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**“You wouldn’t do that to an animal, would you?”  
Ethical Issues in Managing Pain in Patients with Substance Dependence**

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### **Abstract**

In this article, we present a secondary analysis of a descriptive phenomenological study that we conducted in the United Kingdom exploring nurses’ experiences of working with patients with substance dependence and pain. Our aim was to focus upon the ethical issues that emerged in the empirical data and so we used the Four Principles of Biomedical Ethics plus attention to scope to guide and inform our analysis. We present six key themes: trust, paternalism, coercion, failure to respect autonomy, advocacy and withholding. We discuss how these themes intersect with the four principles plus scope to illuminate practice and the ethical issues that emerge when managing this patient population’s pain. We recommend that clinicians adopt a collaborative approach to managing pain for patients with substance dependence that they remain aware of the power differentials inherent within the clinical setting and ensure that communication and teamwork remain at the forefront of decisions. Clinicians need access to ethical guidance to inform their practice decisions and clinical ethics support services could provide one solution.

### **Keywords**

Pain, substance dependence, pain management, ethics, ethical issues, clinical ethics

### **Introduction**

Managing patients’ pain is a constant challenge for nurses working in clinical settings. Pain is a subjective experience; patients both experience pain and respond to pain management treatments in disparate ways. The challenge of effective pain management can become increasingly complex with different patient groups, such as patients with substance dependence (SD). In 2014, we conducted a phenomenological study exploring the experiences of nurses caring for patients with substance dependence and pain.<sup>1</sup> The International Statistical Classification of Diseases and Related Health Problems (ICD-11, World Health Organization, 2019<sup>2</sup>) recently re-classified substance misuse and substance-use disorder/syndrome as ‘disorders due to substance use’ to acknowledge that sequelae can occur in one off and short term use. Referring to long term use, the ICD 11 now also identifies different groups of SD (e.g. cocaine or opioid dependence). SD in this paper refers to the long-term use of psychoactive and illicit substances (rather than addictive but legal substances such as alcohol and nicotine) that are associated with harmful consequences, increasing tolerance and withdrawal.

Undertreatment of pain has been recognised as a particular risk for patients with SD due to practitioner fears of relapse, suspicions of ‘drug-seeking’ behavior and feeling underprepared.<sup>2-4</sup> Whilst we acknowledge that best practices regarding opioid treatment in the United Kingdom (UK) are currently being debated in light of the opioid crisis in North America<sup>5</sup>, we nonetheless wish to highlight the ethical issues that arise when treating patients with SD and suggest these issues will occur even if new guidelines for opioid prescriptions are introduced. Research suggests that nurses continue to hold negative attitudes towards patients with SD. These attitudes can affect their pain management strategies, and this patient group report feeling stigmatised and stereotyped.<sup>6-9</sup> Indeed, the nurses we interviewed in our original research perceived patients to be “difficult” and “noncompliant”, and they were suspicious of drug-seeking behaviour.<sup>1 (p.708)</sup> However, they also wanted to do the right thing and whilst they did use stigmatising and stereotyping terminology, they also showed an awareness that SD is a complex condition that involves “behavioural, cognitive and physiological phenomena”.<sup>10 (p.1)</sup> As the participants described their experiences of caring for this patient group, many different challenges which have important ethical implications began to emerge. In this paper, we present a secondary analysis of the empirical data with a focus on the ethical issues that emerged in the nurses’ narratives.

## Methods

As there was a paucity of research conducted in the UK, the original research was exploratory, focusing upon nurses’ experiences of caring for patients with SD and pain, and any possible barriers to pain management. To facilitate an in-depth exploratory approach, we used a descriptive phenomenology following the Husserlian philosophical tradition. All authors had previously encountered negative attitudes to this patient group from colleagues and these experiences piqued their interest in the research topic. However, because we were following the Husserlian phenomenological approach, these preconceived notions were ‘bracketed’ and set aside in order to understand the phenomena.<sup>11, 12</sup> In Husserlian phenomenology, the focus is on gaining a thorough description of the experience with minimal interpretation from the researcher. As the first author collected and analysed the primary data, these prior experiences, background assumptions and expectations were recorded in a reflexive research diary as a way of consciously setting aside preconceived assumptions and reducing the likelihood they would seep into the research process. As this is a secondary analysis, we have deviated from this purely descriptive approach and have added our own interpretations as guided by ethical principles.

When approaching our secondary analysis, we noted Long-Sutehall et al’s<sup>13</sup> suggestion that there needs to be sufficient fit between the primary and secondary research questions to justify secondary analysis, and to assess whether the primary dataset has the potential to answer the secondary research questions. The themes that emerged in the first paper strongly indicated deeper ethical issues for example, one theme was entitled “doing the ‘right thing’”: participants discussed their attempts to adequately treat patients’ pain and their perspectives regarding patients’ attempts to seek treatment for SD. We were able to develop secondary research questions that mirrored the primary research questions. Table 1 shows the primary and secondary research questions.

**Table 1. Primary and Secondary Research Questions**

<b>Primary Research Questions</b>	<b>Secondary Research Questions</b>
<ol style="list-style-type: none"> <li>1. To obtain an in-depth understanding of nurses’ experiences of working with patients with SD and pain.</li> <li>2. To explore common themes arising from nurses’ experiences and perceptions.</li> <li>3. To explore the educational and support needs of nurses caring for patients with SD requiring pain management.</li> </ol>	<ol style="list-style-type: none"> <li>1. To explore the ethical issues that emerged from nurses’ experiences of working with patients with SD in pain, paying particular attention to the four principles of biomedical ethics.</li> <li>2. To identify ethical tensions and the implicit ethical analysis nurses employed when faced with ethical challenges encountered in clinical practice.</li> <li>3. To make normative recommendations for clinical practice in light of the ethical issues.</li> </ol>

There is a lack of empirical research and clinical guidance addressing the ethical issues of pain management, particularly amongst this patient population. We therefore wanted to use an ethical framework to guide the secondary analysis. We employed a quasi-empirical bioethics method informed by Frith’s ‘Symbiotic Bioethics’<sup>14</sup> (see Table 2). Empirical Bioethics is a relatively new methodology that combines empirical research methods (often qualitative methods) and ethical analysis or theory, to produce normative recommendations. Normative recommendations prescribe or suggest actions based upon ethical theories, norms or principles. Symbiotic Bioethics is an empirical bioethics method that sets out ethical theory and practice as mutually informing – as “symbiotically related” (p.201).<sup>14</sup> Ethical theory is used as a lens to analyse and explore the morality of practice, whilst practice and ethical norms can inform and amend theory. In this paper, our normative recommendations are drawn from the four principles which we describe below.

Frith’s approach would commonly be used as a framework to guide an entire research project and not only for secondary analysis; thus our approach is a quasi-empirical bioethics method because of the post hoc ethical analysis. The four principles from Beauchamp and Childress<sup>16</sup> plus attention to their scope of practice (known as four principles plus scope)<sup>15</sup> were used to identify implicit aspects of ethical decision-making that nurses employed when they encountered ethical challenges in practice. We describe this approach in more detail below. In Step 4 of Frith’s method we highlight, as others have, the limitations of the four principles plus scope rather than build on ethical theory. One criticism being that although the four principles are useful for ethical analysis they still need to be applied in the correct way to produce specific guidance for unique clinical situations.

**Table 2: Five Steps Required to Carry out Symbiotic Bioethics**

<b>Frith’s Five Steps to Carry out Symbiotic Bioethics</b>	<b>Five Steps Carried out in this Project</b>
<ol style="list-style-type: none"> <li>1. Seek the views and opinions of key stakeholders and collect the empirical data.</li> </ol>	<ol style="list-style-type: none"> <li>1. Nurses interviewed about their experiences of working with patients with SD in the primary project.</li> </ol>
<ol style="list-style-type: none"> <li>2. Specify theories and principles that may be relevant and explore how they are informed by the empirical findings.</li> </ol>	<ol style="list-style-type: none"> <li>2. Identified ways in which the four principles came into conflict when conducting the primary data analysis.</li> </ol>

3. Use relevant ethical theory and principles as tools for analysis of the empirical data	3. The four principles were identified as relevant and used to inform the secondary analysis.
4. The theory used to analyse the data is built upon by the empirical data	4. We have highlighted the limitations of the four principles with regard to providing specific guidance.
5. The ethical theory and empirical data can be used to inform normative recommendations.	5. Normative recommendations informed by the four principles and empirical data are included in Table 4.

The four principles approach from Beauchamp and Childress<sup>16</sup> was used as the ethical theory to guide our secondary analysis because these principles helped highlight the ethical tensions within the qualitative data. This approach uses four key principles: respect for autonomy, beneficence, non-maleficence and justice, as a guide for moral agents to determine the right course of action. The principles also enable clinicians who may lack confidence and expertise in ethics to explore and express conflicting viewpoints.<sup>17</sup> Although we are using a principle-based approach, we appreciate there are many other moral theories that we could have used. Principlism was selected with the aim of providing ethical analysis and clinical guidance that is accessible to healthcare professionals who may not have an in-depth knowledge of ethical theory or bioethics. The four principles are almost universally taught to medical and nursing students thus increasing the accessibility of our analysis. As Huxtable<sup>17</sup> states the four principles arguably only provide a starting point, not an end point to moral deliberation, so although these principles guided our analysis they did not dictate our themes. To provide some additional flexibility, we adopted the four principles approach plus attention to scope of application as advocated by Gillon.<sup>15</sup> Attention to scope of application acknowledges that these principles can often come into conflict and support different courses of action and can be limited when one is seeking action-guidance.<sup>15</sup> We highlight these conflicts and some of the limitations of this approach in the findings and discussion sections. Table 3 provides a summary of the four principles and lists the areas for scope.

**Table 3: The Four Principles<sup>16</sup> Plus Attention to Scope<sup>15</sup>**

Principle	Summary of Principle
Respect for autonomy	<ul style="list-style-type: none"> <li>- Individuals act autonomously if they are able to act with:               <ol style="list-style-type: none"> <li>i) Intentionality- the action is intended to cause the consequential action, even if the consequences are undesirable.</li> <li>ii) Understanding- a person acts autonomously if they understand the consequences and are free from constraint.</li> <li>iii) Non-control- an action is if it is free of control exerted either by external sources or internal states that may impact self-determination. E.g. another person coercing or manipulating (external), mental illness (internal).</li> </ol> </li> <li>- The principle ‘respect for autonomy’ suggests that these three conditions should be upheld when confronted with ethical disagreement.</li> </ul>
Non-maleficence	<ul style="list-style-type: none"> <li>- Non-maleficence is defined as, “one ought not to inflict evil or harm”.<sup>16 (p.152)</sup></li> </ul>

	<ul style="list-style-type: none"> <li>- Non-maleficence is a prima facie principle. Any action that violates this must be justified, for example the harm caused by inserting a peripheral cannula is justified on the basis that intravenous antibiotics are necessary.</li> </ul>
Beneficence	<ul style="list-style-type: none"> <li>- Beauchamp and Childress<sup>16</sup> warn against conflating non-maleficence and beneficence, arguing that combining the two can obscure critical moral thinking.</li> <li>- The norms of beneficence are: “one ought to prevent evil or harm, one ought to remove evil or harm, one ought to do or promote good.” (p.152)</li> <li>- Beneficence requires the agent to prevent, rather than avoid harm and may be said to be more demanding than nonmaleficence.</li> <li>- Beauchamp and Childress<sup>16</sup> further divide beneficence into ‘positive beneficence’ which requires an agent to provide benefits to others, and ‘utility’ which requires an agent to balance benefits, risks and costs to produce the best overall result.</li> </ul>
Justice	<ul style="list-style-type: none"> <li>- Beauchamp and Childress<sup>16</sup> discuss how a unified theory of justice is incapable of capturing the multitude of conceptions of principles of justice and therefore do not settle on one theory of justice. Instead they present 6 different theories of justice by which one might choose to weigh-up a potential moral issue: <ol style="list-style-type: none"> <li>1. Utilitarianism</li> <li>2. Libertarianism</li> <li>3. Egalitarianism</li> <li>4. Communitarianism</li> <li>5. Capabilities Theories</li> <li>6. Well- Being Theories</li> </ol> </li> </ul>
Scope	<ul style="list-style-type: none"> <li>- Gillon<sup>15</sup> argues that attention to scope when applying these principles enables healthcare professionals to weigh the principles and determine to whom and in what circumstances these principles need to be upheld. Attention to scope can therefore help to determine the morally preferable action if two principles are pulling them in different directions. We also use scope to bring attention to other ethical issues that cannot be categorised into one of these four principles.</li> </ul>

Secondary data analysis was conducted using the same five-stage approach used for primary phenomenological analysis guided by Giorgi and Giorgi.<sup>18</sup> We also paid particular attention to the ways in which the new emerging themes were related to the four principles plus scope to inform our analysis. All authors coded the transcripts and discussed and debated the key themes.

Ethical approval for the primary research was provided from King’s College London Psychiatry, Nursing and Midwifery Research Ethics Committee (PNM/12/13-140). As this was a secondary analysis ethical approval was not required. Long-Sutehall et al.<sup>13</sup> argue that professional judgement

is needed to assess whether the secondary questions shift the intention of the original research focus. This secondary analysis does not shift the intention of the original research but rather builds upon and provides further depth to those findings. Table 1 shows the primary and secondary research questions. Participants consented to use of their anonymous data for publishing purposes and risk to participants remains small as their identity is anonymous. Purposive sampling was used to recruit post-registration nurses who had experience of working with patients with SD and pain. All the participants had experience in the acute care setting and many discussed experiences caring for patients post-operatively. Participants were recruited via an email advertisement with a total of five participants recruited. All participants were female, had varied levels of nursing experience and worked in different clinical areas, increasing the transferability and representativeness of an admittedly small sample. As this was a qualitative study, the aim was not to recruit a large number of participants but rather to gather rich, in-depth data.

## Findings

After re-analysing the data using the four principles plus attention to scope as our guide, we identified the following key themes. Many of the themes related to more than one principle and there was considerable cross-over between themes as they frequently related to more than one ethical principle (Table 4).

### Trust

Participants discussed the perception that lack of trust between nurses and patients with SD and pain could be mutual. In the following quotation, participant A discussed the difficulty of trying to care for patients who do not adhere to the routines and rituals inherent within healthcare settings.<sup>7</sup> This failure to follow the expected patient role seemed to heighten this participant's lack of trust as she discussed worrying that the patient could go outside to use illicit drugs.

*"...you would go and see him for a review and actually he wouldn't be there he would be outside the front door and then with all the suspicions of why is he going downstairs, this is a hospital not a hotel, he may be up to all sorts, you know, you don't know. Is it safe for him to be going off the unit anyway and should we be allowing that behaviour, but what do you do about it? It is not a prison."*  
(Participant A)

The participant's reference to how the patient is in hospital, not a hotel suggested that patients ought to conform to the implicit rules and standards of behaviour. This theme intersects with respect for autonomy as the patient was trying to exert his autonomy and yet because of SD, he could not do so without arousing suspicion. This raises the question of whether another patient, without SD could have left the ward without being subject to the same mistrust, and highlights how these patients are at risk of being treated unjustly.

Whilst participant A seemed to be driven by beneficence, as she questioned whether it was safe for the patient to go off the ward, we may question whether it is justifiable for this to override respect for the patient's autonomy. Indeed, the participant was aware that she could not control the patient's movements and suggested that whilst she appreciated the patient's right to exercise their autonomy, she struggled to do so in practice.

In the next quotation, participant C also showed an appreciation for the patient's possible viewpoint as she described how the patient knew their own body and what analgesics worked for them. She was also suspicious of this knowledge and was conflicted as to whether this represented drug seeking behaviour or the patient exerting their autonomy.

*“Again it makes you suspicious when they have such a knowledge and they come in demanding a certain drug... it makes you think, is this drug-seeking behaviour but, at the same time, patients are experts on their bodies and of course you know what works for you and what doesn't when you have a recurrent problem then you know what you need so again, it is a double edged thing like is this drug seeking or are you really in pain, there is no way of knowing” (Participant C)*

To manage the subjective nature of pain, nurses have been taught that “pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does.”<sup>19</sup> (p.95) This approach to pain relief is reliant upon mutual trust and honesty, therefore when pain and addiction meet, pain management becomes more complex.<sup>2</sup>

## **Paternalism**

Paternalistic attitudes and behaviours were described by some participants and these could be used to treat or govern patients as if they lacked decision-making capacity. By adopting some of these behaviours, clinicians overrode respect for the patient's autonomy. This resonates with the ‘medical model’ where defects or dysfunctions are ‘fixed’ using a problem-solving approach. Conversely, participant A suggested that if a patient had taken steps to ‘fix’ themselves by entering a drug dependence programme, this was seen as being more acceptable and the patient perceived as more trustworthy.

*“I think if someone is in a programme and they come in and can say I am on this much Methadone, or this much whatever, that may be has more of an air of acceptability about it because a professional is involved and is managing it and the person is trying to do the right thing whereas maybe if you are just buying things randomly off the internet or off a dealer, it is more kind of underhand and illicit and criminal and those things.” (Participant A)*

The paternalistic mission to ‘fix’ the patient of their addiction could override the patient's therapeutic treatment with analgesics. Participant B described such a scenario when a patient who had multiple fractures, was given inadequate pain relief because, from her perspective, the doctor was distracted by the perceived need to fix the patient's SD:

*“I had one doctor who said oh we can't give him opioids because he is meant to be weaning so that he only gave him 5 milligrams of Oramorph and he had a fractured pelvis, fractured limbs and a clavicle fracture (...) but our doctor seemed obsessed with weaning and fixing the drug abuse problem” (Participant B)*

This approach could be viewed as fulfilling beneficence, by restricting opioids to avoid further harm, but this approach conflicts with non-maleficence. The appropriateness of trying to ‘fix’ the patient's addiction at the time of major trauma is questionable. In addition, effective pain management in this acute period is essential to avoid the patient developing persistent pain after surgery.<sup>20, 21</sup>

The imperative to ‘do no harm’ often led to a paternalistic approach in the doctor's choice of medications. Participant A described patients requesting certain medications, sometimes



intravenously. However, due to mistrust she described a reluctance to allow the patient full control and instead highlighted how it was important to try to work together:

*“you do have a right to have good pain management but that doesn’t mean the same as you having any drug you tell me you want to have at any dose you tell me you want to have it. We have to try and work together on that and we would always try to be quite collaborative in that and try and get someone on board because if you can’t make that link, I think you are doomed to failure and it is a difficult situation which becomes even more difficult.” (Participant A)*

Participant C expressed a paternalistic approach of having to ‘harden’ herself and remain constantly vigilant, so as not to facilitate maladaptive ways in patients with SD:

*“so there is always dread when the doctor says to me or the nurse handing over to me says this is potential drug use behaviour or they have substance misuse and there is pain there because basically you have to harden yourself. Any other patient you wouldn’t hesitate to give them analgesia, you wouldn’t hesitate to give them Morphine if that is what is going to make them comfortable” (Participant C)*

## **Coercion**

At times, paternalism could be deemed coercion as patients with SD could be forced to do something that they did not want to do. An example was provided by participant B; she described a patient with complex needs, diagnosed with both SD and human immunodeficiency virus (HIV). The patient left the ward for a few hours and when he returned they stopped his pain relief because they felt he was under the influence of illicit drugs. Later when these effects wore off, he was crying out in pain, became threatening and security was called. The medical team were concerned that his medical condition was deteriorating and wanted to perform further blood tests:

*“They wanted to take bloods because they wanted to add in a query of Hepatitis as well and so they were wondering about Encephalitis with his HIV and they wanted to take bloods and he wouldn’t let them so there was a really weird deal that they would let him take his Oramorph if he would let them take bloods, so that was the compromise that was reached.” (Participant B)*

Although this could be viewed as acting in the patient’s best interest (beneficence), the clinicians seemed focused on treating the patient, but they acted in such a way that violated the patient’s moral agency. In this scenario, the compromise reached infringes upon the patient’s right to equal and fair access to pain relief, prompting concerns that the patient was treated unjustly. It could be questioned whether similar techniques would be used for patients without SD; would antibiotics ever be withheld from a non-compliant patient?

## **Failure to respect autonomy**

Failing to respect a patient’s autonomy was closely bound with beneficence and paternalistic behaviour. In the following quotation, participant A described how patients lacked autonomy because of their disease process:

*“So, I think there are people who if those are their drugs of reliance and you are giving them that, that is a temptation which is right there for them and it is not surprising then I think if they then give in to that temptation, like if you put them in a chocolate factory or something.” (Participant A)*

The fact that patients with SD could be driven by their addiction provided a rationale for some clinicians to limit patient autonomy, believing patients could not act in their own best interests. Indeed, the ability to act freely and without constraint is a condition for autonomous action<sup>16</sup> and participant A is highlighting how patients with SD autonomy is already constrained because of their addiction. However, rather than legitimizing paternalistic behaviours on the basis of beneficence, healthcare professionals should carefully balance beneficence with respect for the patient’s autonomy, to provide patient-centered care. This will likely involve open communication about the risks and benefits of various analgesics rather than making decisions about appropriate analgesics without the patient. Furthermore, the participant hinted at the power dynamic between clinician and patient; she compared the patient to a child who was unable to control themselves in a sweet shop. This infantilisation of the patient seems to provide some justification for paternalistic supervision from healthcare professionals.

## **Advocacy**

Importantly, participants wanted to do the right thing for patients but struggled to know what that was, and this moral uncertainty was a key theme in our primary analysis.<sup>1</sup> One participant framed this in terms of acting as the patient’s advocate. In the following quotation, participant C described feeling uncertain about what to do; she did not want the patient to be in pain but she also did not want to ‘reward’ what she thought could be drug-seeking behaviour.

*“I am my patient’s advocate and my patient is in pain but if the doctor is not willing to prescribe anything what can I do and especially if it is drug seeking behaviour. It is difficult then to be objective in your mind to make sure you are not rewarding someone’s drug seeking behaviour and you are not giving them what they think they need when they don’t need it. It is a very difficult balancing act because as nurses it is preached to us that pain is what the patient says it is and yet the doctor is saying this pain might not be real so it colours your vision and you try not to treat them differently but you are treating them differently because you are not giving them the painkillers you know are going to help.” (Participant C)*

Participant C expressed frustration and feelings of powerlessness because she felt uncertain about how to respond to the patient’s pain. Adopting a broader understanding of moral distress, this could be regarded as moral-uncertainty distress<sup>22</sup> because she was morally uncertain about whether the best thing for the patient was to treat their immediate pain or mitigate potential exacerbation of their SD.

Participant C also seemed to feel compelled to act because of her responsibility to be the patient’s advocate but again seemed to feel powerless because the doctor retained the ultimate decision-making authority about what to prescribe. This highlights the problematic nature of advocacy: nurses feel motivated to act because they are responsible for patient advocacy and yet they are often constrained because of the decision-making hierarchy. This can result in another type of moral distress: moral-constraint distress because nurses believe they should advocate for patients but they are unable to carry this out effectively because they are constrained.<sup>22, 23</sup>

Participant E also expressed frustration because she wanted to act as the patient’s advocate but struggled to remain neutral and not stigmatise patients based on their past behaviours.

*“you know, you want to control people’s pain and that they are an IV user is neither here nor there really, you don’t want anyone to be in pain and it can be very difficult and that is frustrating when you, you know, and you have to put aside the fact that they wouldn’t be in this much pain if they hadn’t done all these things in the past”. (Participant E)*

Participant D however could frame this issue as the purely clinical problem of opioid tolerance.

*“if people build up such tolerance over a period of time their normal is not like someone else's normal so you still have to give them appropriate analgesia and I think it is completely safe and right to do that”. (Participant D)*

## **Withholding**

Participants described experiences in which analgesics, most frequently opioids, were withheld from patients with SD. Again, this was often justified by appealing to the principle of beneficence. In the following quotation, participant D questioned whether withholding pain relief might not be the right course of action:

*“I don’t know how to phrase this in a way that is appropriate, but I think there is always that worry that... perhaps giving opiates to somebody who is addicted to opiates is not a good idea but sometimes that is what they need.” (Participant D)*

Participant D did not appear to be certain that withholding analgesics was the wrong thing to do whereas participant E expressed anger as she reflected on practitioners’ fears of feeding addiction and withholding analgesics:

*“You wouldn’t do that to an animal, would you? You wouldn’t leave them in pain.” (Participant E)*

Participant E felt powerless to provide adequate pain relief because she could not prescribe and had to rely on the doctor’s prescription. Participant E seemed to articulate moral-constraint distress because she was unable to effectively treat the patient’s pain and suggested that leaving patients in pain was inhumane.

Despite some understanding that patients with SD required opioids for effective analgesia, when medication was withheld, nurses did not want to tell the patient in order to maintain a relationship with them. This deception legitimised the mistrust that participant A hypothesised patients with SD felt towards healthcare professionals.

*“It was difficult because he was crying out in agony and it was difficult to say to him we are not giving you [opioids] or we are withholding...obviously we would not say that to a patient that we are withholding painkillers. But it was difficult looking after him when he was in pain because obviously as a nurse one of my main jobs is to get analgesics fast and get pain under control.... it was difficult for him because of hearing him cry out and not be able to give him anything medically other than to check that he was okay and trying to give reassurance. So yeah that was kind of how just keeping up communication with so that he didn’t think we had forgotten him when he was in agony.” (Participant C)*

All participants described situations where patients with SD were given lower than usual doses despite, in some cases, extensive injuries.

**Table 4: Key Themes**

<b>Key Theme</b>	<b>Ethical Principle</b>	<b>Application of the Four Principles plus Scope to each Theme</b>	<b>Normative Recommendation</b>
<b>Trust</b>	Respect for Autonomy  Justice  Beneficence	<ul style="list-style-type: none"> <li>- Heightened clinician mistrust means patients with SD are more likely to have their autonomy constrained.</li> <li>- The principle of justice raises the question of whether patients without SD could more effectively exercise their autonomy and therefore whether patients with SD are being treated unjustly.</li> <li>- Although the clinician may be driven by beneficence, it may be questioned whether this should override respect for autonomy.</li> </ul>	Clinicians should acknowledge the potential for mistrust and unjust treatment of this patient population. This could be mitigated by being open and transparent with patients about which treatment modalities they are willing to provide.
<b>Paternalism</b>	Beneficence  Scope  Non-maleficence	<ul style="list-style-type: none"> <li>- Driven by beneficence, clinicians adopted paternalistic behaviours, such as restricting opioid prescriptions which could leave patients in pain.</li> <li>- In these situations, nurses reported feeling powerless to treat reported pain because of inadequate prescriptions thus causing moral-constraint distress.</li> <li>- By trying to act beneficently, clinicians were in fact violating the principle of non-maleficence as restricting analgesics caused the patient to experience further pain and increased the risk of chronic pain.</li> <li>- Paternalistic behaviours ultimately meant that</li> </ul>	In the acute pain period, restricting opioid prescriptions causes unnecessary pain and increases the risk of chronic pain. There should be a legitimate justification (beyond practitioner fears of exacerbating SD) to restricting opioids and analgesics in this period. It should be acknowledged that this is not the time to fix SD.

	Respect for Autonomy	respect for autonomy was overridden.	
<b>Coercion</b>	Beneficence  Non-maleficence  Respect for Autonomy  Justice	<ul style="list-style-type: none"> <li>- Clinicians believed they were acting beneficently when in fact they were coercing patients.</li> <li>- By attempting to act beneficently, clinicians were in fact causing harm as they risked damaging the therapeutic relationship by enforcing what they believed to be right.</li> <li>- Coercion violates patient autonomy.</li> <li>- Coercing patients with SD and pain is unjust.</li> </ul>	Clinicians should not coerce patients even when motivated by the desire to act beneficently. Open, honest and transparent communication should be used to build a therapeutic relationship and when patients have decision-making capacity they should be able to make poor choices.
<b>Failure to Respect Autonomy</b>	Beneficence  Paternalism  Scope	<ul style="list-style-type: none"> <li>- In their attempts to act beneficently, clinicians often failed to adequately respect autonomy.</li> <li>- Failing to respect autonomy is often a consequence of paternalistic behaviours.</li> <li>- Patients with SD may be regarded as already lacking autonomy because of their addiction making them more vulnerable to power differentials.</li> </ul>	There needs to be sufficient justification - beyond the diagnosis of substance-use disorder - to constrain patient autonomy.
<b>Advocacy</b>	Scope    Beneficence	<ul style="list-style-type: none"> <li>- Nurses are often driven to act as the patient's advocate but this may in fact exacerbate their feelings of powerlessness because of their position in the hierarchy.</li> <li>- Acting as a patient advocate can at times</li> </ul>	Although nurses are taught to advocate for patients, it should also be recognised that all members of the healthcare team can act as advocates, as long as the patient's values and preferences remain

		provide justification for acting beneficently but this must be carefully weighed with respect for autonomy as the patient's voice must be central.	central to decision-making.
<b>Withholding</b>	Beneficence  Scope	<ul style="list-style-type: none"> <li>- Withholding analgesics was justified by appeal to the principle of beneficence, believing they were preventing harm because they were not feeding patient's addiction.</li> <li>- Some participants described feeling powerless because they were not in control of prescriptions and felt that withholding pain relief was not the right thing to do. This caused them to feel moral-constrain distress.</li> </ul>	There needs to be sufficient clinical justification - beyond the diagnosis of SD to withhold analgesics from patients.

## Discussion

The purpose of this secondary analysis was to examine the ethical issues that emerged when nurses described their experiences of trying to provide pain management for patients with SD. We have highlighted some of the ways in which these practices conflict with the four principles of biomedical ethics plus attention to scope. Our aim is to illuminate current pain management practices and to provide some normative recommendations for clinicians who are charged with managing pain in this patient population. Whilst we use these individual experiences to highlight the ethical issues, there are limitations to this study. The extent to which these data can be generalised could be questioned considering it is a small sample from one professional group, although participants were from different practice settings and had different levels of experience. Another limitation was the homogeneity of the participants, as all were white European females. The inclusion of participants from diverse backgrounds is a challenge and the research community continues to explore ways to incorporate different voices.

The four principles have been subject to criticism, for being imperialist, inapplicable, inconsistent and inadequate.<sup>17</sup> Huxtable suggested that the four principles can limit ethical considerations to an Anglo-American perspectives; are inapplicable in certain situations (for example young children lack autonomy); are inconsistent because adherence to different principles can pull the moral agent in different directions and inadequate because the principles do not provide clear solutions.<sup>17</sup> Whilst these criticisms of the four principles have some validity, this approach was used because it provides a clear framework through which to consider the ethical issues. By including Gillon's<sup>15</sup> attention to scope, we have considered how the principles conflict, thus highlighting the ways in which strict adherence to these principles when faced with ethical challenges concerning patients with SD pain management, may be inadequate.

Patients with SD can be complex as they may experience addiction and other psychosocial issues.<sup>24</sup> Patients may be used to living their lives in ways that are incompatible with the routines and rituals of the acute care setting and this conflicts with clinicians' expectations of 'usual' behaviour.<sup>1, 7</sup> It is important therefore that healthcare professionals work towards concordance models of care, rather than use power to manipulate and coerce patients, as has been found within our data.<sup>25</sup> Whilst participants reported believing they were acting with beneficence, in many cases they were potentially causing harm. For example, withholding opioids in the belief that these patients can be 'cured' of their dependence during trauma is deeply mistaken. The aim of acute pain management is not only to relieve the immediate pain and suffering experienced by the patient, but also to prevent the development of chronic or persistent pain. The concept that pain can persist after surgery is relatively new.<sup>20, 26, 27</sup> Persistent post-surgical pain (PPSP) can affect between 5% and 75% of patients, with amputation, thoracotomy and mastectomy having the highest incidence.<sup>21</sup> Risk factors for PPSP are relatively well known and include taking opioids prior to surgery, but patients can also be susceptible to developing PPSP in the post-operative period.<sup>21</sup> There is a strong correlation between uncontrolled pain at 24 and 48 hours after surgery and the development of PPSP,<sup>27</sup> therefore we need to ensure that all patients, especially those with SD experience minimal pain post-operatively. These patients may require larger doses of opioid to control pain due to tolerance, a fact often unknown or overlooked by ward clinicians.

It is important that all clinicians recognise they may possess biases which risk stigmatising patients with SD and may affect their treatment plans. It is important to consider the principles of justice and equality when constructing treatment plans to ensure equity between patients. Deciding the most ethically justifiable option is not easy and organisations must also recognise that clinicians are likely to experience different types of moral distress when caring for this group of patients and will require support regarding clinical-ethical decision-making. We recommend that firstly, clinicians ensure the specialist pain team are involved in these complex patients. Englander et al.<sup>4</sup> recently reported the development of a system-wide intervention in the United States named IMPACT (Improving Addiction Care Team) that was aimed at creating institutional policies and care pathways for these complex patients, including addiction specialists and links to outpatient resources. They reported that this system-wide intervention helped clinicians to recognise that addiction is a disease, not a moral choice. Secondly, we suggest that practitioners consult with clinical ethics services, such as clinical ethics committees or clinical ethics consultation services for advice regarding patient management.<sup>28</sup> Clinical ethics support services can also guide pain specialists, addiction specialists and psychiatry to ensure a holistic approach is being taken and the patient's values are guiding the plan of care.

We recommend that healthcare professionals critically reflect and are adaptable when caring for patients with SD who are in pain, by understanding their perspective and building collaborative care plans.<sup>2</sup> Interdisciplinary and team-based practice is vital, along with communicating and listening to one another to mitigate power differentials that are inherent within the hierarchical healthcare system. It is important for prescribers to recognise the potential power they have over patients and other professional in providing access to analgesics.

Further research and analysis are required to explore the ethical issues that arise when considering pain management for patients with SD. There is guidance in the literature regarding how patients with SD pain should be managed, but the guidance does not cover the ethical issues or implications.<sup>10, 29</sup>

It is recognised in the literature that inadequate pain management causes nurses to experience moral-constraint distress. We have also suggested nurses experience moral-uncertainty distress, because they feel uncertain about whether they should treat pain or mitigate addiction. They experience moral-constraint distress when they believe that treatment of pain should be prioritised but they have

inadequate prescriptions. We suggest that clinical ethics support should be available to help guide and support nurses navigating these difficult encounters. In addition, pre-registration and postgraduate education should explore pain management through an ethical framework highlighting sources of support when moral distress occurs. Ethical values and competencies are fundamental components of pre-registration and specialist post-graduate pain curricula by national and international pain organisations.<sup>30-33</sup> Practitioners need complex, real world examples in the classroom to explore the ethical dimensions of pain care and potential ways of navigating these in practice.

## **Conclusion**

Patients with SD are complex and at risk of inadequate pain relief, stigmatisation and unjust treatment. Our analysis suggests that nurses struggle to balance conflicting ethical principles when providing pain management. Whilst the four principles approach plus scope offers a framework to understand these ethical issues, they do not provide patient specific guidance that, we argue, clinicians need. To effectively support clinicians working with patients with SD, we propose the following: national guidelines that address the ethical issues, additional education for pre-and post-registration nurses and the availability of clinical ethics support services.

## **Conflict of Interest**

None of the authors have any conflicts of interest to declare.

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## **Author Contributions**

GM collected and analysed the empirical data. GMC and EB analysed the empirical data. All authors were involved in writing and preparing the paper and all approved the final manuscript.

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