

CHANGING THE PRACTICE OF PAIN MEDICINE WRIT LARGE AND SMALL THROUGH IDENTIFYING PROBLEMS AND ESTABLISHING GOALS

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Recently, medical ethicist and educator Laurence McCullough has stated that the professional responsibilities of the physician define the nature and experience of what it is to be a patient (1). According to Professor McCullough, the reality of patienthood is a function of whether and/or how these foundational responsibilities are maintained by the physician. Citing the late eighteenth century work of John Gregory and Thomas Percival, McCullough describes the core obligations and responsibilities of the physician to be 1) a commitment to becoming and remaining competent through the acquisition of knowledge and skill, 2) the consistent, primary focus upon patients' best health-related interests, and 3) the preservation and advancement of medicine as a public trust.

Although these obligations and commitments seem just as viable today as they were in Percival's day, it is a matter of fact that the industrial market model and its correlates (e.g.- technocentrism, consumerism, entrepreneurship, time- and resource restriction, cost-escalation, and economic self-interest) have fostered a mercantile, contractual, and legally-dictated contem-

porary medical culture, and have generated increasing tension(s) both in the relationships between physician and patient, and between medicine and society (2).

In this issue of *Pain Physician*, Laxmaiah Manchikanti's testimony to the Congressional Subcommittee on Criminal Justice, Drug Policy and Human Resources synthesizes how these tensions have become manifest in contemporary pain medicine, addressing the problem of a system-wide ineffectuality of pain care that has led to an increased prevalence of pain, escalation in analgesic drug mis-use and abuse, and the potential effects and harms that these factors exert upon healthcare and society (3, 4). Manchikanti quotes Schweitzer and Voltaire, whose conflicting perspectives summarize the polar orientations that drive many of the ethical issues that arise in modern pain medicine. Schweitzer's imperative to treat pain is grounded in reverence and beneficence and is sustained by our increasing knowledge of mechanisms of pain, and the availability of new analgesic drugs, and therapeutic technologies. However, we must use this knowledge prudently. For given 1) the often enigmatic nature of pain and the pain patient, and 2) systematized impositions of time and resource limitations, pain physicians could easily commit the "can implies ought" fallacy, and improperly prescribe excessive doses of drugs, and/or interventional techniques in an attempt to maximize outcomes within an increasingly restrictive window of opportunity. Moreover, the perva-

sive consumerist mindset, fortified by a misconceived rubric of patient autonomy that establishes the pain patient as "client" and the physician as "provider" can foster "acquiescent practice" in which the patient's "autonomy" trumps or supersedes the professional autonomy and clinical judgment of the physician, and ultimately de-professionalizes the practice of pain medicine.

While such acquiescent practice can incur severe legal retribution and professional sanctions, so too can the actions of well-intended physicians who attempt to manage the chronic pain patients through the use of progressively increasing doses of narcotics within a medical system that constrains the possibilities for effective clinical continuity, and patient monitoring. The increasing frequency of legal ramifications have led many pain physicians to become reluctant to prescribe narcotics or treat complex cases of co-morbid pain and addiction, adopting a stance of "defensive practice", in which pain is under-treated and the patient is distanced from the medical care required.

Clearly this too is practically and ethically inappropriate on numerous grounds. First, it denies the pain physician's act of profession – if one declares that they possess the knowledge and skills to treat pain, then it is contradictory, if not anathema not to do so within the full scope of practice, as defined. Second, such 'partial' treatment is tantamount to abandonment in that it denies and prevents the patient from receiving the care that he/she requires. Third, it disavows the intellectual and moral

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virtue(s) required of the pain physician (5), for while pain is complex and pre- or co-morbid substance-related disorders are not uncommon in chronic pain patients (6), our knowledge of neuroscience should compel this to be considered and treated as part of a larger clinical picture of pain as a neurological spectrum disorder that involves genotypic and environmental interactions (7), and not be grounds for disenfranchising patients from medical care.

As Manchikanti notes, both over, and under-treatment of pain can lead to 1) patient frustration, non-compliance, attempts at self-medication, dose-escalation and drug dependence and abuse, and 2) dis-enablement of the physician through role distortion and/or over-systematization by (actual or fear of) medico-legal retribution. Quoting Voltaire, Manchikanti (3) alludes to the fact that part of the problem may lie in a “trickle down” effect of knowledge; namely, that while new information about mechanisms of pain and analgesia, and the actions of various pharmacologic and technical therapies is being acquired at an almost exponential rate, this is not uniformly incorporated into the educational resources available to many practicing pain physicians, and is not routinely taught in medical school curricula. Thus, this knowledge remains somewhat isolated, only “trickling” to specialized audiences, and does ordinarily not “flood” down to the level of the community pain practitioner at a pace or extent that is commensurate with the progress of meaningful developments in the field. As a result, there often tends to be an informational gap between newly available knowledge and the actual knowledge that is applied and utilized in the clinical encounter.

Manchikanti is correct in stating that “...despite numerous scientific advances in medicine...we have to look at...the by-product of compassion coupled with lack of understanding of the complex puzzle of pain and its management” (3, 4). For while it is true that scientific advances may address the lack of knowledge that Voltaire laments, we

must recall that science, technology and pain medicine are all human enterprises, and while understanding the body is critical, the context of medicine does not morally relate to a generic body, but to the embodied person who is the patient within a larger societal context (8). This sustains the responsibility of both pain medicine, as a practice, and the individual pain physician.

The philosopher Hans Lenk notes that any such responsibility is enacted within a compound relationship of persons, circumstances, actions and consequences (9). Thus, the pain physician is responsible 1) for the right and good treatment of pain, 2) to the patients in his/her care, 3) in the face of the power invested upon him/her through education, training and evaluation, 4) with regard to the inherent affirmations and obligations of the practice, and 5) within the framework of any/all relevant actions engendered by that practice.

Lenk holds that intellectual and technical capability cannot be divorced from the moral responsibility of being a professional. Likewise, Manchikanti reminds us that such moral responsibility is part of the benefit and burden inherent to the profession and practice of pain medicine, and calls for a “closer partnership between the general medical community...pain and addiction specialists” (3, 4). I agree, but add that a closer partnership between physician and pain patient is also necessary, for while policy is certainly vital to enable pain medicine as a practice, that practice is an exchange of good between a physician and a patient (10), and thus professional responsibility is individually borne by the physician. But to recognize what is “good” for a particular patient requires an appreciation not only of the technical aspects of pain medicine (i.e.- the biomedical good), but what treatments should be provided so as to accommodate a specific patient’s values, choices and goals as a human being.

These issues are addressed elsewhere in this issue by Waters and Sierpina, who recognize the complexity of pain – as symptom, disease and illness-

and the distinctly different impact that pain incurs upon the life of each person (11). These differences cannot be ascertained solely by objective means, and Waters and Sierpina speak to the need for the physician to gain subjective insight so as to address the therapeutically and morally prudential question of “what should be done to help *this* patient?” (12, 13). Waters and Sierpina acknowledge that the current culture of medical care and extant paradigm of practice in many ways has only exacerbated inappropriate expectations, frustrations, and led to therapeutic failure. Waters and Sierpina echo Manchikanti’s observation that “...balanced, multifaceted pain treatment is often difficult to achieve...and [therefore] ends up aggravating rather than ameliorating prescription pain medication abuse...” (3), and describe a method, Goal-Directed Health Care (G-DHC), that seeks to 1) define the physician as a steward of knowledge, but equally 2) enjoin the patient to the therapeutic effort, by 3) engendering a sharing of responsibilities toward 4) developing and working to achieve realistic goals that the patient has identified and formalized.

This re-establishes the professional role and responsibility of the physician, committing him/her to act in and with the patient’s interests to achieve a right and good healing (14, 15). But it also commits the patient to being a responsible participant in the medical relationship. Further, by re-identifying values and goals, and defining responsibilities for actions, G-DHC seeks to internalize locus of control, decrease vulnerability and enhance patient agency. Fulford has addressed the need for a values-based medicine, in which physician and patient can agree to disagree, but work toward the dialectic process of addressing and realizing common values (16). Waters and Sierpina are cognizant that such values motivate the direction of, and actions toward objective life goals, and G-DHC builds upon a consideration of underlying values, realizing that these values and goals have been affected by pain.

One criticism might be that G-DHC may only be viable when dealing with “ideal” patients and therefore would not be truly effective as an approach to dealing with more difficult problems of chronic pain patients. I disagree, and believe that their methods are broadly applicable to any and all patients and reflect a particular patient’s willingness to accept a reciprocal role in the clinical relationship. Waters and Sierpina do not make *a priori* assumptions about, or develop expectations of the patient to be treated; instead, their approach works from a basic premise of shared intentionality and responsibility.

After all, what can be realistically expected of any person who is pain-ridden, encumbered by illness, and vulnerable? My colleague, Dan English has emphasized that the feasibility of expecting patients to uphold moral obligations beyond veracity and non-harm is questionable, as such obligations tend to vary considerably based upon the context, content and nature of each patient’s clinical reality (17). Thus, perhaps the “best” that can be expected is that patients assume responsibility for their values, goals, intentions and (co-) participatory role in the medical relationship.

Both Manchikanti, and Waters and Sierpina illustrate specific problems, call for change, and elucidate potential paths to such change(s) within the larger system, and individual practice of

pain medicine, respectively. Yet what I feel these authors truly reveal is a certain circularity of cause and effect - if pain medicine is to move toward positive change, it must occur through 1) the re-assertion of individual, professional responsibility of the pain physician, that is 2) enabled by the group responsibility of pain medicine as a field that is 3) supported by public policy. For despite the technologic and often political nature of modern pain medicine, it is, at its essence, an interaction between persons – and as such incontrovertibly remains an ethically-grounded, humanitarian endeavor.

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