"Finding the Moral Frameworks of Pain Management"

Presented by:
Esther I. Bernhofer, PhD, RN, PMGT-BC, CPE
on March 16, 2021

Webcast Questions and Answers
*(Answers are in **bold**)*

Questions:

1. What is your "go to" to treat for patients on either methadone or buprenorphine?
    a. **Unfortunately, I am unable to answer this question – I do not work in this clinical setting.**
2. Do you have any advice for patients who strongly oppose opioid therapy due to their concerns around the stigma of addiction?
    a. **Respect for patient autonomy is critically important. It must be remembered, however, that autonomy is not fully achievable unless the patient is fully informed and has a clear understanding of the situation. If a patient's pain is severe and their condition is such that opioids are the most effective and safe (yes, opioids are safer for some people than other analgesics), then you must have a good discussion with the patient – ask questions to find out why they are reticent to use opioids for pain – what is the background? What are the alternative analgesics? Are they safe with at least partial relief? Is that acceptable? That is key. If, after presenting pros and cons and achieving a clear understanding of the patient's personal situation, the patient still prefers pain over opioids, then so be it. It is their choice and should be honored and supported.**
3. Could you give some further examples of cases in which different ethical frameworks collide or in which no framework is completely satisfying in clarifying the challenging case?
    a. **Ethical frameworks "collide" when their concepts and premises describe different values. One example is deontology vs consequentialism: follow the rules no matter the outcome vs doing whatever works to provide a certain 'right' outcome. So that would be like following the dosage rules to treat patients' pain according to their pain scores no matter the outcome (level of relief of pain) vs. doing whatever it takes to relieve pain (the 'right' outcome) even if the rules (policies) are broken. Another example: Ethics of caring is the theory about decisions made in the course of a caring relationship (often gets emotional) and that could collide with the ethics principle of nonmaleficence (do no harm) if over-caring means providing pain medication that could be unduly harmful under emotional duress to relieve un-relievable pain. Regarding cases where there is no framework that satisfies a challenging case – it is important to remember that few cases rely on one solo ethical framework. It usually takes a combination of theories to**

understand what is going on. For example: the principle of justice may be insufficient to explain a lack of resources for treating a case of chronic pain – adding a look at narrative theory and understanding the full story of the patient will help to shed light on what is going on and how best to approach the gaps in pain care.

4. Can you refine the difference between the moral and the ethical?
    a. **Morals are strongly held beliefs that are based on an enduring premise – such as a religion or strong community values. Morals usually do not change in a person's life although application of them may change. Ethics is the application of morals. For example, ethics is when someone takes the moral dictum of 'it's wrong to kill' and applies it to killing humans, but not to pigs for meat. There is always reasoning behind moral applications. The reasoning my change depending on life situation. Ethics is often also codes of conduct – rules that a certain group agrees to follow.**
5. How do you start changing the mindset of the medical care team? Example - one hospital only gives Tramadol for gastric bypass. Nothing more. How do you change that and meet in the middle?
    a. **Changing the mindset of clinicians can be incredibly difficult. I know that mere education will not do it because there is little incentive to learn about better pain care when you don't understand the pain of others. I have battled this for over a decade where I used to work. Interestingly, we had a couple of physicians/surgeons endure severe illness and surgery themselves and both experienced judgement when they tried to get their pain medication and how unrelieved pain (especially while in hospital and extremely vulnerable) negatively affected their perception of their nurses and providers (to put it mildly). These two returned to practice with a very deep understanding and caring of their patients with pain – their patients' pain medication was carefully selected and safely titrated to provide optimum safe relief. But how can we influence other providers and policy-makers without having to have them endure similar hardship? (That would be unethical!) We need to use the moral argument. If there is a moral obligation to care for patients with pain, then it is a moral obligation to do it right. Otherwise, explain where the moral obligation ends.**
6. Why the maximum number of pain pills are prescribed and consumed in U.S. compared to other countries? Can we educate patients more about resiliency, patience and alternative healing instead of relying on opioids to manage long term pain management? It is totally understandable in acute care though.
    a. **Interesting. Why is it totally understandable in acute care and not with chronic pain? Usually, those who have not experienced ongoing, unrelenting pain advise those who are suffering to 'be more resilient and patient'. Why should a person who just had extensive abdominal surgery not be required to 'be patient' about their pain post-op? Do we not trust or believe people with chronic pain? I challenge anyone who thinks that people should be more patient with their pain to think of how it would feel to burn your whole hand in a cooking accident – then put your hand in a bowl of cold water for immediate relief (analogous to receiving**

a dose of opioid) – then have the water and any medication taken away – and be told to be patient, we have an appointment for you in 3 weeks at the provider's office to investigate the best treatment for your pain. And then you realize that this horrible burn pain is unique and is not dissipating at all and you're going to have to live with it FOR AT LEAST 3 WEEKS! This is what many patients experience FOR YEARS, only no one believes them because the burn is not visible. Providers need to work to understand patients' pain, trust their report of the pain, and work to provide them with the most effective, safe treatment regimen possible, as soon as possible.

7. How about Psychologist?
    a. **Yes, psychologists are essential to the pain team for good chronic pain management due to the deep psychological effects of chronic pain. Mental health is complexly intertwined with pain.**
8. Easy and extreme accessibility and innate need to feel good may compel one to get hooked up, right?
    a. **Yes, it's true if someone suffers from substance use disorder (SUD) (addiction). If I (and many like me) have a cabinet full of oxycodone (easy accessibility) and need to 'feel good' (rough day, losses, just want to finally be happy, etc.), we are not going to down a bottle of pills. Why not? Because we are not addicted to these substances. This example works with people who have a full liquor cabinet too. Addiction (SUD) is a disease that may be a 'crime of opportunity' only if all of the aspects of the disease line up and are present: the substance, a genetic predisposition for addiction [according to some], lack of social support for a deep need (or perception of such), and a perceived need for that substance over any other resource to meet their needs.**
9. How to deal with patients in pain who have psychiatric conditions such as anxiety and depression that can affect the patient's report?
    a. **Good question – the quick answer is that anxiety and depression affect the report a lot! But it may not be what you think. It may not be that the anxiety and depression create false (or inflated) reports of pain, but rather that the anxiety and depression actually amplify the pain experience and the report of pain is actually that much more severe due to the psychological impact. Good assessment takes all this into consideration. Be sure the psychological aspects are treated as well as the physical.**
10. What about the fact that everyone has a different pain tolerance? How does that come into play when treating a patient?
    a. **This is exactly why a detailed pain assessment is critical to good pain management. One person's pain rating of 7 is another person's pain rating of 4. This is why pain medication doses tied to pain rating numbers (so often seen in hospitals because they see a need to quantify pain and dosage) are very problematic and actually often result in overmedication (and confusion!). Good individualized pain treatment with frequent re-assessment and revisions is critical.**

11. I work for an interventional pain physician, what is the best way to approach patients who have for most of their lives depended on opiates for pain relief and believe that this is the only treatment for their pain?
    a. **These patients view their opioids as their oxygen supply in their underwater life. They cannot be expected to agree to have that lifeline taken away without another lifeline ready to replace it. SLOW taper with other pain relief treatments, medications, counseling, etc. is necessary to wean them off the opioids. Also, depending on their quality of life – if they are working, socializing, living responsibly, and taking oxycodone every night so they can sleep without pain, what's the harm? It all must be taken into context with benefits vs risks.**
12. What broader questions arise with the institution of Pain as the 5th vital sign in assessments and the prescription opioid epidemic. How do we address this in the context of recent pharma indictment and ongoing settlement conversation?
    a. **Deep questions! Pain as the 5th vital sign was ushered in during a time of recognition that patients' pain was not being properly addressed and many suffered unnecessarily. Same with the over-prescription of opioids – a reaction to the realization that the needs of those with pain were not being addressed. Of course, pharma saw an opportunity to market their analgesics – opioids. Modern opioid production in conjunction with pain knowledge, good assessment, and follow-up was a really useful way to manage pain for many. But we all know it went bad. I cannot comment on the pharma settlements – I do not know who is responsible for what. I do know that the public wanted to see someone – ANYONE – punished. And so it had to be. (Blame and punishment are critical elements of moral theory.) I think that we must all decide where our values lie – is it more important to prevent possible addiction? Or is it more important to meet the obligation to care for those with pain and provide the best analgesia?**
13. I think most of us have probably seen the graph that shows other methods of pain management are as, or more effective at treating pain than opioids. I have seen the same professionals who cite this data also claim that opioids have their place and are still needed. If these other methods are just as effective, then the logical conclusion seems to be that there is no reason to prescribe opioids. Could you clear up this up for me as it seems I am missing a data point. I am not a doctor so perhaps the answer is obvious to everyone else. Maybe it has to do with the type of pain being treated?
    a. **It is interesting that some 'studies' show that opioids are unnecessary because other medications work 'just as well' or better. The knee-jerk reaction to 'ban' opioids is not based on science, it may be based on politics. Ethically, it is imperative that every prescriber know all the risks and benefits of every analgesic for every individual case – NOT every ailment – because medications work differently for different people. Opioids are an important tool in the tool box. They work quickly and often *without* other side effects such as kidney and liver damage. Morphine or fentanyl is often the safest for older adults with many chronic conditions. Safety and careful monitoring are essential for any medication.**

14. With a person who has almost 5 years in recovery breaks an ankle would you advocate prescribing a pain medication?
    a. **Yes! A broken ankle is likely very painful. Without adequate analgesia and nowhere to turn for relief, this patient might return to past opioids, alcohol, or other dangerous substances. Furthermore, poorly treated acute pain has been shown to lead to chronic pain issues thereby violating the principle of nonmaleficense (do no harm). This patient must be able to trust the provider to prescribe the right, effective analgesics – not necessarily opioids – whatever is effective and safe.**
15. We were just discussing some of these (moral) issues in team today. Such as is it ethical as a provider to take away a patients autonomy related to type of medication? For example when a patient in the hospital and states IV medication "only works) and refusing oral. Often we educate and then if eating/drinking etc. order oral. Going against the patients "wishes"/ taking away autonomy.
    a. **Your example is a classic. In cases such as this, it is likely that the patient retains capacity and is therefore able to make their own choices. Their right to have their autonomy respected includes the right to be educated on risks/benefits, hospital policy, any other legal issues, dosages, all of that. There is also a professional responsibility for the provider to be well-educated on IV opioid medication and its effects and alternatives. That is to say, the decision to disallow the IV opioid must be based on contextual medical risks/benefits, knowledge, patient preference (remember that *evidence-based-practice* includes 1) the best medical evidence, 2) the provider's clinical expertise, and 3*) the patients' preference*). Emotion and biases against the patient for whatever reason or "I don't want to be manipulated" are not ethical reasons to withhold patient preference – they generally create distrust and rarely help the pain situation.**
16. With pain being quantifiably unmeasurable how best should we (Nursing) perform continued research?
    a. **Never let this stop pain research! Not all research must use quantitative measures. But pain research is possible using current quantitative tools such as the pain scale (even though it is not fully valid and reliable, it's the current tool we've got) and should always add a *qualitative* element where the subjects with pain can describe their experience – this makes whatever you are studying more valid.**
17. I am curious to know the proper response to those inquiring about the use of medicinal marijuana for pain, as we are seeing this more and more.
    a. **Medical marijuana for pain is controversial. Some cite a few studies that indicate there is not enough benefit for the possible risks. Other studies indicated possible benefit with limited risk! First, look to the law – if it is permissible by law in your state, then it can be a consideration. Then, it is ethically permissible to allow it for those for whom you can determine more benefit than risk.**
18. Can you discuss differentiation morals and ethics? I've considered morals to be personal, and ethics refers to the majority moral opinion. But I'm not sure that's the framework here.
    a. **Please see answer to question # 4.**