the nurse midwife ordered morphine sulfate and promethazine (PHENERGAN®, Wyeth Pharmaceuticals) for additional pain relief and comfort. Again, the usual doses of medicines for such cases provided relatively little relief. After another hour of ever increasing and more excruciating pain and little progress, the nurse midwife called her obstetrician colleague and an anesthesiologist for assistance and the placement of an epidural (regional nerve block) for better pain control. After placement of the regional anesthetic, it appeared to the team that some of the discomfort the patient was experiencing was in part resulting from the tissue tension and stretching. The patient required another small dose of morphine and promethazine and then delivered a term baby with some mild depression believed secondary to the narcotic and antihistamine.

This hypothetical case should remind health care providers that pain (I) occurs during "normal" (for example, delivery) as well as "abnormal" (for example, diseases or traumatic injuries) body function processes; (II) that it can be anticipated or unanticipated, expected or unexpected; (III) that it is completely subjective to the individual patient; and (IV) that autonomous patients are at liberty to change their minds about available treatments and interventions as time goes on. It would seem quite awkward—some might say ludicrous—for a physician or a pharmacist in the delivery room (or operating room, recovery room, intensive care unit, or emergency department, or an outpatient setting for that matter) to engage in some sort of disagreement or argument with a patient or the patient's legally authorized representative about the nature, character, degree, or duration of pain symptoms. At least initially, one would think it might be best to give the patient the benefit of any doubt and treat pain symptoms for resolution until more information is available.

This case allows opportunity to discuss the ethical nature of the mother-fetus treatment unit and the doctrine
of proportionality. Some may be reluctant to offer the pregnant patient treatments that might be considered injurious to the fetus. Undoubtedly there are some medicines that may be administered during the childbirth process or pregnancy that might “harm” the unborn child (for example, magnesium sulfate administered to slow the delivery will cause neonatal hypotonia and may negatively impact neonatal respiratory efforts). But usually, the care team defers to the mother for informed consent with little other question except to more fully understand that any consent or refusal truly is informed (that is, that the mother understands the risks to the fetus and the possible ill effects on the child after birth). Perhaps a more extreme example might be considered: the pregnant woman who has been diagnosed with cancer and the contemplated or proffered chemotherapy will unquestionably harm the fetus or endanger the pregnancy itself. Even more conservative ethical reflection—as expressed in the Ethical and Religious Directives for Catholic Health Care Services adopted by the United States Conference for Catholic Bishops—understands the implications on the mother-fetus unit and the mother’s unique position to give informed consent:

“Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permissible when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child [United States Conference of Catholic Bishops, 2001].”

Hypothetical case 3

Josiah Quincy is three years old; he was diagnosed with neuroblastoma at eight months of age when he presented to his doctor for a well-child examination and an abdominal mass was identified. At the time of diagnosis, cancer cells were seen in his bone marrow. He received treatment at a world-class children’s research and teaching hospital with a new “up-front” chemotherapy regimen which included irinotecan and gefitinib with sixteen months of maintenance chemotherapy after stem cell transplant with alternating oral 13-cis-retinoic acid and toposamide (the drugs were an experimental protocol offered to fewer than 25 children). Unhappily, the cancer has progressed. The caregivers believe the child remains in continuous discomfort and pain and is irritable and fretful almost all the time. He gets very little restful sleep. His irritability and pain are relieved temporarily or short-term with increasing doses of morphine by intravenous drip. He is taking less and less food and liquids by mouth. His parents have allowed artificial feedings with a nasogastric tube in the past, but now refuse because they believe the tube causes more discomfort and the patient has abdominal distention and loose stools. He has just been admitted to the hospital for a fever of 39°C and better pain control. He is somnolent with the narcotics and near coma, but still appears fidgety and waxy even when asleep. His parents are asking his attending physician and hospital’s clinical pharmacist now about “terminal sedation” as a pain relief option.

This hypothetical case with such sad and unfortunate facts offers opportunity to think about: (I) the “goals of medicine” more completely; (II)“I do medical futility; (III) surrogate decision making and the role of surrogate decision makers in assessing pain and discomfort; (IV) the doctrine of double effect; and (V) “terminal sedation”.

Hippocrates was reported to have said that it is the “master physician” who learns the signs and “refuses to treat those patients over-mastered by their illness” [Hippocrates, 1950]. It is not an accepted goal of medicine to continue to treat in order to achieve a cure when a “cure” is no longer possible. Similar in thought to Hippocrates “master physician” characterization is an aphorism attributed to the “To cure sometimes, to relieve often, to comfort always” [Cayley, 2006]. The word comfort is derived by joining the two Latin words cum (meaning “with”) and fortis (meaning “strength”); to comfort is to “come along side with strength.” At the end of life, maybe all caregivers can do is to come along side of the patient and give some meager strength, support, and comfort.

To treat for a cure when a “cure” is no longer possible may be one definition of medical futility. Philosopher Mark Wicclair has suggested that a medical futility intervention situation occurs in three instances, when treatment: (I) is physiologically impossible; (II) “will not achieve the goals of the patient” and (III) is one in which “there is no reasonable chance [the proposed treatment] will achieve any goals that are consistent with the rules of professional integrity” [Wicclair, 1996]. In the hypothetical case, it seems that the most appropriate medical intervention is comfort care (with as many pain medicines as are necessary to relieve symptoms), particularly when the artificial feedings previously tried now might cause more discomfort or burdens than give benefit (that is, the burdens outweigh the benefits, more harm results from the attempts to do good).

In this case, the caregivers and parents believe that the
patient is clearly dying and appears septic. The parents request as much pain medicine as needed to keep the child comfortable. Few would doubt the parents’ moral authority to better judge their child’s condition and symptom level, but if there is concern it should be addressed calmly, compassionately, and deferentially. Some pharmacists and physicians might hesitate in providing higher and higher doses of morphine in this instance because of the fear of respiratory depression and death. The doctrine of double effect in the ethics literature—as described in Jonsen-Siegler-Winslade’s *Clinical Ethics*—might offer those at the bedside some consolation:

“The principal of double effect recognizes that, occasionally, persons are faced with a decision that cannot be avoided and, in the circumstances, the decision will cause both desirable and undesirable effects. These effects are inextricably linked. One of these effects is intended by the agent and is ethically permissible [for example, treating severe pain], the other is not intended by the agent and is ethically undesirable [for example, respiratory depression and death]. Roman Catholic medical ethics employs this argument to justify clinically appropriate pain medication for relief of pain, even if the unintended foreseen effect is the shortening of the patient’s life [Jonsen et al., 2002].”

“Terminal sedation” is used to provide comfort and pain control to patients at the end of life when other treatment modalities have failed [Orentlicher, 1997]. Terminal sedation in this context is described in the reference *Pain Management in Children with Cancer* published by Texas Children’s Hospital and Baylor College of Medicine:

“In very rare circumstances, children may experience such unrelenting pain or other symptoms, that the need for sedation may be considered. Sedation is generally indicated when pain and distress cannot be controlled by any other means either due to limited timeframe or risk of excessive morbidity. The health care professional must determine what are truly uncontrollable pain or symptoms versus under-treated pain and/or symptoms. It is important that prior to considering sedation, all efforts have been made to achieve pain and symptom control.

Sedation must not be confused with euthanasia. Euthanasia refers to the active intent by another person to end a terminally ill person’s life for the sake of compassion or mercy [Hockenberry-Eaton et al., 1999].”

**Hypothetical case 4**

Mr. Williams, a ninety-six year old retired policeman and part-time Methodist minister who lives in Portland, Oregon, has colon cancer that has metastasized to his lumbar vertebrae. The severe back pain he experiences is controlled with liquid morphine, liquid DOLOPHINE® (methadone, Roxane Laboratories Inc.), and a DURAGESIC® (fentanyl, Janssen Pharmaceuticals) transdermal patch. The patient is enrolled in a hospice program. Because, terminally-ill Oregon residents may avail themselves of physician-assisted suicide under the authority of the Oregon Death with Dignity Act, Mr. Williams received a prescription for 100 SECONAL® (secobarbital, Ranbaxy Pharmaceuticals Inc.) from his oncologist. When filled, the directions on the prescription label were to read: “Take as directed. Prescribed per Oregon Assisted Suicide Law.” When the prescription was presented at the pharmacy counter, Mr. Williams’ pharmacist and life-long friend, John Able, took Mr. Williams aside to the private counseling station and quietly informed the patient that he—“in all good conscience”—could not fill the prescription because he believed that he would be a party to a “murder.” Mr. Williams said, “John, you’re a good friend—I understand.” The patient left the pharmacy with the prescription. Within minutes though, three of Mr. Williams’ granddaughters demanded to see Mr. Able, loudly calling him a “heartsick bastard” in front of other patrons and pharmacy staff before he even had opportunity to say hello.

Oregon has permitted physician-assisted suicide since 1998 [Egan, 1998]. Between 1994 (when Oregonians first voted to approve Ballot Measure 16—the Death with Dignity Act or DWDA—by public referendum) and 1997 (when Oregon voters re-approved the law as Ballot Measure 51), there were several federal and state attempts to overturn the law and prevent its going into effect [White, 2007]. (Some might say that it was the 2006 US Supreme Court decision—Gonzales vs. Oregon—that finally settled the matter conclusively) [Greenhouse, 2006].

According to the 2007 official report [Oregon Department of Health Services, 2007], 341 persons have received drugs to have available to take their own lives since the practice began:

“During 2007, 85 prescriptions for lethal medications were written under the provisions of the DWDA compared to 65 during 2006. Of these, 46 patients took the medications, 26 died of their underlying disease, and 13 were alive at the end of 2007. In addition, three patients with earlier prescriptions died from taking the medications, resulting in a total of 49 DWDA deaths during 2007. This corresponds to an estimated 15.6 DWDA deaths per 10,000
total deaths.”

Thus, the law appears to be settled public policy in Oregon regardless of what those who oppose assisted suicide personally think about the ethics or “rightness” of the issue. It would not seem proper for anyone to characterize a death from a self-administered lethal dose prescribed under the law as a murder or otherwise unlawful death. The law sanctions the autonomous decision of a terminally ill patient to die pain-free and in control [Schmidt, 2007]. The law similarly respects the right of Oregon health care providers—of course, including pharmacists—not to participate in the process if they do not wish to do so [Schnabel and Schnabel, 2007]. It remains to be seen how far this policy might extend into other states; but to date Washington, Montana, and Vermont have adopted DWDA-like physician-assisted suicide schemas for terminally-ill patients.

This case shows how a pharmacist may as a conscientious objection opt not to fill a lethal—and legally prescribed—order for a terminally ill patient under the law:

“Conscientious objection arises from the concept that people are not obligated to perform acts that violate their conscience, even if the acts are legally or professionally sanctioned. Conscientious objection by health care professionals is a principle that is upheld by professional codes of ethics, for example, the refusal of a nurse to participate in an abortion done in a hospital. The Oregon Death with Dignity Act endorses conscientious practice and respect by stating unequivocally: “No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his/her life in a humane and dignified manner” [Dunn et al., 2007].”

Pharmacists are under no legal or ethical obligation to fill every prescription that is presented at the counter. In fact, it is in their financial best interests to fill as many prescriptions as possible since pharmacy income is generated typically on a per prescription-filled basis. However, pharmacists may not illegally or unethically discriminate between prescriptions to be filled or not. Refusals to fill prescriptions should be just, fair, impartial. One dictionary definition of justice is “upholding... what is just, especially fair treatment and due reward in accordance with honor, standards, or law” [Soukhano, 1992]. Examples of decisions not to fill prescriptions then may turn on: law (for example, the pharmacist may believe that the prescription was written by a practitioner outside the “course of professional practice” or for a reason other than a “legitimate medical purpose”) [Drug Enforcement Administration, 2004]; standards (for example, the pharmacist may believe the dose of the ordered medicine is too high and might risk injury (malpractice standards) or because the pharmacy does not participate in the patient’s insurance or prescription reimbursement plan (business standards)); or honor (for example, a conscientious objection).

This hypothetical case includes another ethical issue for pharmacist Able: communication of confidential information or invasion of privacy associated with meeting professional obligations. It is unfortunate that the patient’s granddaughters had the conversation they did with the pharmacist. However, Able perhaps should just say: “I’m unable to talk with you about this.” Further conversation risks violating confidence or invading Mr. Williams’ privacy. Any medicines that Able fills or does not fill for a patient is a private professional matter and should not be discussed with others outside the pharmacist-patient relationship unless authorized by the patient or law, standards, or honor.

Summary

Any chapter written as a survey of the field of ethics to be included in a book about a healthcare professional’s role in quality pain management is sure to omit material that may be important to address if used to attempt resolution of specific dilemma. In this vein, the chapter would have much in common with professional codes of ethics, works by noted bioethicists, and casebooks more generally. There are some questions not easily answered or dilemmas not comfortably or effortlessly resolved. Ethical dilemmas are by their very nature not settled without difficulty, sometimes many difficulties. Ethics too is a personal field of study and resolutions may depend on the unique qualities of the decision maker(s) as well as a particular set of facts.

In this regard, ethics differs in many respects from the law. Law is intended to have universal application and set minimum standards of behavior. Resolution of ethics dilemmas is done case-by-case; ethics attempts to set an ideal or aspirational standard of conduct. However standards in law may at times be more rigorous and demanding because they are enforceable by the community and thus carry penalties for noncompliance. For example health care law professor Barry R. Furrow has written: “Failure to properly manage pain—to assess, treat, and manage it—is professional negligence” [Furrow, 2001].
Healthcare ethics and pain management

The number of ethics dilemmas about pain management that physicians and pharmacists will face in the future is certain to increase: newer agents with greater benefits and undeterminable burdens will be synthesized or identified; different professional and legal standards of conduct will evolve; and the delivery of health care will continue to transform as it becomes more interdisciplinary and costly. However, ethical principles and philosophical values—like beneficence, nonmaleficence, autonomy, and justice—if for no other reason than the fact that good persons have had to deal with moral problems since civilization began—will continue to vex compassionate, caring professionals in theory and practice.

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