

## Editorial

## Grounding Guidelines in Ethics: Recommendations for Implementation in Practice

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*To walk safely through the maze...one needs the light of wisdom and the guidance of virtue.*  
Gautama Buddha (1)

The ongoing opioid and COVID-19 crises have altered the current landscape and realities of treating chronic non-cancer pain. Reminiscence upon the proverbial war on pain fought against the backdrop of the war on drugs allows insight to the significant collateral damage produced on both sides of the proverbial battlefield (2). Employing this history as lessons learned, the Updated American Society of Interventional Pain Physicians (ASIPP) Guidelines presented herein are provided to inform evidenced-based, safe, effective, and efficient care of patients suffering from chronic pain.

For the professed “pain physician”, there is a grounding obligation to use such information to understand the bio-psychosocial realities of patients’ experience(s) of pain – as symptom, disease, and manifest illness (3). As Sternbach has noted, pain can be regarded as one of a variety of entities, a multiplicity of concomitant entities, a relativistic entity based upon the perspective of observation and/or presentation, or some combination of each and all (4). The International Association for the Study of Pain (IASP) defines pain as both a physiological event and a psychological experience (5). This “embodied bio-phenomenology of pain” is the pain physician’s object of care. But it is the patient, as person-in-pain, that is the subject of their moral regard (6). Dual appreciation of pain as the object of technical focus, and the patient as the vulnerable subject of concern, is required for ethically prudent pain care. The instruments and methods of care are, and will be changing as a consequence of developing increasingly capable tools of observation, evaluation and intervention, which represent the exchangeable goods of pain medicine as a practice.

The Updated ASIPP Guidelines are provided to enable sound use of opioids, which have been, and remain an important, and often necessary component of the current toolkit of pain medicine (7). We opine that any such guidelines must be based upon, aligned with, oriented toward, and supportive of the fundamental ethical structure and function(s) of pain medicine as a practice (8). Practice, as defined by the philosopher Alistair McIntyre is an exchange of goods defined by those in relationship (9). Said goods are the services, resources, and methods of pain care. Axiomatic to such care is the need to regard the entirety of the person, who by virtue of their human predicament, has become the patient – as translated from the Latin, *patiens*, as “the one who suffers” (10). And any consideration and deliberation of the nature, scope and provision of such goods are, as matter of fact, the foci of ethics.

As illustrated by Fig. 1, the overarching ethical duties of pain medicine establish its structure, and these duties are articulated in the settings and constraints of socio-economic and legal ecologies in which patients and physicians exist, and are engaged. Rule utility establishes that the pain clinician must function in accordance with the dictates of their duties within the scope and tenor of law.

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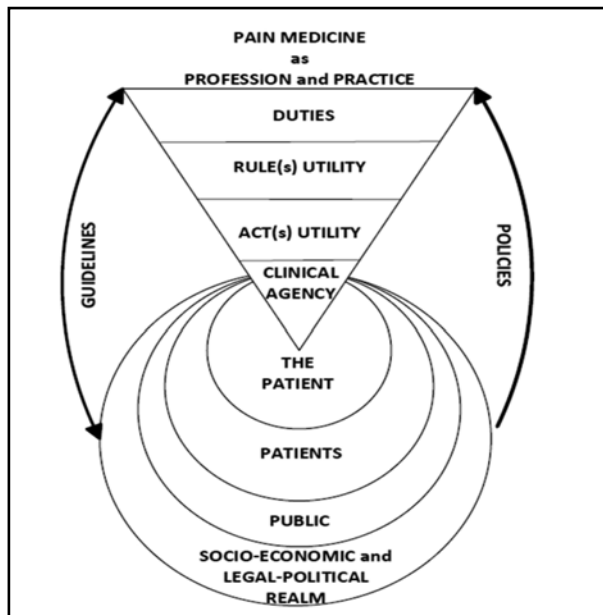


Fig. 1. Schematic diagram of the structural and functional architectonics of ethics in pain medicine. The profession and practice of pain medicine establishes core duties (i.e. - a deontological structure) of each and all who choose to enter into its practice (as defined in text). These duties are structurally sustained by defined rules of professional practice, focused upon the utility of patient best interest(s) as the primary good. However, in quotidian execution of each clinical encounter, the clinician negotiates and articulates actions toward the primacy of patient benefit, in accordance with her/his professional discretionary space to “enact rules in practice”. The enactment of the utilitarian goods, as focal to patients’ best interests establish the clinician as both a therapeutic and moral agent (in accordance with their own moral compass, and in engagement of particular moral and intellectual virtues). These actions serve individual patients, and serve as invitation for the collective of all patients to trust that the clinician will exercise the structure and functions of ethical pain medicine in their care. The establishment of this open invitation to what Pellegrino (10) has called “beneficence-in-trust” thus extends to all persons, and to the institutions, and organizations of the polis at-large, in which these clinical engagements are endeavored. Guidelines support these actions (from profession to various points of practice); policies (of the socio-economic and legal-political domain(s)) affect (and ideally should positively support) the architectonic structures and functions of pain medicine in its real world enterprise. Additional details provided in text; also see: refs. 16-18.

Act utility affords the clinician particular functional latitudes to exercise their individual therapeutic and moral agency (11-13). This is where guidelines such as those presented here play a viable and valuably supportive role.

Guidelines should do exactly that: provide parameters that guide executive agents’ useful acts to articulate the goods of practice. Simply put, guidelines guide – they do not direct; rather, they afford views to pre- and pro-scribe actions in light of the settings and circumstances in which the pain clinician and the patient are nested. Such guidance must be grounded in ethical duty and utility with respect to the probity of both morality and law. Further, good guidelines afford evidence-based recommendations that enable flexibility in practice to support fixity of purpose. Here we feel it important to mention that etymologically, the term recommend, as taken from the Latin, means to “re-dedicate to continuity of care” (14). Intrinsic to this continuity is the commitment to non-abandonment (15). Indubitably, the current environment of clinical pain care is laden with economic, legal, social, and political liabilities, which can prompt “defensive practice” (16). But the pain clinician, through their act of profession, explicitly declares their knowledge and skill in navigating this often tenuous and sometimes hazardous geography to uphold their patients’ best interests; and in so doing, invites their trust, and refuses their abandonment (17,18).

It is in that spirit that these ASIPP guidelines are offered to afford capable recommendations for ethically sound pain medicine. Of course, other guidelines exist; and commentary and critique of these other guidelines are not intended to be denigrative, but instead are presented through a lens of gap identification, and compensation, so as to: 1) indicate limitations and constraints of extant guidelines; 2) enable the consideration of ASIPP guidelines as a means to close these gaps; and in this way, 3) facilitate an integrative guideline approach that can be employed to best suit and accommodate particular practice settings and conditions.

But words are vacant without action. How then might guidelines be engaged and employed within the various administrative venues of pain practice? To such ends, we recommend – literally, as a call to continued commitment to continuity of care - consideration and application of core principles of implementation science (IS). Defined as the “...study of methods to promote systematic uptake of research findings ...into routine practice”, the aims of IS are to identify those conditions that affect adoption of some method into real world use (19). We posit that IS methods can – and arguably should – be used to facilitate current ASIPP guidelines in clinical settings (Table 1).

Table 1.

1. Assessment of the Current State	
Identify Barriers and Facilitators	Conduct thorough assessment to identify factors that may hinder or facilitate the implementation of ASIPP guidelines. This may include organizational, provider, and patient-level factors.
2. Stakeholder Engagement	
Involve Key Stakeholders	Engage all relevant stakeholders, including healthcare providers, administrators, patients, and families. Ensure their input in implementation process to increase compliance and address concerns.
3. Adaptation to Local Context	
Broad Employment of Guidelines	Employ ASIPP guidelines as appropriate to the local context and resources. Consider factors such as available personnel, infrastructure, and equipment.
4. Education and Training	
Training Programs	Develop and implement comprehensive training programs for healthcare providers to ensure they understand and can effectively implement ASIPP guidelines.
5. Implementation Planning	
Develop an Implementation Plan	Create a detailed plan outlining the steps, timeline, and responsibilities for implementing ASIPP guidelines. This plan should address potential challenges, and strategies/tactics for overcoming them.
6. Continuous Quality Improvement	
Monitoring and Evaluation	Establish mechanisms for ongoing monitoring and evaluation of the implementation. This could involve regular audits, feedback loops, and performance metrics.
7. Feedback Mechanisms	
Feedback Loops	Implement regular feedback mechanisms to allow healthcare providers to share their experiences, challenges, and suggestions for improvement.
8. Policy Integration	
Incorporate into Policies and Procedures	Ensure that ASIPP guidelines are integrated to organizational policies and procedures, thus reinforcing their importance in routine practice.
9. Patient and Family Involvement	
Educate and Involve Patients and Families	Provide education to patients, families and responsible caregivers about ASIPP guidelines, so as to involve them in shared decision-making processes related to pain management.
10. Sustainability Planning	
Long-term Planning	Develop strategies for the sustainability of the implemented changes, including ongoing education, regular updates, and integration into the culture of the organization.
11. Dissemination of Information	
Communication Strategies	Implement effective communication strategies to disseminate information about ASIPP guidelines among healthcare providers, staff, and other share- and stakeholders.
12. Policy Advocacy	
Advocate for Supportive Policies	Advocate for policies at organizational and higher levels that support the implementation of these ASIPP guidelines.

There are a number of potential tools and templates that individual clinicians, administrators, and/or care systems may employ to evaluate the relative viability of adoption of revised or new guidelines, as shown in Table 2 (20-23); each of which may be appropriate and worthy to utilize given the contingencies, needs, and demands of various settings, circumstances, institutions and organizations in which pain care is delivered.

We have previously posited, and reassert here, the palliative nature of much of pain care (24). Our use of the term palliative is in its most fundamental sense, to mean “a lifting above” the burdensome dimensions

and effects of patienthood (25); because although there are instances in which the source of chronic pain can be identified, accessed and affected to the point of complete resolution, there are, very often, those cases in which the source of pain may be cryptic, occult, and/or far too multifactorial to completely relieve. To be sure, co-morbidities – inclusive of substance abuse – can make treating pain – and management of patients’ chronic pain – difficult, but these are not a priori grounds for denying or restricting care (26). We opine, pro Derek Doyle, that “...it is the [ethical] right of every person who needs it to receive high quality

Table 2.

The Consolidated Framework for Implementation Research (CFIR):
o Key Components: CFIR provides a comprehensive set of constructs that influence implementation success, including intervention characteristics, outer setting, inner setting, characteristics of individuals, and the process of implementation (20).
The Implementation Science Framework (ISF):
o Key Components: The ISF highlights key factors such as the intervention, the outer and inner settings, the individuals involved, and the process of implementation. It emphasizes the dynamic and iterative nature of implementation.
The Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) Framework:
o Key Components: RE-AIM focuses on five dimensions: Reach, Effectiveness, Adoption, Implementation, and Maintenance. It provides a systematic approach to evaluating the impact of an intervention at both individual and organizational levels (21).
The Practical, Robust Implementation, and Sustainability Model (PRISM):
o Key Components: PRISM considers factors related to the intervention, the implementation process, the outer and inner context, and individual characteristics. It places a strong emphasis on sustainability (22).
The integrated-Promoting Action on Research Implementation in Health Services (iPARIHS) Framework:
o Key Components: iPARIHS emphasizes the interplay between evidence, context, and facilitation. It suggests that successful implementation depends on the nature of the evidence, the context in which it is implemented, and the way it is facilitated. In that vein, using facilitation as the foundational key to success (23).

care, irrespective of diagnosis. And it is the responsibility of every clinician to provide such high-quality care” (27). It is in accordance to this ethical imperative that these guidelines are provided, with recommendation for their implementation toward prudent, responsible practice.

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