ETHICAL PERSPECTIVES IN NEUROLOGY

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The practice of neurology presents a series of ethical challenges for the clinician. These rarely have simple or straightforward solutions, but require careful consideration by the neurologist. This section of CONTINUUM, written by colleagues with particular interest in the area of bioethics, provides a case vignette that raises one or more ethical questions related to the subject area of this issue. The discussion that follows should help the reader understand and resolve the ethical dilemma.

NOTE: This is a hypothetical case.

A 32-year-old postal worker is evaluated by a new neurologist for burning foot pain occurring in the context of suspected small-fiber neuropathy. No records from prior evaluations are immediately available. The patient is seeking documentation of her disability as well as renewal of her prescriptions for high doses of multiple opioids. The patient states that all prior attempts to treat her pain with nonopioid agents were unsuccessful and that her current opioid doses are inadequate.

COMMENT

Any dialogue involving patient care, with or without a substantive ethical dimension, involves consideration of at least three elements: (1) an understanding of the medical context, including the natural history of the disease, treatment options, and the likelihood and magnitude of their attendant risks and benefits; (2) to the extent possible, the wishes of the patient or the designated surrogate; and (3) from a moral perspective the least important element, the interests of other potential interested parties, including the legal system.

The first decision-making obstacle in this case arises from the ambiguity contained within the medical context, ie, the diagnosis of small-fiber neuropathy. Although widely accepted as a valid diagnosis and a common cause of painful, burning feet, objective evidence of small-fiber nerve pathology and identification of etiologic cause frequently provide daunting challenges to the practitioner (Lacomis, 2002).

Another dilemma in this case pertains to the determination of the propriety and proportionality of treatment. As always, treatment decisions are best made with knowledge of the diagnosis. The patient’s new neurologist has an obligation to provide this patient with due medical diligence by obtaining old records to determine the details of prior diagnostic evaluations and treatment attempts. If inadequate, further testing to confirm both the diagnosis of small-fiber neuropathy and identify an underlying etiology (if possible) should be initiated.
In the spirit of the fiduciary relationship that exists between patient and physician, the patient should be provided with the benefit of the doubt regarding his or her concerns and expectations. The neurologist should provide the patient with adequate attempts at pain relief. In the short term this may include renewal of current prescriptions with the caveat that future prescriptions may be modified following the availability of additional diagnostic information. Unfortunately, this benefit of the doubt cannot be provided on a blind-faith basis. Statistics tell us that the cost of prescription opioid abuse is estimated at $9.5 billion (Birnbaum et al, 2006) and that approximately one-sixth of the US population over age 12 have used prescription drugs for nonmedical reasons in their lifetimes (National Institute on Drug Abuse).

With the assumption that this patient’s diagnosis of small-fiber neuropathy is validated and considered idiopathic after careful evaluation for secondary causes, how should the neurologist proceed? Although opioids have proven effective in the management of neuropathic pain, concomitant use of nonopioid agents effective in neuropathic pain have been shown to have synergistic opioid-sparing properties (Passik, 2009). Review of prior treatment paradigms would hopefully uncover opportunities to use nonopioid agents in the hope of reducing opioid doses and both pain intensity and frequency to more acceptable levels.

In this case, the patient’s expectation is that her new physician is obligated to renew her narcotic prescriptions. Potential for disagreement exists as to who is in the best position to judge what is in the patient’s best medical interests and which party is empowered to make these decisions. Where do a physician’s obligations to a patient begin and end? This question can be discussed within the boundaries of at least three ethical domains: (1) autonomy, (2) professionalism, and (3) the balance between potential benefit and harm.

Autonomy exercises considerable influence on ethical considerations in our culture but remains frequently misunderstood. Although of paramount importance in medical decision making, neither patient nor physician autonomy is absolute. For the patient with decision-making capacity who has been duly informed, autonomy provides the right to refuse unwanted treatment. It does not, however, empower patients to demand and receive treatment that is not medically judicious (Bernat, 2008). Through the licensure process, our society provides physicians and other health care professionals, not patients, the authority to exercise medical judgment in the determination of rational medical recommendations.

Professionalism in medicine establishes a fiduciary relationship between physician and patient in which the burden lies largely on the shoulders of the physician. The patient, however, bears some of that relationship and, in particular, has an obligation to be truthful. Health care providers should be aware of the risk factors that increase the probability that prescribed opioids will be diverted or misused, such as concurrent abuse of alcohol or illicit drugs, deterioration in the ability to function vocationally and socially, and seeking or obtaining prescription medications from alternative sources, particularly when done surreptitiously (Passik, 2009).

An additional ethical consideration is the relative balance between the good and harm associated with the continued and perhaps escalating use of opioid use, both from the perspective of the patient and prescribing physician. Pain relief is a noble goal but is not mutually exclusive from the harms potentially associated with opioid use. A physician needs to be vigilant regarding the behaviors that may suggest adverse physical and psychosocial opioid effects and introduce suggested programs that may prevent or mitigate these risks (Passik, 2009).
A fear that may underlie a physician’s reluctance to freely dispense controlled substances is the specter of potential harm to self, family, and patient population if loss of professional license were to occur from inappropriate opioid prescription practices. Experience would suggest that this risk is negligible and should not play a significant role in decision making (Goldenbaum et al, 2008).

CONCLUSIONS

The management of patients receiving opioids for chronic neuropathic pain syndromes frequently produces physician angst, in part because of the associated ethical concerns. What then, would be the best course of action in this case? The clinician would be obligated to address the patient’s pain until old records are reviewed to confirm the small-fiber neuropathy diagnosis, the extent to which secondary causes of small-fiber neuropathy had been considered and investigated, and prior treatment history. If necessary, repeat evaluation should be offered.

Ideally, there would be means by which to gauge that a given analgesic was effective and the dosage proportionate to the desired effect. As with all pain cases, this ideal cannot be achieved and the clinician is left to extrapolate from subjective pain scales, patient mannerisms, autonomic signs, and previous clinical experience to determine appropriate drugs and dosing schedules.

The physician should engage in a dialogue that provides an explanation as to why the addition of opioid-sparing drugs would provide potential benefit to the patient. The physician and patient should establish a mutually agreed-upon plan/contract that includes realistic goals. Although the benefit of the doubt should always extend to the patient, it should occur in concert with physician vigilance regarding potential patient harm related to inappropriate opioid use. The willingness of the physician and patient to work together to achieve a goal of pain reduction without adverse drug effect is undoubtedly a prerequisite to the success of the relationship.

REFERENCES


