

The case of Ms. C.

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In previous columns, we presented Jonsen and colleagues' practical, user-friendly paradigm for a case-based approach to ethical questions. The paradigm consists of four topics that are fundamental for analysis in every clinical encounter where an ethical issue is identified. We focused on medical indications in the case of Mr. T., contextual features in Ms. R.'s case, and patient preferences in the case of Mr. S. In our fourth and final case introducing this series, we will review the case of Ms. C. and focus on quality of life (QOL). When QOL is limited, the loss seems apparent from the PA's viewpoint. However, as in previous cases, respect for autonomy is the guiding principle in the analysis.

The core issue of this case is the use of opioids in the treatment of chronic nonmalignant pain. Complicating the case is the patient's history of addiction. Of the ethics papers that I review for PA students and the ethics questions I receive from PA colleagues, approximately one third involve pain control and the use of opioids. The questions commonly involve patients with a current or past history of addiction. I would like to thank Jennifer Tso, PA-C, for this case.

Case

Ms. C. is a 49-year-old woman who has been receiving care at a community clinic for a number of years. The PA member of the primary care team has been her provider for most of this time. Ms. C. is in today for a routine visit. Her medical history includes osteoarthritis, suboccipital and sacroiliac myofascial pain, gastroesophageal reflux, coagulopathy, hepatitis C virus infection, cirrhosis, and polysubstance abuse, including a history of addiction to heroin and a 15-pack-year history of cigarette smoking. Her current medications include baclofen, nadolol, furosemide, spironolactone, docusate sodium, rabeprazole, trazodone, oxycontin, morphine, and methadone. She has a history of therapeutic and pharmacologic noncompliance. Mrs. C was the vice president of a prominent software group until approximately 5 years ago, when she took medical retirement. She has always preferred to receive her

health care from the community clinic, and she volunteered at the clinic during its formative years.

Physical examination reveals an ill-appearing, jaundiced female with scleral icterus. She is oriented to time, place, and person. She has multiple spider angiomas on her chest. Respiratory examination reveals regular breathing with bilateral crackles at the bases of both lungs that do not clear with cough. Cardiovascular examination discloses a regular heart-beat at a rate of 90 beats per minute. Ms. C.'s lower extremities are well perfused and noted to have 2+ pitting edema at her ankles bilaterally. Abdominal examination reveals distention. The liver is easily palpable, measuring 10 cm below the costal margin at the midline. The consistency is hard and somewhat nodular. The remainder of the physical examination is unremarkable.

In addition to receiving care from her primary care team, with whom she has a pain contract, Ms. C. sees a gastroenterologist for treatment of her hepatitis. She had a pain contract with a private pain clinic but has left their care. On recent visits to the community clinic, she has occasionally become very verbally abusive to the PA and staff, with the result that the clinic is considering making her ineligible for care.

The ethical question

As the medical provider, the PA must determine if and when Ms. C. truly needs pharmacologic pain therapy. Is she using the PA to obtain narcotics for her personal addiction? Is she selling the medication to obtain illegal narcotics?

Discussion

Medical indications (beneficence and nonmaleficence) The major medical issues in this case are Ms. C.'s liver disease, which is life threatening, and her pain secondary to cirrhosis. The prognosis of cirrhosis is quite variable and depends on a number of factors, including etiology, comorbid disease, complications, and severity of disease. Ms. C.'s prognosis is poor, and she is not expected to live more than 2 years.

The goals of treatment in this case are to reduce pain and to maintain the patient's ability to have a functional and meaningful life. Treatment of pain in the 21st century continues to rely on opioids for severe, unremitting pain from malignant disease or chronic nonmalignant

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pain, though controversy in this area remains. Patients with liver disease can be treated in the same way as other patients with chronic pain; however, careful observation of the patient's liver function is vital.¹ Ms. C. should not take NSAIDs because they increase the risk of variceal hemorrhage and adversely affect renal function.² She may take acetaminophen, 2 g daily.³ The most effective pain medications are opioid derivatives, but because opioids are metabolized in the liver, the dosage must be monitored and adjusted. Methadone's pharmacokinetics appear least affected by liver dysfunction, and this agent appears to be safe if the dosage is reduced as liver damage increases.⁴

Patient preference (autonomy) This section addresses the patient's right to choose within the law and ethics. What is the patient's preference? How does the principle of autonomy affect the right of Ms. C. to expect treatment for her chronic pain?

Ms. C. wishes to be free of pain and functional with the use of pain medications. She is a competent woman who is handling her daily activities well. She will continue to be treated by the clinic team for her pain if she adheres to her treatment contract. Ms. C. has been fully informed of her treatment options. However, she understands that if she is found to be taking pain medications obtained outside the treatment plan, her pain medication may be tapered and no further pain medications would be available through the clinic. She also recognizes that if she misses appointments or continues to be abusive to clinic staff, she may have her medication tapered.

Quality of life (nonmaleficence, beneficence, and autonomy) This section reviews the issues of restoration, maintenance, or improvement of Ms. C.'s QOL. Information to explore includes the likelihood of the return to a normal life with and without treatment.

A frequently missed question in QOL assessment is whose values are being applied in the appraisal. Is the assessment utilizing "objective" quantitative information or more in-depth, but often unclear, "subjective" qualitative information? In an early QOL study, we evaluated mobility, activities of daily living, pain, mental acuity, and social relations, but we lacked an in-depth discussion that would put into context a multidimensional appreciation of the patient's life quality.⁵ Here we consider the QOL issues Ms. C. may experience if pain control is successful or unsuccessful. We should also be aware of any personal biases that may unduly influence the PA's assessment of Ms. C.'s QOL. At its core, QOL judgment is the assessment of values; the question for the PA is whose values are paramount if there is conflict in this PA-patient relationship: the values of the patient within the context of autonomy or those of the PA based upon the concepts of beneficence, nonmaleficence, or justice?

Ms. C. describes her quality of life as tolerable to good, depending on her pain control. Recently her pain was a constant 6 on a 10-point scale, although at times her pain was almost intolerable because it never went away. When taking her pain medication on a regular schedule, she described the pain as a 4 or 5 out of 10. She told the PA she had once run out of medication and her pain level was almost unendurable. She briefly considered suicide although she could not think of a specific method. She continues to have a persistent fear of running out of pain medication. Sullivan and Ferrell argue that to maintain a close patient-provider relationship, the pain information patients provide must be accepted as authentic.^{6,7}

Ms. C. is able to conduct many of her activities of daily living. She sees friends and family and attends services at her church. When her pain is under moderate control, she is able to go to the movies and shop with friends. When pain is more intense, she stays home in bed. If she continues taking her pain medication and antidepressants and attends psychotherapy, her QOL may improve instead of deteriorating.

There is a "double effect"⁸ with chronic opioid treatment that can include dependence, tolerance, addiction, or pseudoaddiction.⁹⁻¹²

- Dependence is the foreseeable clinical course of long-term opioid therapy. It is a physiologic state in which persons receiving such therapy will respond negatively if the opioid is terminated.
- Tolerance is a physiologic response requiring increased dosages of opioid to achieve the same effect.
- Addiction is dysfunctional behavior caused by preoccupation with obtaining opioids.
- Pseudoaddiction is characterized by running out of medication prematurely, self-administration of an increasing dose of medication, and "drug-seeking behavior." These behaviors end when adequate pain control is achieved.

The Joint Commission on Accreditation of Health Care Organizations considers pain to be the fifth vital sign and assesses whether pain is being treated appropriately during routine certification site visits.^{13,14} Potter and colleagues disclose the harm that is caused by undertreatment.¹⁵ They also confirm there are few dependable outcome studies to guide primary care providers in the proper utilization of narcotics for controlling chronic nonmalignant pain. In this case, with Ms. C.'s history of addiction, the PA may well have a bias about using opioids in high enough dosages to control Ms. C.'s pain.

The final issue to consider in this section is Ms. C.'s length of life. At what point should the primary care team reevaluate Ms. C.'s condition and move from chronic pain management to palliative care? The shift to

palliative care could change the QOL equation dramatically, though the intricacy of such a shift precludes a full exploration of this issue here.^{16,17}

Contextual features (justice) External forces that come into play when evaluating the case include economic, legal, social, and institutional matters. The patient-provider relationship is affected by the larger society. In Ms. C.'s case, another patient reported that Ms. C was selling her pain medication. In America today, the PA is responsible for maintaining optimum pain control but is also required to adhere to strict legal regulations regarding the prescribing of narcotics that, if violated, could bring severe consequences. These two often seem to be in conflict.⁹

Even though the problem of inadequate pain management in the United States is critical,^{18,19} the government, law enforcement, and medicine have created the misconception that taking opioids for pain will cause addiction. Many providers assume that chronic use of narcotics will inevitably cause a patient with a history of addiction to revert to illegal drug use. These competing stresses may cause opiophobia in clinicians,²⁰ even though no studies have demonstrated that these assumptions are true. In this context, a PA may prescribe the minimum dosage of a narcotic with an extended period of time between dosages to decrease the chance that addiction will recur.

Gilson and Joranson²¹ describe the responsibilities of the federal government to oversee access to controlled substances and to ensure that a supply is available for medical needs. The state grants the license to practice medicine and regulates the use of opioids. Both the practice of medicine and regulation of opioids vary significantly from state to state, increasing tension and bewilderment for clinicians. It is not surprising that many providers prescribe opioids in a restrained manner.

Recommendations

Ms. C. says that pain is the major influence on her QOL. The ethical concerns for the PA include the following:

- Is Ms. C. exhibiting drug-seeking behavior? Is she diverting her prescription medication because of her addiction? Is addiction a character flaw or a chronic disease needing constant vigilance and aggressive treatment? How should Ms. C.'s verbal abuse of the clinic staff be handled?
- Is Ms. C. physiologically dependent upon her opioid medication?
- Is Ms. C. suffering from pseudoaddiction exacerbated by fear of running out of pain medication?
- Are Ms. C.'s pain regimen and dosing schedule optimal?

The ethical principles involved in QOL analysis are nonmaleficence, beneficence, and autonomy. Nonmaleficence "sanctions rather than suppresses quality-of-life judgments."⁸ Does undertreatment of pain cause harm to

QOL? Does creating a probability of physiologic dependence or addictive behavior violate this principle? Beneficence assumes action that helps others. Improving Ms. C.'s QOL by prescribing adequate opioid medication may uphold this principle. Autonomy requires supporting Ms. C.'s request to be as free from pain as possible.

Gilson, Weaver, and Cohen all note that appropriate pain treatment does not appear to create a significant increase in addictive behavior in those with an abuse history or present dependence.^{9,12,21} The challenge is the ability to treat pain, as Weaver explained, in the face of sometimes convoluted state laws and regulations.⁹ Again we see that the tension between beneficence and autonomy is a constant struggle. The human and professional concern to do everything medically possible for the patient, the patient's control over decisions affecting health and QOL, and issues of justice, laws, and regulations that control the practice of medicine all compete in the effort to meet the best interests of the patient. □

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