

Bioethical dilemmas in clinical practice and chronic pain management

Dilemas bioéticos en la práctica clínica y el manejo del dolor crónico

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Abstract

Clinical bioethics has evolved in the affirmation of the fundamental general principles that protect people's health. The management and relief of pain is a universally recognized human right, susceptible to ethical and bioethical scrutiny, since it involves making decisions that compromise people's quality of life. The ethical dilemma of pain management often involves conflicts of values in crucial decisions, especially when there is no single alternative, treatment and intervention strategies that are sufficiently shared and accepted. The ethical and bioethical problem in pain management, especially in patients with chronic conditions and/or stress, at the end of life continues to represent a challenge for clinical practice, with diverse consequences in

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adult patients and repercussions in health systems and the family and social environment of these patients.

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1. Introduction

Pain could be considered a global health problem that particularly affects the demographically growing adult population (1), with chronic and disabling conditions, with consequences on the quality of life of these people. However, due to the characteristics of these patients, generally affected by comorbidities or chronic degenerative diseases, the medical practice of pain faces the ethical and bioethical dilemmas of their attention and care, in terms of intervention and adequate treatment, which have not yet been sufficiently resolved. The deficit, in this sense, is still notorious, despite the development experienced by clinical bioethics during the last decades (2).

In general clinical terms, pain could be defined as a symptom or manifestation of systemic or peripheral inflammation, assessable in the diagnosis of innumerable disorders or complications that, depending on their causes and manifestation, can be mild or severe, chronic or acute, localized or diffuse. Acute pain is intense and may or may not be linked to an intervention, a trauma or the evolution of a pathological process; on the other hand, chronic pain, generally less intense than acute pain, presents the symptomatology of being prolonged and caused by some disease, generally chronic or acute chronic, associated with the patient's age. In this sense, although, as has been documented, patients over 50 years of age usually require less analgesics than younger patients, chronic pain, linked to chronic conditions with degenerative effects, with long periods of suffering and even depression and isolation, occurs mainly in the adult and elderly population, in the presence of chronic comorbidities (3). In addition to pain as a physical manifestation, characterized by the

sensation of discomfort in the body or part of it, there is also, generally coincidentally, suffering and feelings of sorrow, frustration, sadness and desolation in the patient.

Pain and suffering are inherent to the human condition (4), and even, at certain thresholds, duration and form of manifestation, inevitable and necessary as part of the body's defensive strategies and life preservation mechanisms (5). Pain is a condition inherent to the disease in its "natural process", not exclusive to the patient in critical or terminal phase. However, with the increase in chronic degenerative diseases, in particular chronic pain—which leads to greater functional deterioration and increased patient suffering—it has become endemic and, in this sense, is considered a public health problem that, as such, demands greater attention and changes in the patterns of patient—physician relationships. In particular, clinical and hospital care under stress, at critical thresholds of uncontrolled pain and risk of death, complicates medical intervention by activating a set of values and beliefs of the patient and his/her family and those of the physician himself/herself beyond the usual conditions, in circumstances in which technical and human resources are not always available to provide adequate patient care.

Ethics and bioethics, properly speaking, are inseparable components of medical practice (6). The starting precept of bioethics emphasizes the right to the preservation and care of health as a human right, in this sense, as a universal right that aims to ensure the quality of physical, emotional and psychological life of people. The health professional has the ethical obligation to benefit the patient, to avoid or minimize harm, but at the same time, to respect his values, beliefs and decisions and to provide equitable attention to his personal and social condition, according to his requirements. Nevertheless, these rights to the protection and care of patients, both in clinical practice and in experimental and non-experimental clinical research, could be violated in certain circumstances, to the detriment of patients' dignity, health and quality of life.

From a legal perspective, based on bioethical principles, adequate and timely pain relief is a right of the patient and a duty of both the

physician and the health institution providing care. However, until a few decades ago, medical research documented “under treatment of all types of pain by physicians”. This paradoxically in a context in which the field of bioethics had already evolved significantly, but in which “the phenomenon of pain received almost no attention in the bioethical literature”, and bioethicists themselves did not recognize it as such, let alone consider “under treatment of pain as an ethical, and not merely clinical, failure of the medical profession” (2). The ethical and bioethical problem in the management of pain, especially in adult patients with chronic conditions and/or stress at the end of life, continues to represent a challenge for clinical practice with diverse consequences for patients, as well as repercussions for health systems and their family and social environment.

The main objective of this paper is to provide a theoretical framework for clinical practice and appropriate pain management from a legal and human rights perspective, based on bioethical principles. In particular, chronic pain has acquired the character of a public health problem. Recent studies report that about 30 percent of adults in Western countries, developed and undeveloped, suffer from chronic pain associated with some underlying condition and that about 80 percent of chronic pain patients “are dissatisfied with their pain management” (7). Hence, the high prevalence of chronic degenerative diseases, associated with the rapid process of demographic aging and changes in the epidemiological profile, poses new challenges in clinical practice in the management of chronic pain, particularly in adult and elderly patients.

It is within this framework that, in particular chronic pain and the suffering associated with it, what Cerdio considers “an emerging bioethical challenge” (8) arises, which makes it necessary to emphasize the care and relief of pain as a human right based on bioethical criteria and principles, detached from prejudices and discriminatory valuations of the patient, attributable to his or her condition or ethnic belonging, origin, group or class and social vulnerability.

2. The principles of medical bioethics

Bioethics, as a discipline or science of human behavior that links biology and health care with universal ethical principles and moral values. It has as its antecedent Rensselaer Potter's book *Bioethics: Bridge to the Future*, published in the early 1970s, in which the author focuses his attention on the march of scientific and technical progress and its undesirable environmental and ecological consequences, which, according to him, due to their unbridled excesses, threaten human life itself. Although Potter emphasized the ecological dimension, based on his concern for the industrial processes that took place after World War II, he laid the foundations for later reflections that placed health care as a human right based on bioethical principles at the center.

Bioethics was thus born in the context of the social contradictions that arose during the second half of the 20th century, but also in the context of the rights that gave rise to the Nuremberg Code in 1947, the Universal Declaration of Human Rights in 1948, and other international instruments derived from these. The Nuremberg Code was, in fact, the first response to the atrocities committed by the Nazi regime on human beings in the name of medical research. In a way, the code is a referential and symbolic document.

The frequent problems of human experimentation, many of them carried out under the auspices of the military or other state institutions, and many with a high racist component, attracted the attention of the scientific communities in the United States. The manifest "normality" of this type of research promoted and sponsored by the government and universities of this country, began to be strongly questioned. The revelations regarding the violation of human and bioethical rights in the Tuskegee, Alabama, syphilis studies in the early 1970s, among others, were crucial in this regard. *The Belmont Report*, now known as the "Belmont Report," established shortly thereafter, instituted the first framework for the bioethics of clinical practice and experimental human research.

The 1950s called into question the principles of medical morality associated with the intervention, manipulation and control of certain human processes, which made it necessary to review the ethical criteria of medical practice. As a result, the 1970s gave rise to two levels of reflection and theoretical developments in clinical bioethics, in view of the establishment of experimentation on human beings and the transformation of medical activity, linked to the rapid development of new diagnostic and therapeutic techniques, and the consequent ethical dilemma in making decisions that compromise the health and life of patients. The starting precept emphasized the right to health as a human right and, within this, pain relief as a universal human right, which affects and compromises the physical, emotional and psychological quality of life of patients (9).

In general, clinical practice is or should be developed on the basis of certain ethical principles and foundations. Based on the “principle of autonomy”, the patient should be involved in the decision making process regarding the indicated treatment. The “principle of beneficence” guides in the search for the protection and achievement of the good of the patient. The “principle of non-maleficence” obliges not to cause harm, either deliberately or as a result of the action, omission or negligence in the care strategy adopted; and based on the “principle of justice”, to guarantee the equitable accessibility of resources, adequate analgesic treatment and ensure the quality of the comprehensive care demanded by the patient (1). Notwithstanding these requirements, the limits of the duty, particularly in pain management, are not always well defined or are not always well known and shared by health personnel, especially in the relief of patient suffering in critical conditions or states such as, for example, uncontrolled pain, in cases of advanced cancer, burns or the patient in intensive care units (2,10,11,12).

The Belmont Report established specific parameters for the constitution of clinical and experimental bioethics in the field of human research. It formulated, for the first time, a standard frame of reference and the principles of clinical bioethics, focused on the protection of patients and the establishment of general and specific guidelines for

medical practice. Adequate pain management and relief should be considered and assumed in medical practice as a human right, as such, morally and ethically supported by principled clinical bioethics (13). These principles, central to theoretical bioethics and applied to medical practice (14), are the following:

- *Principle of non-maleficence*: this principle, fundamental to clinical practice and clinical research, postulates as a maxim not to cause harm to the patient, deliberate or as a result of the action, omission or negligence in the care strategy and/or intervention adopted in clinical practice, or as a consequence of the intervention, as a result of the medical research process. Patient care and protection must be ensured at all stages or processes of care. In no case may the effects, harm or risks to the patient be greater than the benefits derived from the research or, in the clinical setting, the treatment and care must be in accordance with the patient's requirements, avoiding, as far as possible, greater collateral risks.
- *Principle of beneficence*: it is oriented towards the protection and achievement of the good of the patient; it is a principle that must also be assumed as a benefit for society. Hence, it is the responsibility of the physician or, where appropriate, of the researcher, to inform the patient of both the potential benefits and foreseeable risks of the chosen treatment and/or intervention. In this framework, confidentiality is a right that must be preserved, but, in each case, the physical and emotional safety of the patient is paramount. As can be seen, these principles of medical bioethics complement each other: the maxim of not harming the patient entails his safety and sense of beneficence, which requires information and informed knowledge on the part of the patient in the exercise of his autonomy and decisions, which, in turn, should result in an equitable distribution of benefits, taking into account the differences in the social and economic conditions and particularities of the patients. This principle obliges the physician to

always act in the patient's best interest, and to prevent him/her from any harm, which could eventually interfere with the patient's values and beliefs and generate tensions in making appropriate or clinically relevant decisions.

- *Principle of autonomy*: this principle grants the patient independence in making decisions about the indicated treatment, or his exposure and risks of his participation in a given study. The patient must decide and choose for himself/herself his/her participation, without coercion, duress or pressure from the physician, the researcher or the entity interested in the research or in the testing of a given treatment. This principle is linked to the right to have all the information necessary to give consent to accept the treatment or, as the case may be, to participate in the corresponding research, in order to know the foreseeable or contingent risks of the study. Informed consent occupies a central place as part of the normativity of research involving human subjects. From the clinical point of view, and based on this principle, the patient in full possession of his or her mental faculties can renounce the treatment of choice of the medical practitioner and opt for an alternative in accordance with his or her values and interests. What is remarkable, in this sense, is that the physician's "ethical judgment" is also based on personal experiences and opinions, on his beliefs and values, and not necessarily on scientifically founded bases, and many times, lacking the criteria of bioethics.
- *Principle of justice*: this principle is aimed at guaranteeing the equitable accessibility of resources, treatments, services, attention and patient care, and also warns about individuals or patients who, in certain circumstances, may be entitled to different types of care, attention or treatment, according to their particular requirements. Both in clinical practice and in research, care, treatment or adequate analgesia are central, in addition to ensuring the quality of the comprehensive care demanded by the patient. However, the sense of equity that

recognizes differences should prevail, over which “casuistry” could be important, although not necessarily sufficient, in the decision-making process regarding the treatment and care prescribed to the patient.

Despite advances in knowledge and the emergence of new biomedical technologies, several factors hinder the adequate management and relief of pain, especially chronic pain, in an early and satisfactory manner (13,4). Adequate pain management is not limited to the access and availability of drugs, it is necessary that those who perform it are properly trained for its evaluation and treatment, but also have the knowledge about the due care and the ethical role in front of the pain and suffering of the patient (15,16,13).

3. Pain management as a human right

Human rights are a set of principles, norms and general precepts, socially and legally recognized about the individual as a person, aimed at guaranteeing his or her realization and development in a dignified, integral and harmonious manner in relation to others, under principles of equality, freedom and reciprocal respect. Human rights are legally established in the Universal Declaration of Human Rights of the United Nations, proclaimed in 1948, in the immediate aftermath of World War II, which consists of 30 articles. All the countries of the world are signatories to it, subscribing to it through their direct or indirect adhesion, through their political constitutions and particular laws, as well as through the subscription of international treaties and conventions, whose application is obligatory for any authority in the particular field of its competence.

Human rights refer to universal principles of recognition of rights and obligations under the maxim that “all persons are equal” in that they are human beings and, as such, have common rights applicable to all persons without distinction of sex (or sexual orien-

tation), age, race, nationality, socioeconomic level, culture and beliefs, religion or ideological and political orientation or any other characteristic or quality of persons. Hence, these rights are indivisible—inherent to the person, insofar as they derive from his or her dignity and human condition—, are socially interdependent—i.e., their exercise is in relation to the other or others and presupposes reciprocal respect and compliance—, in addition to being inalienable and indivisible—in the sense that they cannot be waived, transferred, alienated, violated, violated or ignored—; Likewise, they must be recognized, respected, safeguarded, protected and promoted by the State and institutions and enshrined in laws in all countries and circumstances of human coexistence.

These rights, which also entail obligations, are classified according to the nature, origin, content or matter to which they refer. Hence, in the first instance, the first human right is the right to life and integrity of the person. This implies the right not to be excluded or discriminated against in the person, social group, nationality or other individual or collective condition. The right to be free, without restrictions other than those established or imposed by law in particular circumstances. To exercise personal rights such as decisions about the body, which do not compromise life, as well as sexual orientation. The right to security, free from violence of any kind or gender; the right to exercise civil, political and religious freedoms, such as the right to organize, to belong to political parties or other civil or political or religious associations; economic, social and cultural rights, such as the right to have a job, to education, to form a family, to public opinion and information, and, among many others, the right to discern and not be coerced, forced or punished for one's beliefs and values.

The right to decent living conditions and access to social security and health services that guarantee conditions of well-being is a human right that is usually widely and systematically violated in countries with weak institutions, particularly in the underdeveloped world. In particular, the right to health, enshrined in the constitutions of democratic countries, refers to the right of individuals to health care

and proper health care as an obligation of the State and of the institutions designed to guarantee these fundamental obligations. However, the very compliance with the precepts established in this regard, in one sense or another, could in many situations or circumstances face the ethical and bioethical dilemma of the health professional to decide in the face of the dilemma that implies, on the one hand, the unavoidable responsibility to guarantee the patient timely, adequate and sufficient care according to the diagnosis and the corresponding protocol and, on the other hand, the patient's right to "legitimate" self-determination to decide freely whether or not to accept the therapeutic intervention or treatment indicated.

The management, treatment and relief of pain is a human right, increasingly recognized as such (9). At the beginning of this century, Brennan and Cousins also considered "pain relief as a human right" (17), susceptible to ethical and bioethical scrutiny, since it involves making decisions that compromise the quality of life of individuals. Hence, "the practice of medicine and, more broadly, health care is theoretically an ethical enterprise. In this sense, the relief of all forms of pain and suffering is an ethical duty of health professionals and society and has been recognized worldwide as an ethical requirement and a human right" (17).

However, in spite of this, medical practice oriented to patient care is recurrently exposed to the ethical dilemma resulting from the decision taken and its consequences and risks on the patient's health and quality of life; therefore, as such, it must be relativized, contextualized and evaluated in relation to its ethical implications and consequences. The consideration of pain management from a human rights perspective obliges the health professional and health care institutions to guarantee due care in pain management according to legal criteria and bioethical principles.

4. Chronic pain and the bioethics of pain

Pain is one of the most common reasons why patients seek medical care (18). Pain management poses numerous ethical challenges

(4,11,12,18,19,20). Pain, in any of its manifestations, but especially in critical or uncontrolled pain situations, poses ethical dilemmas of unavoidable recurrence in health professionals. The subject of pain raises a set of (non-trivial) questions regarding the importance of pain in medicine and in personal life, the role of pain management in the comprehensive clinical care of patients, and the limits of the health professional's responsibility in pain relief, not only in the final phase of life, but in any of its stages and circumstances. The assessment and justification of the intervention varies according to the model or paradigm of attention and care adopted, and its limitations, as well as the ethical approaches and principles from which one or another form of analgesic intervention and treatment is acted upon and justified.

The clinical conception of pain management or its negligence is a matter of competence of bioethics, considering the doctor-patient relationship. The ethical issue does not only refer to the decision and action of the medical staff, but also involves the patient and, eventually, his or her relatives. The adult and competent patient can participate in the decision taken, adhering to the principle of autonomy, accepting or even refusing the chosen treatment (1). In the same sense, on the physician's side, theoretically there is also the possibility that he/she may refuse to provide a certain treatment to which he/she has moral and/or religious objections. This raises questions such as the following, which are the subject of consideration in bioethics: would it be ethical for health professionals to express their objections to patients? Should health professionals have the right or not to refuse to discuss, provide or refer patients for medical interventions to which they have moral objections?

Certainly, the decision and duties of medical practice may conflict with their values and beliefs, to which they may appeal in crucial issues such as the management of chronic pain and patient suffering and the administration of analgesics that are not illegal, but also not conventional or not clearly established. In this regard, tensions and debates have mainly revolved around the beliefs, on the one hand, that health professionals should not apply treatments to which they

have conscientious objections and, on the other hand, that patients should have access to legal treatments even in situations where their physicians raise moral objections. Pain management and treatment “is an ethical obligation” (19). Bioethicists such as Savulescu, cited by Curlin et al. took early and radical positions on this issue, arguing that, in this regard, “a physician’s conscience has little place in modern medical practice” and that, “if people are not prepared to provide legally permissible, efficient, and beneficial care to a patient because of conflicts with their values, they should not be physicians” (21).

The affirmation of the right of patients to pain relief is not a simple medical recommendation. It must be assumed as a moral conviction and a legally instituted provision, which has its basis in the premise that assumes the defense of health as a universal human right. It is contemplated in the Universal Declaration of Human Rights, and in a number of national and international instruments such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the American Convention on Human Rights, known as the American Convention on Human Rights, known as the American Convention on Human Rights; the American Convention on Human Rights, known as the “Pact of San José”; the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the “Protocol of San Salvador”; the Universal Declaration on Bioethics and Human Rights; the Single Convention on Controlled Substances, etc., in which the right to the enjoyment of the “highest attainable standard of physical and mental health” is upheld. The right to pain relief is implicit and/or explicit in the defense of the right to health, which the World Health Organization defined in 1949 as “a state of complete physical, mental and social well-being”.

Pain, assumed as a personal experience and a state of consciousness, generally linked to chronic conditions or situations, leads to prolonged suffering, not only physically disabling, but also destructive of the emotional state and self-esteem of people, as it generates

constant psychological tension, frustration and bitterness in these patients. Certain conditions, such as those associated with rheumatoid arthritis, damage to nerve endings caused by diabetic neuropathy, but, above all, cancer pain in general, have the particularity of triggering these prolonged and annihilating effects on patients. Chronic pain, especially in very prolonged periods, not only tends to generate physical disability, but also emotional alterations in the patient and in his immediate family environment (22, 23). This theoretical point of view refers to authors such as Cassell, for whom suffering occupies a central place in medical practice and in theoretical and practical research on pain (6) and who, from the bioethical point of view, by assuming its approach from an integral focus, taking up Gómez and Grau, quoted by De Vera and Guerra, considered insufficient pain relief as “the most scandalous and persistent of medical negligence” (12).

In particular, chronic pain not only represents a type of physical disability, it is also characterized by the emotional disturbances prevalent in patients with long-term conditions, susceptible to special considerations in medical practice and bioethics focused on pain management. Pain is not a simple problem, but a complex process of causes and mitigating influences that is expressed differently in each person who suffers from it (24). In this regard, recent research provides evidence regarding the inequalities and mechanisms of social exclusion faced by patients with chronic pain, associated with class factors and race or ethnicity to which they belong (7,25).

Reports from chronic pain patients about their conditions and experiences reveal that forms of misunderstanding, rejection and stigmatization largely shape their suffering. Patients face these experiences of ostracism and isolation in various social constellations. [...] These aspects contribute to the problem of social exclusion of patients that is an essential part of the suffering of chronic pain patients (25).

Certainly, in recent decades there have been important advances in this regard, especially from approaches that assume palliative care as a universal human right, in which, among other aspects of clinical

policies and strategies for pain relief, socioeconomic and sociocultural conditions, such as class, ethnic and racial belonging of patients, are contemplated. This is because, among many other forms of social exclusion, in different parts of the world there are still “discriminatory practices against certain groups of people with respect to pain management, including the withholding of necessary analgesics altogether” (26). Disparities in pain care, as in other forms of health care, result from stigma and racial and other biases, such as gender, economic disparities and other factors that impose barriers to equal patient care.

In this regard:

western medical practices have a long history of maintaining discriminatory and false beliefs about pain tolerance in different races. [As a result], black patients were often operated on without anesthesia even though anesthesia was commonly used in white patients (26).

In the United States although not exclusively in that country, pain relief management continues to face obstacles stemming from stigmatization and social exclusion based on class, racism, and social discrimination.

Evidence has shown that minorities, people with lower incomes, and non-native speakers with chronic pain are less likely than others to receive pain medication. Research has also shown that primary care physicians are likely to underestimate the pain intensity of African Americans, and pharmacies located in minority areas are less likely to have adequate stocks of analgesic medications (18).

A collateral problem resulting from their approach is that of the epidemic in the use of opioids or medications used to reduce pain, which include the use of analgesics available legally through prescription or over-the-counter, as well as the use of illegal drugs of various types. The harms of indiscriminate opioid use have been widely documented in high-income and low-income countries with varying consequences on such patients (27). Hence, the need to recognize

systemic barriers in the delivery of pain care and urge action to remove such barriers.

[...] there is a need to expand knowledge and skills to address pain and dismantle pain-related stigma [...]. When indicated, physicians should prescribe opioids safely and in the best interest of patients. Legislators should work with the medical community to eliminate arbitrary prescribing limits that have caused uncertainty and fear for patients and physicians. Until barriers to effective pain care are removed, the transformation necessary to provide effective, evidence-based pain care will not occur (18).

Hence, the importance of emphasizing a paradigm shift that repositions or affirms clinical practice and appropriate pain management from a legal and human rights perspective based on bioethical principles.

At no other time in the history of the pain fields, have neuroethics and bioethics been so important in helping people in pain. The confluence of scientific and technological developments coupled with a global epidemic of chronic pain creates ethical challenges for sufferers, their families, clinicians, scientists, and policy makers (28).

The prevailing curative model of care also suffers from being paternalistic and deliberative, placing the patient and the physician in separate and distinct spheres, competing with that of person-centered care, integration and the active and collaborative patient. In contrast to this traditional model of clinical practice, the ethics and bioethics of the integrated model, based on care in general and palliative care in critical circumstances that compromise the quality of life or the life of the patient, becomes important. This new practice in pain management poses changes of different orders in the barriers, even cultural, necessary to prevent, evaluate and better treat pain of all kinds, but particularly chronic pain, due to its deleterious effects in the adult population with chronic degenerative conditions. In the face of this, what seems appropriate is to appeal to an intermediate model that involves an open and conscious dialogue regarding the multiple possible options and treatments.

5. Final considerations

The medical practice of health care “is an ethical enterprise” and, as such, is susceptible to the evaluation of the decisions that are made, since they compromise in some way the quality of life and/or the life of the patient. On many occasions the doctor-patient relationship could assume a “paternalistic” character on the part of health professionals, based on the assumption that they know best what is in the best interest of their patients and that they can, consequently, make decisions without the obligation to inform them of the facts, alternatives or risks. However, this view could be severely criticized for violating patients’ right to legitimate self-determination, as it refers to a human right. An option opposed to such clinical paternalism would be the absolute defense of patient autonomy, which would reduce the health professional to a mere provider of services, on which the patient would decide freely, with all the implications that this would have on his or her health and living conditions. Both reductionist positions have been harshly criticized, as they nullify the moral agency and responsibility of the physician.

Pain science and clinical practice have undergone important advances with the development and incorporation of technologies, as well as the establishment of medical protocols and the availability of greater treatment options for pain relief (29). Nevertheless, there is evidence that stigma continues and that “pain is still not well managed” (30), since, on the other hand, faced with the interpretations and practical application of bioethics and the dilemmas involved in the management of pain in complex circumstances, the “ethical judgment” of the physician based on his or her professional experience prevails. On the other hand, there is a prevailing lack of interest in evaluating and considering the social and cultural aspects that underlie and have repercussions on the adequate management of pain, particularly in states of crisis and complications of the patient in the terminal phase (25).

The ethical dimension in the change of paradigm in pain management has entailed a comprehensive reconceptualization of patient

care and attention in the circumstances, state or phase in which the patient finds himself/herself. Decisions may vary in relation to many factors, not only personal, but also of the sociocultural context, as well as of the institutional environment from which the intervention takes place. The ethical dilemma in such circumstances is highly complex, as it involves various factors beyond the regulations, the patient's will and the ethical considerations of the health professionals, and even the clinical protocols of care and pain management in the different circumstances and clinical complications of the patient.

Clinical intervention focused on people with pain conditions requires the training and updating of health professionals, as well as the adaptation of decision support systems for the sustained management of pain, with multidisciplinary approaches that contribute to its gradual reduction and to minimize the use of opioids. The problem in this, or other senses, merits a change of approach, with a double perspective: on the one hand, that contemplates a greater approach of the medical practice with the approaches, principles and criteria with foundations in bioethics and, on the other hand, that takes into account such bioethical implications in the treatment of chronic pain (17). This implies an interdisciplinary dialogue that rethinks traditional medical ethics, updates the spheres of action and influence and guarantees the establishment of suitable and acceptable guidelines and conditions for the improvement of patients' quality of life.

Clinical practice in the management of pain, particularly chronic pain, thus poses great bioethical challenges. Limitations in pain management, may be due not only to the lack of effective treatments, but also to insufficient medical training and knowledge, particularly in palliative care strategies in patients suffering untreated pain at the end of life, to which may be added the fear of violating established ethical and legal principles (23), given the risks of hastening the death of critically ill patients or generating collateral consequences not necessarily foreseen. Inaction may prevail in the face of the risk of complications. However, untreated or inadequately treated pain can have devastating consequences and effects for the patient and family.

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