Ethical Issues for Psychologists in Pain Management

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ABSTRACT

Pain management is relatively young as a specialty. Although increasing attention is being paid to issues such as pain at the end of life and pain in underserved populations, only recently has an open discussion of ethical issues in chronic pain treatment come to the fore. Psychologists specializing in pain management are faced with a myriad of ethical issues. Although many of these problems are similar to those faced by general clinical psychologists or other health psychologists, they are often made more complex by the multidisciplinary nature of pain management and by the psychologists’ relationships to third-party payers (health maintenance organizations, workers’ compensation), attorneys, or other agencies. An open forum exploring ethical issues is needed. This article outlines major ethical considerations faced by pain management psychologists, including patient autonomy and informed consent, confidentiality, reimbursement and dual relationships, patient abandonment, assessment for medical procedures, clinical research, and the interface of psychology and medicine. American Psychological Association ethical principles and principles of biomedical ethics need to be considered in ethical decision making. Further exploration and discussion of ethics for pain management psychologists are recommended.

Key Words. Ethics; Biomedical Ethics; Pain Management Psychology; Health Psychology; Pain Management

The field of pain management is young in the context of medical history. The International Association for the Study of Pain was founded in 1973, and the American Pain Society was created as an International Association for the Study of Pain chapter in 1978. In 1995, Howard Fields suggested a list of ethical issues with which pain management practitioners should be familiar [1], but thus far no published standards of ethical practice specific to pain management exist. Each specialist under the umbrella of pain management has been guided by the standards of that specialty and has been left with the job of fitting general standards to a very specific setting.

The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA) are designed to cover clinical relationships, business and educational relationships, and research in both animals and humans [2]. The guidelines for clinical psychology were primarily developed from the model of therapy as a private dyadic relationship between the therapist and client. With the growth of behavioral medicine as a specialty, including pain management, the ethical concerns have become broader and more complicated. Weighing the benefit to patients of confidentiality versus adequate communication between specialists in hospital charting is an example of the dilemmas commonly faced. Pain management psychology, as well as certain other behavior medicine subspecialties such as rehabilitation psychology, is additionally complicated by the frequent involvement of worker’s compensation and legal proceedings. The traditionally private relationship between the psychologist and patient has expanded to include managed care or insurance case managers, workers’ compensation case managers, multidisciplinary treatment teams, and often employers, lawyers, and judges as well. Multidisciplinary pain center psychologists are called on to assess and treat patients and families, evaluate clinic outcomes, and develop research and program protocols. They are increasingly relied on to evaluate patients before
decisions are made regarding surgeries, implantation of stimulators and pumps, initiation of opioid therapy, and other medical interventions. Clearly, there are multiple ethical issues that need to be considered.

A groundswell of interest in the ethics of pain management has been seen over the past 2 years, with the establishment of the American Pain Society/American Academy of Pain Medicine Ethics Task Force and the American Pain Society Ethics Special Interest Group. These groups are discussing and researching many ethical issues, including end-of-life care, managed care, and undertreatment of pain in vulnerable populations. The American Pain Society’s Bulletin and the American Academy of Pain Medicine’s Pain Medicine have published articles and case discussions regarding ethical issues.

However, there are problems specific to the practice of psychology within the field of behavior medicine in general and pain management in particular that require closer scrutiny. Although these issues are frequently similar to those faced by physicians, the dictates of the professions are not identical. In the treatment of pain patients, psychologists must carefully consider issues of informed consent and patient autonomy, confidentiality, dual relationships, and patient abandonment. Ethical issues regarding assessment for medical procedures are problematic. There are ethical considerations to the problems of funding and third-party payers for pain management clinicians. Clinical research also requires attention. Finally, psychologists working in a medical field must walk a fine line to avoid practicing medicine without a license and at times may have to deal with differences of opinion in treatment options between professionals on the team.

The purpose of this article is to explore some of the ethical issues faced by psychologists in a pain management setting. It does not purport to solve these quandaries or to set ethical standards but rather tries to illustrate the problems and complexities involved in the attempt to provide the highest quality of patient care. Dialogue and exchange of ideas will ultimately improve awareness and consensus regarding these ethical issues.

**Basics of Biomedical Ethics**

Sullivan [3] suggests that a principle-based theory of medical ethics provides pain management practitioners a template for conceptualizing ethical issues. He derives four basic principles of biomedical ethics, from the work of Beauchamp and Childress [4], that ideally underlie the ethical medical decision-making process.

The first principle is that of patient autonomy, or the ability of the patient to follow a self-chosen plan. Autonomy requires two conditions: independence from undue or controlling influence; and agency, or the cognitive capacity to make rational plans. Pain management specialists must be aware that unrelenting pain may impair rational decision making. Likewise, the use of narcotics and benzodiazepines may enhance a patient’s dependence on the healthcare providers. Can we be sure patients are making autonomous decisions if they fear that saying “no” may mean losing their medications?

The second basic principle is nonmaleficence, the Hippocratic dictum, “first do no harm.” The obligation to do no harm is fundamental to biomedical ethics. Pain management treatments that do not protect the patient from intolerable side effects or long-term problems are considered unethical.

The third basic principle is beneficence, or the obligation of the healthcare provider to do what is good for the patient, over and above the avoidance of harm. Pain management specialists understand that they cannot always provide benefit to all patients and that providing a treatment that does not have the potential for benefit is unethical.

Finally, in ethical decision making, one must consider the principle of justice. Healthcare providers have an obligation to provide a just and fair distribution of goods and services. Although many of these decisions regarding distribution of health care are left to governments and social agencies, healthcare providers must grapple with the problems of inequality of treatment.

Whereas these four principles—autonomy, nonmaleficence, beneficence, and justice—are applied to the field of biomedical ethics and not specifically to psychology, the role of the psychologist as part of the treatment team in pain management necessitates that they be considered in ethical decision making. All ethical problems need to be approached by first asking these questions: Is the patient making autonomous decisions? Will the proposed action cause harm? Will it provide benefit? Is it just?

**Patient Autonomy and Informed Consent**

Pain management centers most often are structured around a team approach, where any number of specialists (physicians, psychologists, physical and occupational therapists, vocational specialists, and social workers) may be involved in the patient’s care. Some programs are “packages”—to be accepted
into the program, the patient must agree to participate in psychology and in all other aspects of the treatment protocol. Patients seeking treatment in centers that are more medically oriented still often find they are required to see the psychologist for evaluation or treatment before receiving invasive procedures or narcotic medications. It is in these situations that patient autonomy requires special consideration. Patients who would not autonomously participate in psychological assessment or therapy may feel subtle or overt threat from third-party payers or employers, including threatened loss of employment or compensation. Patients may also believe—and may be accurate—that their physician will not treat their pain unless they agree to the psychological component of the program. The relief of pain may be such an overriding goal that patients will feel coerced into psychological treatment against their will.

**Case Example**

Marty W., a 57-year-old factory worker, sustained an L4-5 disk herniation while lifting a box at work. He underwent a course of conservative treatment before having a lumbar fusion. Eight months later, he remains off work due to pain. His workers’ compensation case manager has arranged a pain management center referral and has insinuated that lack of cooperation on his part may jeopardize continuing workers’ compensation. Mr. W. does not want to be evaluated by a psychologist but believes he has no choice.

Informed consent is an issue closely related to patient autonomy. APA standards state that informed consent to therapy generally implies that the person has the capacity to consent, that the person has been informed of significant information concerning the procedure, that the person has freely and without undue influence expressed consent, and that consent has been appropriately documented [2]. Junkermand and Schiedermayer [5] instruct that the elements of information needed to allow informed consent in medical settings include the prognosis, benefits, and burdens of recommended treatment; benefits and burdens of reasonable alternative treatments; and the likely effect of no treatment. This information must be presented to the patient in easily understandable language at the beginning of treatment [5]. For pain management psychologists, this requirement often puts them in the position of explaining medical procedures that may be the alternative if the patient does not wish to pursue therapy.

Psychologists have an obligation to explore these issues with patients, as well as to explain billing procedures, confidentiality, and so on, as soon as possible in the treatment setting. Although the principle of beneficence requires that a psychological component is offered if it is deemed to be an appropriate and positive treatment for the patient, coercion of treatment clearly violates patient autonomy. Working jointly with physicians, patients and other treatment team members to ensure autonomous consent is critical.

Contracting also presents a problem for patient autonomy. In pain management settings, psychologists are often called on to create and/or implement “agreements” that patients are expected to sign before certain treatments. The most problematic of these are narcotic agreements. There is obvious benefit to having the rights and responsibilities of both the healthcare provider and the patient delineated at the beginning of treatment. However, in practice, patients are often obligated to sign the document to get the pain medication they seek. Does unrelenting pain and the pursuit of pain relief limit a patient’s ability to weigh risks and benefits? Do the stipulations of most such agreements (take medication only as prescribed, only get medications from one pharmacy, do not sell or give pills to others, no early refills, agree to random urine screens) imply distrust of the patient and impair the establishment of a therapeutic relationship? Should contracts be used in all cases? Dubler, Director of the Division of Bioethics at Montefiore Hospital, argues against standard contracts, urging that “ethically constructed care plans must be based on the needs and behaviors of each patient as assessed and responded to by the physician and care team. In ethics, and certainly in an area as sensitive as chronic pain management, one size does not fit all” [6].

Behavioral contracting, common in many pain management programs, also carries with it the possibility of coercion, especially when failure to sign the contract means that the patient forfeits all treatment for pain. Psychologists have the duty to protect the ability of patients to weigh costs and benefits and make valid choices for themselves. All contracting must be done in a manner that ensures patient understanding and promotes appropriate patient decision making and therapeutic goals.

**Confidentiality**

The APA Ethics Standards are very clear on issues of confidentiality and privacy. Psychologists are required to discuss the limits of confidentiality at the outset of services. They are mandated to include in written and oral reports only information that is
germane to the purpose of the communication, to
protect confidentiality in the maintenance and dis-
posal of records, and to disclose information only as
mandated or permitted by law or with explicit con-
sent of the patient. When consulting with colleagues,
they must have patient consent or eliminate informa-
tion that would identify the patient, and they must
only share information necessary to achieve the pur-
poses of the consultation. They must protect against
misuse of databases and patient information used for
instructional purposes. They may not withhold rec-
ords due to nonpayment. They must keep records
reasonably available to patients and make plans in ad-
vance for confidentiality of records in the event of
death, disability, or withdrawal from practice [2].

These standards, although clear, are also fraught
with difficulty in a pain management or hospital
setting. Insurance companies often have patients
sign consents for the release of all information: This
is especially true when patients are receiving
medical as well as psychological services. In most
states, workers’ compensation agencies legally have
a right to all documents in a patient’s chart. In eval-
uation reports, referring physicians expect the in-
clusion of details, and participants in treatment team
meetings or family conferences often look to the
psychologist for information that at times may be
quite intimate and embarrassing to the patient.

Case Example
Ellen M., a 45-year-old woman with chronic pelvic
pain after endometriosis and a total abdominal hys-
terectomy, indicates in a psychology therapy ses-
sion that she has become avoidant of sexual inter-
course with her husband, and this has caused feelings
of guilt and diminished self-esteem. The psycholo-
gist, part of a treatment team in a multidisciplinary
clinic, gets the patient’s permission to include the
physical therapist in the discussion to explore possi-
ble treatment options. The psychologist must de-
cide how to chart the issue, knowing that the chart
notes will be available to vocational counselors, in-
surance company workers, and so forth.

In pain management, the most important man-
date for psychologists is to discuss confidentiality
with their patients. Limits of confidentiality, meth-
ods of handling release of information requests,
charting or electronic data storage practices, con-
sultation, and team meeting practices should all be
outlined for the patient and, ideally, should be pre-
sented in written and oral form. Patients need to
know before the onset of therapy whether private
issues discussed in sessions, such as sexuality or em-
ployer relations, will be charted, discussed in team
meetings, or provided to insurance companies. In
addition, patients need to be able to decline to take
part in discussing such topics if they are uncomfort-
able with the level of confidentiality.

In report writing and charting, the unwritten
rule has often been “the more, the better,” espe-
cially for initial evaluations or evaluations for sur-
urgery, implantable technologies, and so on. Like-
wise, the team treatment model is based on the
belief that a free exchange of information between
disciplines improves the quality of care. However,
APA standards mandate that psychologists include
only that information that is pertinent to the refer-
ral question or “germane to the purpose for which
the communication is made” [2].

Quality of care is the key to decision making for
psychologists in a medical setting. Decisions re-
garding which information to disclose to others are
best made in the context of the basic principles of
biomedical ethics: Will the proposed action cause
harm? Will it provide benefit? In cases where it
might cause harm but is mandated by law, psychol-
ogists work to minimize potential problems: nego-
tiating with insurance companies to provide sum-
mary reports germane to their billing rather than
chart notes or full evaluations, for example.

Newer technologies, such as faxes, e-mail, and
cellular phones, further complicate issues of confi-
dentiality. Psychologists must be aware of the threats
to privacy presented by these media and must work
to protect their patients’ rights. Notifying a patient
when you are speaking on a cell phone or calling
ahead to be sure a fax will be received by the in-
tended recipient are examples.

Finally, psychologists also need to be aware that
evaluations, even when appropriately labeled as
confidential and not to be released without the pa-
tient’s written consent, are often forwarded to
other parties. In one instance, an evaluation pro-
vided to a workers’ compensation company was
then faxed by that company to the patient’s em-
ployer—and it was the patient’s job to retrieve and
distribute faxes! Though not legally responsible for
such violations, psychologists have an ethical re-
sponsibility to inform the requesting agencies of
the proper handling of psychological data.

Making A Living and Dual Relationships
The issues of funding and dual relationships are
separate and distinct but often combine to become
even more ethically challenging for the pain man-
agement psychologist. Most reimbursement for
pain management psychology services is made by third-party payers: private or government health insurance, workers’ compensation, or liability insurance. Like other professionals, psychologists must attract patients to make a living. But often, psychologists are confronted with subtle or covert pressures that may influence their practices. Pain management programs that serve a large number of patients funded by workers’ compensation may have a strong incentive to release their patients back to work or to reduce restrictions on work activity: Recommending disability too frequently may result in fewer referrals. Health maintenance organizations (HMOs) may stop referring if patients require more than the minimum number of visits. Physicians referring patients for evaluation for implantable technologies may stop referring if the psychologist recommends multidisciplinary treatment instead. Forensic pain management psychologists are under unspoken pressure to conform to the payer’s point of view, whether they are employed for the plaintiff or the defense. These subtle and sometimes not-so-subtle pressures can influence patient treatment and therapeutic decision making, unless the psychologist remains alert to these possibilities.

Who is the client—the patient or the payer? Most often it is the patient, and in those cases, psychologists must look at all decisions in light of the principles of beneficence and nonmaleficence. However, at times the client is the payer, such as when the psychologist is hired to evaluate a person for the defense in litigation. In these cases, APA standards require that the psychologist “clarifies to the extent feasible, at the outset of the service, the nature of the relationship with each party. This clarification includes the role of the psychologist (such as therapist, organizational consultant, diagnostician, or expert witness), the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality” [2].

Dual relationships have always been discouraged in psychology. However, there are times when psychologists may be put in the position of a dual relationship, ostensibly to benefit the patient. A treating psychologist may be asked by a patient’s attorney to testify as a fact or expert witness in court, for example.

There are many reasons why such testimony may benefit the patient. The treating psychologist is most likely to have a more complete view of the patient’s functioning than would an independent examiner. The psychologist may be able to provide a balance to the views of the expert witness for the defense. However, psychologists must be aware of the potential for negative impact on the patient as well. There may be changes to the therapeutic relationship if the patient believes that the psychologist’s testimony will be stronger if the patient remains “sicker.” Kulich and Mehta [7] suggested that the clinician may unwittingly collude with the patient to document pain, suffering, or functional impairments. Thoroughly discussing these issues with patients and seeking consultation with colleagues is advised.

**Patient Abandonment**

“Psychologists do not abandon patients or clients” [2]. The ethical psychologist would never intentionally abandon a patient. However, in a multidisciplinary setting, the decision to treat or not treat is often influenced by other factors.

**Case Example**

Jeremy S., a 35-year-old construction worker with chronic pain after multiple bone fractures of the left lower extremity, is being followed by a physician, psychologist, and physical therapist at a pain management center. He is taking 80 mg sustained-release morphine twice a day. His use of breakthrough medication has been escalating, and he has called once for an early refill. The terms of the medication agreement he signed at the onset of treatment were reiterated to him. Subsequently, his pharmacist called to inform the physician that the patient brought in another prescription from a different doctor—again, a violation of his agreement. The physician provides the patient with a tapering schedule for medication and a referral to a detoxification program. He discharges the patient from the center.

In the event that a patient taking narcotics is dismissed from the clinic due to misuse of medication, does the patient continue with psychological services even if medical services are no longer being provided? Significant pathology may be uncovered in the course of a structured multidisciplinary program: Does the patient continue with therapy when the program ends? What about HMO patients who exhaust their insurance benefits?

APA standards provide sound counsel: “Prior to termination for whatever reason, except where precluded by the patient’s or the client’s conduct, the psychologist discusses the patient’s or client’s views and needs, provides appropriate pretermination counseling, suggests alternative service providers as ap-
appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately [2].”

However, discussion of alternatives and transfer of responsibility may not be enough. Nagy [8] argues that the psychologist is also obligated to be familiar with the appeals process when sessions are limited by third-party payers and should act as the patient’s advocate to seek coverage that would not prematurely terminate treatment. In the case of discharge from clinic due to the client’s behavior, abrupt termination would be appropriate only if this possibility had been previously discussed with the patient; if not, a termination session would be needed to provide alternatives and to facilitate further treatment with another therapist if needed.

Assessment for Medical Procedures

Psychological evaluations are increasingly being used in deciding a patient’s appropriateness for surgery, for implantation of spinal cord stimulators or medication pumps, and for initiation of narcotic pain medication. Although such evaluations are generally considered beneficial in the decision-making process [9,10], psychologists must be aware of potential pitfalls.

There are three purposes for such psychological evaluations. First, assessment can identify patients who have symptoms that are known to interfere with the efficacy of the proposed treatment. Second, assessment can identify problems that need to be addressed or other treatments that need to be offered to increase the patient’s likelihood of success. Additionally, the evaluation session gives the psychologist an opportunity to assess the patient’s level of understanding of the procedure, to ensure the patient has enough information to make a truly informed decision. The psychological evaluation is part of the overall patient assessment.

In practice, patients often arrive at the psychologist’s office under the assumption that they have to “pass” the evaluation to get to their goal: the pump, stimulator, surgery, medication, or whatever. The psychologist is seen as the gatekeeper or an obstacle. Under these circumstances, it is understandable that patients may try to minimize problems or be less than forthcoming with information they may perceive as threatening their goal of winning the psychologist’s “approval.”

Case Example

Penny J., a 53-year-old hair stylist with Complex Regional Pain Syndrome (CRPS) who is being considered for implantation of a spinal cord stimulator, is visibly nervous at the beginning of her psychology evaluation session. “The doctor says the stimulator will help my pain, but you have to approve it first,” she reveals. When asked about previous psychological problems or therapy, she fails to mention a significant postpartum depression after the birth of her second child or the 2-year period when she took antidepressants after her husband’s death.

Psychologists can reduce these problems. First, they can educate the referring physicians about how to introduce the psychological component of assessment to reduce defensiveness. Second, psychologists must educate the patient directly, clarifying their roles as members of the decision-making treatment team and the evaluation as a way of identifying what treatments would be of maximum benefit to the patient. Additionally, psychologists and physicians must keep in mind the limitations of such evaluations as predictors of success and must safeguard against substituting biases and hunches for evidenced-based criteria.

Clinical Research

Psychologists in multidisciplinary pain management settings are often called on to design and execute or to participate in clinical research. As the field of pain management becomes more sophisticated, studies to document efficacy of specific elements of treatment and to study outcomes are necessary. Although the ethical considerations in the pain management setting are no different than those in other behavioral health or medical settings, the pain management psychologist is often faced with difficult ethical choices. One concern is choosing adequate and appropriate control groups. There has been ample documentation in the past quarter century to suggest benefit of psychosocial interventions in the treatment of chronic pain. To use a no-treatment control group then, or to put patients on a waiting list until the end of the active study, goes against the concept of equipoise: the theory that patients should be assured of receiving the best standard care in any therapeutic study [11]. Choosing control group conditions that provide best standard care and comparing them with the experimental condition can be costly and time consuming. The development of improved experimental designs is helping to alleviate some of the pitfalls of psychosocial clinical research [12].

There are other situations where psychologists may face difficult choices. There may be times, for example, when a patient randomly assigned to one group is clearly not benefiting from the treatment.
The ethical challenge requires weighing the benefits of the research to patients in general against the needs of the individual patient. In clinical research settings, patient autonomy and informed consent must be given careful attention. Though a signed consent form may meet the requirements of the institutional review board, elements of subtle coercion and the patients’ desperation for pain relief in these settings is critical.

**Case Example**

Ed G., a 49 year old with chronic low back pain, is participating in an intensive multidisciplinary pain management program. He has accepted the staff’s invitation to participate in a study of pain management education via workbook versus education-based group therapy. He is randomly assigned to the workbook condition. Despite prescreening, it becomes clear to the psychologist during the study that the patient’s problems with anger and stress are more severe than those of the other patients and that he would be better served with individual therapy.

It is important to recognize the economic and logistic factors that may influence the study director to continue a patient in a treatment study even after it becomes clear that participation is not in the patient’s best interests. A high dropout rate may influence the study results or the effectiveness of the randomization. The patient’s withdrawal means lost resources and lengthens the duration of the study if new subjects must be recruited.

**Psychology’s Interface With Medicine**

Psychologists in pain management, as in other areas of health psychology, often treat patients with multiple medical issues who may be concurrently seeing multiple specialists. Although communicating with multiple treating clinicians is time consuming, adequate exchange of information is necessary to provide optimal patient care. Standards regarding informed consent and confidentiality apply to these communications.

However, a larger ethical issue arises when psychologists are put in the position, either by patients or physicians, of providing medical advice. A good pain psychologist knows physiology and pharmacology of pain and pain treatments. APA standards state that psychologists must provide services “only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience” [2]. Making the distinction between providing advice and practicing medicine without a license is critical. Medical decision making must be deferred to the patient’s physician or the treatment team staffing.

**Case Example**

Janet D., a 32-year-old physical education teacher, is seeking treatment for chronic back pain. In the initial psychological evaluation, she seeks the psychologist’s opinion regarding conservative treatment versus lumbar surgery versus chronic opioid use. To make an informed decision about participating in pain management, the patient needs to be given the risks and benefits of the proposed treatments, alternative treatments, and no treatment.

Another important consideration is the handling of disagreements among treating professionals. What is the appropriate course of action for psychologists who believe their patients are receiving inadequate or inappropriate pain treatment from other professionals? APA ethics standards do not directly address this issue. Many problems can be resolved by discussing the patient and treatment with the other professional, with appropriate patient consent. If the other professional’s actions are ethically questionable, APA standards recommend attempting an informal resolution before taking formal action [2]. In all cases, the biomedical ethical principles of nonmaleficence and beneficence need to be weighed. The goal of optimal care at times may require the psychologist to be an advocate for the patient. Under more problematic circumstances, consultation with colleagues or institutional intervention may be necessary.

**Conclusions**

Psychologists who specialize in pain management face a myriad of ethical challenges, some of which are intensified by the multidisciplinary nature of the relatively young field. Informed consent, patient autonomy, and confidentiality are primary ethical issues confronting pain management psychologists each day. In pain management, communication is not solely between the therapist and patient but may include multiple medical disciplines, third-party payers, lawyers, employers, and family members. Dual relationships, patient abandonment, use of assessments, practicing within boundaries of competence, and advocating for adequate pain management treatment are also issues that need to be continually monitored and explored within the context of the pain management psychologist’s practice.

The APA’s ethical principles and standards provide a structure within which these issues may be approached. Additionally, it is useful to apply the
basic principles of biomedical ethics—autonomy, nonmaleficence, beneficence, and justice. A decision made after carefully considering if the patient is acting autonomously, if the choice risks harm to the patient or will provide benefit, and if it is fair will almost always be the ethically appropriate decision. Consulting colleagues and looking to state psychology boards or the APA may provide additional guidance in making difficult choices.

As the field of pain management expands, attention to ethical issues and the problems unique to the field is critical. An open forum and free exchange of ideas among psychologists and between psychologists and other healthcare providers is evolving and is a welcomed development. As new issues arise, working to establish ethical standards and norms will help to ensure the highest quality patient care.

References

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