

Guide to professional conduct and ethics nursing essay

[Health & Medicine](#), [Nursing](#)



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pain can last for weeks, months or years. It is caused by pain signals that keep firing in the nervous system. The start of chronic pain may be due to initial trauma or may be ongoing due to a pathological condition, but it can also occur with no form of injury or damage. In the following paragraphs, we will discuss the various aspects of this issue and see how the various aspects intertwine.(Stroke)The biopsychosocial model integrates the biological, psychological, and sociological. According to the biopsychosocial model, it is impossible to fully understand the problem of pain using physical or medical concepts alone. Thus the biopsychosocial is a holistic perspective in that mind and body are seen as automatically intertwined, and a person suffering from chronic pain is affected in all three areas (Gatchel 2009). Psychosocial factors play in the mental, emotional, and behavioural perception of pain. Pain is now viewed as a complex set of phenomena, rather than as a simple, specific or discrete entity. However, in the past, organic pain was viewed as different from " psychogenic" pain, suggested that the pain was due to psychological causes only, and that it was not " real" pain because no specific organic basis could be found. The assessment or diagnosis of organically caused pain does not rule out the important role that psychosocial factors can play for any particular patient. The general term " Pain Disorder" is used, with subtypes coded according to the relative degree of psychological and/or medical conditions associated with it. The social

environment is also a factor that contributes to pain perception. Having a serious illness or a chronic pain condition described in the case can cause stress to the family system often requiring other family members to change or adapt (Bruns 2005). The family can either be supportive or unsupportive with the latter most likely leading to conflict. People outside the family may also judge the person that the pain is "in their head" and that the motives for claiming to be in chronic pain are due to laziness, an excuse not to work, and/or are malingerers. The BPS model views physical disorders such as pain as the result of a dynamic interaction among physiologic, psychological and social factors, which perpetuates and may worsen the clinical presentation. Each individual experiences pain uniquely. A range of psychological and socioeconomic factors can interact with physical pathology to modulate patients' report of symptoms and subsequent disability. As with most things today, the Internet's best resources are the best place to find the most up-to-date information. Journals and Medical Press is also a portal for doctors. While we would not expect a GP to be up to date on the tiniest intricacies of neurology and pain, the basics would have been available to him, and possibly should have been known to him. It could also be argued that after the patient's first visit, it would have been good practice for her first GP to make himself more aware of the field. UptoDate is seen as one of the best resources available to doctors at the coal-face. It is constantly under review by experts, meaning the practising doctor does not have to sift through databases and papers. This service is not free, but as this case shows, 375 Euro for a single licence for a year would seem to be good value in exchange for such a powerful resource at one's fingertips. There are specific

publications aimed at G. P. s, carrying articles specially aimed at them. They aim to keep doctors informed, and since Chronic Pain makes up a substantial proportion of the cases seen by G. Ps, it follows that these journals would carry info on it. Like many other articles from other publications, information can become available on PubMed, an online database available to doctors. Doctors must perform Professional Competence Courses in order to keep their Licence, and it would seem prudent for them to keep on top of pain management. These obligations should be enough to stop a doctor getting complacent with his/her current knowledge on any topic. Despite a growing use of the Internet, one study shows that German GPs favours " traditional" media for their learning activities; journals activities, and colleagues (Vollmar, Rieger et al. 2009). In an American study of doctors who deal with Geriatrics, of which G. P. s make up a large proportion; 83% of respondents reported use of internet resources in their medical practice at least once a week; less than 3% reported no internet use at all. The doctors surveyed understood the value of getting good information, with UpToDate, WebMD and Centres for Disease Control the top three sites used. Interestingly, no differences in internet use were found between medical specialities (Galvin, Meuser et al. 2011). Despite the large number of pain clinics in Ireland the services provided are currently inadequate. St. Vincent's Hospital is the only pain clinic at the moment offering a 3 week course in pain management consisting of occupational therapy, physiotherapy, relaxation courses and lectures (Dr. Michael J. Cousins). With statistics showing that around 400, 000 people in Ireland are chronic pain suffers, having only one specialised clinic is not acceptable. On top of this access to these clinics is difficult to

obtain. All of them are found within cities in Ireland forcing people living in rural areas to travel what could be a two hour or more journey for treatment. Even before all this, it has been shown that on average it takes two years for a patient to be diagnosed with chronic pain and to be referred to a pain clinic far above the acceptable 12 weeks set by the government's Health Strategy Document. Structural changes that need to be made are that the standards of care within the clinics must be improved. Excluding St. Vincent's no pain clinic reaches the international standards laid down by the International Association for the Study of Pain (IASP) (Dr. Michael J. Cousins). Some of the criteria that need to be met include the following; access and regular interaction to at least three medical specialties or healthcare providers, better communication between healthcare providers concerning individual patients and programs offered at the clinic, employment of a Director/ Co-ordinator to monitor medical services provided, without the need to be a physician, both diagnostic and therapeutic services on offer to patients, designated space available for the clinic's activities, records on patients so as to allow assessment of each treatment and outcomes and evaluate overall program effectiveness and lastly, appropriate knowledge of basic sciences and clinical practices relevant to chronic pain patients among professionals. The clinic should take a multidisciplinary response when treating chronic pain patients carried out by competent medical team consisting of a holistic medical personnel as well as administrative staff to maintain records on patients. As stated by the IASP both diagnostic and therapeutic services should be provided. Regarding the policy response, more education regarding chronic pain should be given. Even though 1 in 3

households in Ireland have a chronic pain sufferer there is currently no overall training available for healthcare providers targeting chronic pain. It has been shown that GPs require more training about chronic pain and that 48% of those surveyed said that they would be confident if a patient returned complaining about their pain despite treatment. 89% of the GPs surveyed showed that they would be interested in more training regarding chronic pain (McGonagle 2004). A study was done in which the number of timetabled teaching hours dedicated to pain management was obtained from the undergraduate schools from the universities in Ireland for the academic year '02/'03. The same information was obtained from postgraduate studies as well from the Presidents of each training body. It was shown that there were inconsistencies between undergraduate and postgraduate schools not only between universities but also between courses e. g. nursing 11-72 hours and Medicine 4. 5-32 hours. This combined with large numbers of chronic pain sufferers in Ireland show that we need to provide more education and training regarding chronic pain to not only healthcare professionals but also to undergraduate and postgraduate schools (Fullen 2006). The main ethical issue which arises in Emily's case relate to the GP's duty of care. When Emily's pain did not subside after the initial six weeks and she began complaining of what would have appeared to be chronic pain, her GP should have helped Emily develop a pain management plan. The fact that she was left in pain 24hrs a day shows a gross negligence on the part of her original GP and undermines the patient doctor relationship which is built on caring and trust. Emily probably felt betrayed by her GP, and rightly so, their lack of action would have had a

direct negative impact on Emily's experience dealing with what is a debilitating condition both psychologically as well as physically. It could be argued that the GPs duty of care ended with pain killers and further care, being outside their area of expertise, was not the obligation of the GP. This is both ethically and legally inept. If the GP was not in a position to continue Emily's care, either by lack of knowledge in treating chronic pain or any other reason, they are under a professional obligation to transfer the patient to another doctor who is better able to treat them. This is clearly stated under "Continuity of Care" in the Medical Council of Ireland's 'Guide to Professional Conduct and Ethics', a document readily available to guide medics in areas of "consent, confidentiality, end of life care, provision of information to the public, prescribing practices and referral of patients." This professional obligation is clearly stated in section 12. 1 of the Medical Councils guide (Ireland 2009). When dealing with patients in chronic pain, one of the first ethical issues to arise is whether or not the patient is being truthful about the severity, the type or the presence of pain. This is often quite a difficult situation as a definition of pain used by many health care workers is that "Pain is whatever the experiencing person says it is, existing whenever he says it does" (Margo McCaffery, 1986). This analysis of pain leads us to our next question: What should be done for patients claiming to suffer from chronic pain? Firstly, patients often express relief at knowing that their symptoms of pain are being taken seriously. However, believing a patient's pain experience has to start with accurate pain assessment (Waterhouse, 1996; Jacques, 1992; Raiman, 1986) and accurate pain assessment depends on the patient's self-reported pain. Therefore an

accurate pain assessment cannot be completed unless the practitioner believes the patient (Summer J. McGee 2011). Another ethical issue that arises is the burden of chronic pain on the sufferer's daily life. We must ask ourselves how pain affects this person on a day to day basis practically and what we can do to make life easier for them, such as; help in the home, disability benefits and counselling. Chronic pain impacts negatively on the daily lives of all sufferers (Clarke 2008). In 2001, the European Federation of Chapters (EFIC) and the International Association for the Study of Pain (IASP) declared, " Pain is a major healthcare problem in Europe. Although acute pain may reasonably be considered a symptom of disease or injury, chronic and recurrent pain is a specific healthcare problem, a disease in its own right". Healthcare policy makers in Ireland need to realise this and develop strategies that ensure a quick and timely diagnosis that will ensure the provision of an effective and adequate management programme. The responsibilities of Emily's GP are vast and manifold. The GP should show empathy towards Emily. It is important to help educate Emily and put her in contact with various support groups i. e. Irish Chronic Pain Association. Her doctor should also acknowledge various barriers they might face with regards to her treatment e. g. patient compliance, availability, access and financial limitations. It is essential for Emily's GP to consider the entire Biopsychosocial picture and to utilize a multimodal approach. Her treatment could encompass physical, behavioural, interventional, alternative or pharmacological care. It is the duty of the doctor to help this patient and to consider many different therapies that might be available for her. These include; physical therapy at home, improving posture, core strengthening,

pool therapy, cognitive behavioural therapy, as well as alternatives such as myofascial pain trigger point injections, acupuncture, chiropractic, yoga or herbal remedies. (2011). Furthermore, whatever medication the doctor chooses to prescribe or recommend should be on a scheduled basis not " as needed". It is the responsibility of Emily's GP to apply " measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice." (Jane Rae Wilkens 2012)Doctors have limited time and resources. We must decide which outcomes to include in our measurements. Sometimes pain intensity is the most relevant variable. In other cases, an indicator of work or social functioning has more clinical relevance. Sometimes an individual is extremely disabled by low pain intensity. Other times the patient keeps a productive and fulfilling lifestyle despite high levels of pain. Some treatments have little impact on pain intensity, but improve mood, motivation, and functioning. One of the most important decisions to make in testing a new treatment is to decide which outcomes are most clinically relevant. We now review a few of the available pain outcome measures, which range from simple and narrowly defined, to large and multidimensional. One-dimensional tests provide fast pain measurement that can be administered many times with little administrative effort. The numerical rating scale (NRS) scores pain from 0 to 10 (or 0-100). From 0 being " no pain" to 100 being the " worst pain imaginable." An advantage of the NRS is that it is a verbal scale so the patient doesn't have to be mobile. The visual analogue scale involves the patient marking a point along a 10-cm line representing their current pain intensity. This can be measured in millimetres giving a 101-point scale. Sliding rulers have been

developed to increase accuracy. The VAS gives a high level of resolution and is probably the most sensitive single-item measure for clinical pain research. The PGIC (Patient Global Impression of Change) scale is used to estimate pain improvement. The patient is asked to rate their current status ranging from "very much improved" to "very much worse". An advantage of this is it is applicable to a wide variety of conditions and treatments; however it lacks sensitivity needed for some statistical analyses (Breivik 2000) (Younger, McCue et al. 2009). Sometimes a one-dimensional scale isn't enough to accurately quantify pain or quality of life. By measuring the pain experience in a more complex way, multidimensional scales can avoid the lack of association between pain intensity and disability. The short-form McGill Pain Questionnaire (SF-MPQ) is a well-validated measure used extensively in clinical research. Patients rate their pain by describing both the sensation of the pain and how it affected them (e. g. sickening or fearful). There are 15 total descriptors. Each item is rated on a 4-point scale ranging from none to severe. The SF-MPQ also has a VAS item for pain intensity and a VRS to rate overall pain experience. The Brief Pain Inventory short form (BPI-SF) describes both the sensory intensity of pain and the extent that pain interferes with different areas of the patient's life. It is a 17-item scale that describes pain location, medication use and response to treatment (Kitisomprayoonkul, Klaphajone et al. 2006). Behavioural scales are used in non-communicative patients because they can't describe the pain themselves. These usually measure facial or bodily movements to indicate pain. These scales are clinically necessary in some cases, but are generally not acceptable as outcomes for clinical trial reporting (Li, Puntillo et al.

2008). There is no valid and reliable method to objectively quantify the experience of pain. Many physiologic variables have been measured for this purpose (e. g. skin conductance and heart rate), but they don't correlate strongly enough with pain to be used as alternative pain measurements. Pain can exist without changes in these measures, as well as these measures changing drastically with no change in pain. These peripheral measures indicate general autonomic activity, influenced by factors other than pain (e. g. arousal). Treatments may directly change these variables, making them less reliable pain indicators. Research is being carried out in this area, looking for more advanced measurement approaches or biomarkers of pain intensity. This means we must rely mainly on self-report measures to determine the impact of pain (Bossart, Fosnocht et al. 2007). Many new attempts to objectively measure pain have focused neurologic pain markers. These try to take into account the large number of emotional, situational, and other factors which increase or extend pain. Searching for a neuroimaging approach to pain measurement has increased as better technology has improved spatial and temporal resolution. Several brain regions show pain-related activation, and some degree of pain intensity encoding has been described. No neuroimaging technique has yet been established as a reliable method of measuring pain. The technology isn't advanced enough to accurately classify someone as being in pain based purely on a scan; we are further still from judging the amount of pain change based on changes in neural signals (Coghill RC 1999) Physical functioning and performance tests (e. g. range-of-motion) have been used as a proxy for objective pain measurement. Examples include: the loaded forward-reach

test (chronic back pain), timed "Up & Go" test (osteoarthritis), and grip strength (rheumatoid arthritis). Usually these performance tests only modestly predict self-reported pain, with correlations rarely exceeding 0.30. These results suggest that pain is just one component of physical performance, and other factors (e.g. fear of pain) may heavily impact performance scores. Therefore, despite clinic-based tests of functioning complementing self-reported pain measures in chronic conditions, they are not useful as pain-report substitutes (Harding, Williams et al. 1994). Medical and surgical treatment have always emphasized on saving lives rather than actually managing the symptoms such as pain. One of the more important issues to be considered in the given case is whether or not pain should be considered a legal right. Pain management should be viewed as more than a procedure or protocol that needs to be addressed in treatment; it should be viewed as an "imperative founded on human rights". Similar cases to the above have occurred in the US and the doctors involved were disciplined for unprofessional conduct and inadequate pain management (Brennan, Carr et al. 2007). From another point of view, there is no pain management plan in place in Ireland for GPs or any other doctor for that matter to follow. The teaching hours for pain education in healthcare courses in universities in Ireland also vary significantly (Fullen 2006). However, there is a concept called continuing professional development which is defined as a variety of activities undertaken by health care workers to keep their knowledge up to date in their field so that they can practice safely, effectively and legally. Professionals are required to keep a record of their CPD activities and provide evidence on their activities to ensure that their level of CPD is up to

standard. (Council 2013). If the doctor carried out frequent CPD, he would have known that Ireland did not have a pain management guideline and he would have adopted a guideline from another country and this would have enabled him to treat the patient more effectively. Another legal issue that is present in this case is the issue of medical negligence. The four elements required to prove negligence are as follows: There must be a duty of care to the plaintiff, such as the doctor-patient relationship; A failure to meet the standard of care required by that duty, i. e. the current best practice; damage, either physical or psychological, to the plaintiff affected by the failure to meet the standard; and the damage must have been caused by the failure to reach the standard of care (Mills 2006). As stated above, there are no current guidelines in Ireland for the management of chronic pain, however an aspect of negligence which could be raised, is the issue of informed consent. The Medical Council, in their " Guide to Professional Conduct and Ethics", states that " patients must receive sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care." (Ireland 2009) As the original GP did not discuss any pain management plan with Emily, she could not have made an informed decision about her care. If Emily can prove that her original GP deviated from current best practice, and that this deviation caused a decreased quality of life, then she could succeed in a case of clinical negligence. After considering all the issues discussed, it is clear that chronic pain in general is a very underdeveloped field in medicine in terms of management and treatment. Various measures need to be taken,

be it from a biopsychosocial, ethics or legal point of view in order to better manage the condition for patients.