ETHICS IN ACTION

HOW TO APPROACH PAIN MANAGEMENT IN THE EMERGENCY DEPARTMENT

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You are working a busy shift in the ED. You begin to evaluate a 49-year-old male patient for low back pain. He describes an acute exacerbation of his chronic pain that he believes was triggered by lifting some boxes at home. He has had a prior lumbar laminectomy and fusion. His exam shows no focal neurological deficits, no midline bony tenderness, and no fever. Per your department's policy, you initiate a search in the state pharmacy database for his past opioid prescriptions and find 14 prescriptions from 9 providers in the past 12 months. A nurse and one of your colleagues comment that this provides proof he is "drug-seeking." The patient, when confronted, tells you he has no insurance and cannot find a regular physician or pain management specialist to help manage his pain. He is asking for a prescription for an opioid analgesic as these are the only medications that help his pain.

Not since the shift in the late 1990s to enhanced provider awareness of patients' pain levels and oligoanalgesia has pain management gained such attention in the emergency medicine community. A steep rise in the death rate from prescription opioid overdose, coupled with a rise in opioid abuse-related ED visits, has led to renewed scrutiny of prescribing practices and a shift of the pendulum back towards restraint in prescription of opioids. The concerns over the opioid abuse issue have led many states to develop prescription-monitoring programs to track opioid prescription patterns among patients and allow physicians an opportunity to intervene with a patient who may have an opioid addiction. Development of restrictive opioid prescribing policies in many emergency departments has followed the availability of the monitoring programs. This has resulted in an overall effort to identify patients with potential abuse/addiction problems and deter them from obtaining prescriptions from the emergency department.

However, this raises broader ethical questions about pain management in the emergency department. Most providers agree that dealing with opioid-addicted patients who are using all methods at their disposal to obtain an opioid prescription from the physician is a stressful and unpleasant part of the job. Most also agree that the increased availability of prescription opioids has contributed to the rise in opioid-related morbidity and mortality. Patients with chronic pain are particularly challenging in that it becomes more difficult to determine if there is a malingering aspect to their behavior, if they are having legitimate pain, or if there are elements of both in the patient's presentation. This has resulted in a deep schism as to how best to approach the problem.

The basic ethical framework of principlism (beneficence; non-maleficence; autonomy; and justice) can provide a framework for how to approach the issue of pain management in the emergency department. Beneficence requires us to make decisions in the patient's best interest; to alleviate suffering; and to consider the general well-being of the patient. Pain management is considered one of the most beneficent acts we can do as a physician; however, providing prescription opioids to those who are addicted to them may not be in their best interest. This is where beneficence overlaps with nonmaleficence. Nonmaleficence means that we should not cause harm to our patients. Nonmaleficence requires us to walk a fine line between avoiding harm by leaving someone's legitimate pain untreated and contributing to further problems by providing opioids to addicts, which can destroy both their physical and their emotional well-being. Another aspect of the pain management conundrum in which both beneficence and nonmaleficence figure prominently is the use of prescription databases. While the use of these databases is becoming more and more common, the way in which the information obtained is utilized can be ethically perilous. If the goal of obtaining the information is either to identify patients who may be addicted to opioids and refer them for treatment, or to identify patients with poorly managed chronic pain who would benefit from referral to a pain management specialist, then the use of these programs is ethical. If the purpose becomes one of "getting" a drug seeker, then the information is not being used in a nonmaleficent way. Autonomy in this case applies to basic respect

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for patients' independence as people, which in the realm of pain management may include taking them at face value when they are expressing their preferences for pain control. Again, providers frequently respond aversely to a patient expressing a desire or preference for a particular analgesic, especially if it is an opioid. Particularly for patients with chronic pain, they may have had a great deal of experience trying different medications for their pain and may know what works best for them. While this is not by any means a mandate to acquiesce to a patient's wish if the physician feels it is inappropriate, it should serve as a reminder to consider the patient's input into their treatment plan. Finally, justice talks about equal distribution of resources and fair processes. Several studies have detailed racial and ethnic differences in the rate of analgesia administration. We need to ensure that our provision of analgesia is truly fair and even to all people, and that, if we are deciding to withhold a treatment, it is after careful consideration of all factors, and the decision is being made, again, in the patient's best interest.

In summary, pain management has become one of the most scrutinized, and divisive, issues in emergency medicine. We have at present more ability than at any time in the past to test the veracity of what our patients are telling us about their use of controlled substances, and with that ability come potential ethical problems as this information colors and informs the doctor-patient relationship and impacts our prescribing practices. Application of the four general bioethical principles to the patient in front of you as you consider pain management options can help you make ethically sound decisions. ◗

2013 SAEM SOUTHEASTERN REGIONAL MEETING

The 2013 SAEM Southeastern Regional Meeting took place on March 23 and 24 at the One Ocean Resort in Jacksonville Beach, FL. The meeting hosted 80 participants and eight academic EM programs. Participation in regional research and education was outstanding, with seven oral presentations and 32 poster presentations by the end of the conference.

Winners of the presentation awards included:

- **Best Oral Presentation:** Henry Wang, "Long-term mortality after sepsis."
- **Best Research Poster:** Chante Jones; Benjamin I. Lee, MPH; Erin Simmers, MD; Lisa Moreno-Walton, MD, "The need for early antigen testing of acute HIV in the emergency department," Section of Emergency Medicine, Department of Medicine, LSUHSC, New Orleans, LA
- **Best Educational Poster:** Christine Swenton, MD; Tom Morrissey, MD, PhD; David Caro, MD; Colleen Kalynych, MD; Faheem Guirgis, MD, "Mentoring 101 for medical students applying to emergency medicine residency programs," University of Florida College of Medicine, Department of Emergency Medicine, Jacksonville, FL

This year's event was held at a venue designed to take full advantage of the beach and its attractions. The committee recognizes the academic emergency medicine programs in the Southeast region, including the University of Florida COM-Jacksonville; the Florida Hospital EM program; Emory University; and the Louisiana State University – New Orleans for financial and academic support for the conference.

Unique aspects of this year's program included:

1. more oral presentations on the first day;
2. focus on a medical student simulation event;
3. a new resident ultrasound simulation event, which was won by the University of South Florida's ultrasound sim team;
4. an educational track that focused on EM mentoring;
5. and a research track focused on how to obtain grant funding.

The regional planning committee will meet at the SAEM Annual Meeting to begin preparations for next year's regional meeting. Anyone who is unable to attend and would like to participate in next year's planning, please contact Dave Caro at david.caro@jax.ufl.edu or Holly Gouin at hgouin@saem.org.

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