# To Continue or to Withhold Opioid Analgesics? An Ethical Dilemma Involving a 63-year-old Cancer Patient Who 'Broke the Pain Contract'

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## THE CASE

We present a 63-year-old woman with a history of poly-substance abuse, end-stage pancreatic adenocarcinoma and ten recent admissions for pain control. She re-presented with severe epigastric pain and anorexia. Prior to presentation, the patient's pain was controlled with opiates prescribed by a palliative care physician. This physician was no longer prescribing opiates because of a breach in the patient's pain contract: the patient was believed to be selling her opiates to support her methamphetamine addiction. At the time of previous discharges, she would be given a short course of opiates to last until the follow-up appointment. Despite this, the patient would return days after discharge complaining of severe pain and asking for or even demanding more pain medication. Upon each re-admission, even though the patient's toxicology screen was positive for methamphetamines, opiates were restarted. Per the chart, the patient had admitted that she was selling her pills to obtain illicit drugs. Consequently, during the patient's final admission, the patient's treatment team encountered an ethical dilemma.

## THE DILEMMA

Should the team again prescribe this patient opiate pain medication on discharge to treat her pain until outpatient care could be established *or* should treatment be withheld due to the knowledge of the patient's continued illicit drug use and selling of her prescription medications?

## STUDENT ANALYSIS (BL, NL, RO, YS)

The ethical dimensions of this case are complex, especially when one considers the fact that Rhode Island (RI) ranks first in the country in opioid-related deaths. Deaths from overdose have occurred from illicit drugs, prescription medication, and combinations of both. In 2016, there were 1,567 overdose case reports in RI[1], 336 of which resulted in death. This represents a 16 percent increase in drug-related overdose deaths since 2015. Although the rate of deaths caused by prescription drugs has leveled since 2009, deaths from illicit drugs are increasing.[2] In addition, overdose deaths caused by dual use of illicit drugs and prescription medication are up nearly a third since 2011.

Like many other states, the overdose crisis in RI began with prescription drugs. Health-care providers, who are part of the reason for the opioid epidemic[3,4], have an obligation to help to prevent opioid-related deaths by ensuring that those who are prescribed opioids are using them responsibly.[5] Model "pain contracts" typically include terms of treatment including risks and benefits of treatment, prohibited behaviors and points of termination, patient responsibilities, and rules for interacting with caregivers. Typically, contracts include statements that explicitly prohibit patients from giving (or selling) their prescription medications to anyone else, and discourage them from using any mind or mood-altering or illicit drugs while receiving treatment unless authorized by a physician.[6] Willfully prescribing opioids to this patient in the context of her untreated methamphetamine addiction carries risks beyond those of the opiates themselves. For example, providers run the risk of supporting the patient and others' illicit drug addiction, and thereby contributing to the state's opioid crisis. Since the patient is not complying with her end of the pain contract, this provider team may be well supported, under the ethical principle of non-maleficence, to terminate the contract and withhold treatment.

It is important, however, to remember that controlled substance agreements exist not to punish patients who do not act in accordance with physician goals, but rather to allow personalized patient counseling and promote shared decision-making about the risks and benefits of opioid use.[7] The use of these agreements as an enforcement tool only serves to further stigmatize patients with chronic pain and erodes their access to healthcare.[8] Moreover, such usage is frequently ineffective, as patients with legitimate needs for pain medication (as in this case of a patient with pancreatic cancer) can often easily acquire pain medication from other physicians. In this view, it is the role of the physician to build a therapeutic alliance with the patient, instead of effectively forcing her to switch providers to obtain the same outcome of receiving her required pain medications or being left without treatment of *either* her pain *or* her methamphetamine addiction. Such handoffs of patients only cause discontinuities in care, leading to suboptimal management and poor patient-doctor relationships.

Physicians should have a goal of respecting patient autonomy while seeking to optimize outcomes. This means allowing the patient to define what the best goals are, even if they may be at odds with medical opinion. This is especially true

in the realm of oncology and palliative care, where patients are faced with a deeply intimate choice and can make a wide variety of decisions about their goals of care. While physicians should not endorse or become complicit in decisions that harm a patient's health, such as abusing methamphetamine, they must also respect the patient's freedom to decide to continue such actions. It would be more productive to establish a trusting relationship with the patient and explore the patient's motivations for using methamphetamine and encourage treatment, rather than attempting to forcibly reduce her access to methamphetamine by withholding important and indicated medical therapies.

Additionally, this case was noteworthy because it illustrated the competing demands under which physicians are often placed – specifically, balancing the physician's obligation to the patient with the obligation to society. Clearly, the sobering facts surrounding the explosive rise of prescription and illicit opioid abuse epidemic illustrate that physicians and other public health professionals have an ethical obligation to ensure that any opiates provided are in the smallest dose possible and used appropriately. However, in patients with legitimate and ever-changing needs such as this patient, it is very difficult to advocate for cessation of opiate prescriptions even with the suggestion that this patient may be using these prescriptions inappropriately. Ultimately, we recommend a compromise solution such as a discharge with appropriate home follow-up in which a visiting provider could provide medication in small amounts frequently, while continuing to monitor the patient's pain needs. This would minimize the risk that the opioids are sold or exchanged. This setup would give the patient, suffering from a devastating illness, the opportunity to have more of a focus on quality of life at the end of her life.

There is concern that discharging patients from a pain practice serves to further stigmatize them and deny care to those most in need. Pain contracts are an important tool to establish a physician-patient relationship but can become ethically fraught if a patient violates the terms of the agreement and the physician then feels bound to remove them from their practice. This situation may be further complicated if a patient's objectionable actions may have been influenced by their disease itself. A team-based approach that is mindful of community and outpatient resources may prove to be helpful to find creative solutions to continue to ensure appropriate treatment for patients who may struggle to have access to care. This case illustrates the degree to which decisions to continue care or discharge a patient from a practice are individualized and heavily influenced by the details of each patient's case. The specter of the opioid crisis suggests that more attention needs to be given to any possible instance of opioid abuse, but particularly in end-of-life cases, individual physician judgment should take precedence to ensure compassionate and ethical care.

## ETHICS COMMITTEE ANALYSIS #1 (JB)

This case study illustrates a healthcare provider's ethical conflict of wanting to minimize the potential harm of prescribing opioids to a patient who acknowledges active drug diversion while addressing her legitimate need for pain management due to underlying abdominal cancer. The patient was described as seeking recurrent acute care hospitalizations for pain control but, upon discharge, would sell her prescribed opioids to purchase methamphetamines. The patient has a diagnosis of cancer and presumed methamphetamine use disorder. Compton[9] reports that there is a lack of evidenced-based guidelines for the management of chronic pain in patients with a history of addiction.

Although the patient has the autonomy (right) to make her own decisions about the use of prescribed opioids, this right can be overruled by a provider's concern that a requested treatment is ineffective, can cause harm to the patient or others, or is contrary to existing laws.[10] The provider's intent is to provide pain relief for the patient. To continue to prescribe opioids knowing that they are being diverted for illicit drugs is neither minimizing harm nor providing therapeutic benefit for the patient. In fact, the patients' diverting of opioids places others at risk and is illegal behavior. Kotalik[11] believes the opioid prescriber shares with the patient an ongoing ethical responsibility for the proper use of the drug.

From an ethical standpoint, the prescribing physician should stop prescribing opioids and refer the patient for substance use treatment.[12] Ideally, the patient would be seen by a hospital-based substance use team and referral for treatment could be arranged in coordination with on-going medical follow-up. Use of methadone or suboxone would not be indicated as the primary drug being abused is methamphetamines. Chang and Compton[13] strongly believe that untreated addiction results in poor functionality and subsequent poor pain outcomes. Once the methamphetamine use is controlled then use of opioids could be re-considered in conjunction with continued substance use treatment. For patients with a short-life expectancy, deferral of opiate prescribing may not be an option. The question then becomes how to safely manage acute/chronic pain needs. Realistically, there are only two viable options. First, that patient could be admitted to an inpatient hospice unit where the focus of care would be on comfort. Alternately, the patient could have home hospice based services with a designated caregiver who would dispense opiate medication.

## ETHICS COMMITTEE ANALYSIS #2 (MM)

This complicated patient case identifies several ethical challenges. Do drug users deserve to be treated autonomously? Does someone with a personality disorder have that right? Can a provider ethically refuse to provide narcotic treatment for someone with cancer pain? The two principles of

autonomy and beneficence can be applied as helpful lenses with which to consider all aspects of the case.

Caring for this woman respectfully necessitates considering her wishes. However, her history of cocaine and methamphetamine abuse is important. She has an increased risk of opioid abuse due to this history and has now explicitly told providers that she is not taking prescribed pain medication. It is in her best interest – the physician is guided by beneficence – to refuse to prescribe opioids and to offer alternative pain management strategies. While at first pass it may seem rash (i.e., to make treatment decisions based on a patient's addiction, not to mention her non-adherence), this is widely considered a "best practice" when considering opioid prescribing.

When considering the patient-provider relationship, both parties ostensibly want a trusting one. The patient has been truthful in admitting sale of her medication. The provider is bound to use that information to guide her care. Further, the provider should be similarly honest with the patient. At this point, his or her role can focus on clear and open communication: review of the risks of illicit drug use, explain treatment options, review the risks of undertreated pain and discuss non-opioid alternatives. Previous providers terminated the relationship due to poor adherence; doing so again would not be for her own good (previous terminations did not improve her course). Considering the patient autonomous – *truly* autonomous and capable of engaging in treatment discussions rather than seeing her as a meth addict – could lead providers to in-depth care planning discussions suggested above. While she has been honest about what she did with previous prescriptions, she has not been clear or transparent regarding her motives. The physician can present him or herself as honest and forthright and attempt to elicit a reciprocal response from the patient.

Much of this assumes the provider is motivated to expect more from the patient, a difficult task after a frustrating treatment course. She has not followed recommendations and has potentially put one's medical license at risk by selling her medication. She may be emotionally labile and dramatic. She has terminal cancer and cancer-related pain and is using methamphetamines – ultimately disheartening! The provider should seek peer consultation and acknowledge disappointment about the patient's decisions thus far. It is imperative to do so in order that non-medical judgments about the patient's psychosocial background do not influence the physician's medical recommendations. Maintaining compassion and respect for non-compliant patients is a challenge and in this case doing so involves withholding of opioids.[14]

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