

MORAL DISENGAGEMENT OF MEDICAL PROVIDERS: ANOTHER CLUE TO THE CONTINUED NEGLECT OF TREATABLE PAIN?

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“On one occasion—when Kakima had been admitted to hospital for investigation—[her daughter] came to visit and found Kakima crawling on the floor, begging for relief, with doctors and nurses walking by, ignoring her.”¹

I. INTRODUCTION

Kakima was an eighty-five-year-old woman dying from metastatic cancer when her health care providers² appeared oblivious to her pain and suffering.³ This elderly woman crawling on the floor

¹ Paul Komesaroff, *At The Gates of the Labyrinth: Meditations of Suffering*, in *EXPERIMENTS IN LOVE AND DEATH*, 192, 196–197 (2008) (telling the story of the experiences of a woman dying of bowel cancer and her family).

² Throughout this article, I refer to physicians and nurses generally as “providers” for simplicity.

³ See Komesaroff, *supra* note 1, at 194. Komesaroff describes Kakima’s experiences in Australia as a first-hand observer, a physician and someone in whom her family confided. She and her children are also described as determined and pro-active in regard to her care. It is difficult to imagine what passive individuals would have experienced.

in pain conjures up images of the undeveloped world or a time before the advent of modern medicine. To the contrary, Kakima suffered in a modern hospital in the recent past; she suffered despite the ready availability of tools to ease her pain. Her providers ignored her despite the fact that they were certainly well-educated in the assessment and treatment of pain.⁴ While Kakima's experience and her providers' reaction are extreme, health care providers' failure to adequately address their patients' pain remains a current reality.⁵

"If the importance of pain relief and the ethical obligation to relieve pain are so widely recognized, why do we continue to neglect treatable pain?"⁶ Nearly a decade ago, Sandra Johnson introduced the interdisciplinary Mayday Project on unrelieved pain with this question.⁷ Unfortunately, the question remains relevant and the answers remain elusive. In 2010, Section 4305 of the Patient Protection and Affordable Care Act required the Secretary of Health and Human Services to work with the Institute of Medicine to "increase the recognition of pain as a significant public health problem for the United States" and the National Institutes of Health to fund further research and curricula development on pain treatment.⁸ Denying patients in pain the full benefit of our medical resources is unethical because it causes unnecessary pain and suffering in patients. In 2013,

⁴ "Pain is what the patient says it is" from the work of Margo McCaffery has been the mantra of nursing instruction for over twenty-five years (and was one of my first lessons in nursing school in 1988). See, e.g., MARGO McCAFFERY, *NURSING MANAGEMENT OF THE PATIENT WITH PAIN* (J.B. Lippincott Co. 1979). Nurses have a professional and moral obligation to relieve their patients' pain (including the duty to advocate for patients with the prescribing practitioner). All health care providers have an ethical duty to increase benefit and decrease harm to the patients in their care. Mechanisms to address patient's pain are well known and readily available throughout the industrialized world.

⁵ Admittedly, barriers to pain treatment are diverse and complex. A robust discussion of every possible barrier to the adequate treatment of pain is outside the scope of the article. Instead, the focus will be on the ways in which providers hamper the adequate treatment of pain and an examination of whether moral disengagement may allow providers to reconcile their actions with their own "moral code" when they neglect treatable pain in their patients.

⁶ Sandra H. Johnson, *Relieving Unnecessary, Treatable Pain for the Sake of Human Dignity*, 29 J.L. MED. & ETHICS 11 (2001).

⁷ *Id.*

⁸ OFFICE OF THE LEGIS. COUNSEL, 111-1 PATIENT PROTECTION AND AFFORDABLE CARE ACT HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (2010), available at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

treatable pain is too often neglected despite widespread educational efforts, ever-expanding multi-disciplinary research, federal and state policy reform, and organizational-level efforts.⁹ These global efforts, however, have too often failed to change provider behavior at the bedside.

Provider behavior that denies patients the benefit of their skill and resources in reducing pain and suffering does not usually manifest as outright neglect of the patient (as in Kakima's case). It more often manifests as undertreatment, disbelief, and attribution of blame to the patient. Nor do most providers engage in conscious decision making aimed at neglecting pain and suffering or causing harm to their patients. Instead, there are usually subtle, unconscious factors and social cognitive mechanisms that impact provider decisions.

Provider decisions about patients in pain are largely dependent upon social cognition or "how people make sense of other people and themselves."¹⁰ The treatment of pain is somewhat unique in that the provider must rely on the patient to report and explain his or her pain. There are no lab tests, imaging studies, or other purely objective reports by which pain can be measured, and this is often challenging for providers who "have grown worshipful of their diagnostic arsenal."¹¹ While all clinical judgments depend, in part, on the interaction with the patient, the assessment of the patient in pain depends entirely upon that interaction. During the interaction, providers assessing and evaluating patients in pain are most often using intuitive processes.¹² This type of processing is particularly prone to automation and bias.¹³ Thus, provider behavior toward patients in pain

⁹ See, e.g., Raymond C. Tait et al., *Provider Judgments of Patients in Pain: Seeking Symptom certainty*, 10 PAIN MEDICINE 11 (2009); NATIONAL PAIN CARE POLICY ACT OF 2009, H.R. REP. NO. 111-47; RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION AND RESEARCH, INST. OF MED. (2011), available at www.iom.edu/Reports/2011/Relieving-Pain-in-America-a-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx.

¹⁰ See Tait et al., *supra* note 9, at 11, 13.

¹¹ Statement made by Raymond C. Tait on February 17, 2012 during an interdisciplinary group meeting on the treatment of pain.

¹² Tait et al., *supra* note 9, at 14.

¹³ *Id.*

may become ingrained and automatic, leading to a consistent pattern of pain treatment, for better or worse.¹⁴ According to one patient:

I have a master's degree in clinical social work. I have a documented illness that explains the cause of my pain. But when my pain flares up and I go to the ER, I'll put on the hospital gown and lose my social status and identity. I'll become a blank slate for the doctors to project their own biases and prejudices onto. That's the worst part of being a pain patient. It strips you of your dignity and self-worth.¹⁵

Of course, why providers sometimes fail to treat patients' pain and suffering eludes any one answer. This article will suggest that one possible mechanism among many factors is the pervasive and subtle moral disengagement of providers. The theory of moral disengagement describes the social cognitive processes that allow individuals who view themselves as moral to engage in immoral behavior.¹⁶ Moral disengagement allows individuals to behave inconsistently with their internal moral framework.¹⁷ The theory has been applied to settings ranging from capital punishment to business misconduct, but to date, not to the day-to-day treatment of patients in a health care setting.¹⁸

¹⁴ See generally, James R. Detert et al., *Moral Disengagement in Ethical Decision Making: A Study of Antecedents and Outcomes*, 93 J. APPLIED PSYCHOL. 374 (2008) (studying the role of moral disengagement in organizations and offering suggestions to unveil moral disengagement in decision making).

¹⁵ INST. OF MED., *supra* note 9, at 1.

¹⁶ Albert Bandura, *Moral Disengagement in the Perpetration of Inhumanities*, 3 PERSONALITY & SOC. PSYCHOL. BULL. 193, 193 (1999).

¹⁷ *Id.*

¹⁸ A few articles have considered the role of moral disengagement in medical care surrounding extreme acts of inhumanity such as capital punishment, treatment of terrorists, and apartheid. See Paul Gready, *Medical Complicity in Human Rights Abuses: A Case Study of District Surgeons in Apartheid South Africa*, 6 J. OF HUM. RTS. 415 (2007); Jerome Amir Singh, *Treating War Detainees and Terror Suspects: Legal and Ethical Responsibilities of Military Physicians*, 172 MILITARY MED. 15 (2007). A greater body of work applied moral disengagement to settings completely removed from health care. See, e.g., Vicki L. Baker et al., *Moral Disengagement in Business School Students: Predictors and Comparisons*, Academy of Management - Best Conference Paper (2006) (examining the individual correlates of moral disengagement in adults including locus of control and perspective taking ability); Detert et al., *supra* note 14, at 374; Craig Haney, *Structural Aggravation: Moral Disengagement in the Capital Trial Process*, in DEATH BY DESIGN: CAPITAL PUNISHMENT AS SOCIAL PSYCHOLOGICAL SYSTEM 141-161 (2005) (applying moral disengagement to the processes of jurors in death penalty cases); Marianne M. Jennings, *Moral Disengagement and Lawyers: Codes, Ethics,*

Of the patients treated day to day, it is a relatively open secret that providers find dealing with patients in pain challenging.¹⁹ Nonetheless, my personal experiences as a provider and with providers confirm that providers are overwhelmingly motivated to act to maximize benefit and minimize harm to their patients.²⁰ Yet, upon reflection, most providers can recall more than a few instances when they were less than fully present, engaged, and empathetic with the patients in their charge.²¹ Most of us can even recall times when our decisions caused unintended harm to patients. Yet, widespread harm can and does occur without intention.

This article advances that subtle and unconscious processes cause harm to patients in pain through the operation of moral disengagement. Yet, the process of moral disengagement is not intentional; it is not based in deliberate or even conscious decision making or behaviors. Yet, its operation allows providers to reconcile or justify less than optimal (or unethical) treatment of patients.

In the undertreatment of pain, over time moral disengagement

Conscience and Some Great Movies, 37 DUQ. L. REV. 573 (1999); Donald P. Judges, *The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement*, 41 HOUS. L. REV. 515 (2004); Robert J. Kelly, *Moral Disengagement and the Role of Ideology in the Displacement and Diffusion of Responsibility among Terrorists*, in NEGOTIATING RESPONSIBILITY IN THE CRIMINAL JUSTICE SYSTEM, 113–134 (Jack Kamerman ed., 1998); Stavros P. Kiriakidis, *Moral Disengagement: Relation to Delinquency and Independence from Indices of Social Dysfunction*, 52 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 571 (2008); Celia Moore, *Moral Disengagement in the Process of Organizational Corruption*, 80 J. BUS. ETHICS 129 (2008); Scott Vollum et al., *Moral Disengagement and Attitudes about Violence toward Animals*, 12 SOC'Y & ANIMALS 209 (2004) (analyzing survey research of Texas residents on attitudes toward animal violence under a framework of moral disengagement).

¹⁹ See, e.g. ATUL GAWANDE, *COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE* (2003); C. May et al., *Framing the Doctor-Patient Relationship in Chronic Illness: A Comparative Study of General Practitioners' Accounts*, 26 SOC. OF HEALTH & ILLNESS 135, 151 (2004).

²⁰ In this I include actions that are harmful but whose benefits outweigh the burdens—such as the harm associated with cutting open a patient's abdomen to remove a ruptured gallbladder.

²¹ This article adopts the definition of empathy employed by Jodi Halpern as neither detached reason nor sympathetic emersion. Instead, it is the skill of listening “using emotional associations to provide a context from imagining the distinct experiences of another person.” According to Halpern, “to empathize more accurately, physicians need to strive to be self aware, thus avoiding projecting their own unacknowledged emotions onto patients.” JODI HALPERN, *FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE*, Preface XV (Oxford Univ. Press 2001).

may become an unconscious but ingrained component of a regular pattern of providing care. Further, moral disengagement may operate in synergy with other biases and barriers that lead providers to inadequately treat pain.

One modest goal of this article is to ask organizations and providers to reflect on the possible role of moral disengagement in the undertreatment of pain.²² Insight into this mechanism and the associated cognitive processes may lead to new strategies by organizations and individuals that make providers less able to utilize it in neglecting treatable pain.

In addition, the application of moral disengagement to the problem of pain treatment may be a first step in exploring the role that it and other social cognitive processes may play in the day-to-day ethical lapses that impact patient care. This article explores just one possible contribution to the continued disconnect between the obligation to alleviate pain and the evidence that clinical practices often perpetuate the inadequate treatment of pain.

This article does not narrow in on any one type of pain or any one setting in which providers treat patients in pain. Rather, the goal here is to explore the question of whether moral disengagement may be involved in provider behavior that deprives patients of appropriate and adequate pain treatment of any type. If so, it is possible that future mechanisms to predict, prevent and remediate moral disengagement are discoverable.

This article will first provide an overview of the concept of pain, the current status of pain treatment, and the identified barriers to the appropriate treatment of pain in Section II. The relief of treatable pain and suffering as an ethical obligation and a public health problem will be discussed. Section III will review the social cognitive theory of moral disengagement and its application. Section IV will

²² Because of the limited research in this area, I will reference literature in areas of both acute and chronic pain. As Sandra Johnson explains in her article analyzing bad law claims, when relevant research is in short supply and there is no specific empirical research, such generalizations may be unavoidable. Nonetheless, I acknowledge that "this device suffers from the weakness of all generalizations: what one gains in simplicity of reference, one loses in complexity." Sandra Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 978 (2009).

apply the theory of moral disengagement in the healthcare setting to the inadequate treatment of pain. Section V will provide possible methods to ameliorate the moral disengagement of providers as well as recommendations for further study.

II. THE STATUS OF PAIN TREATMENT

A. Pain Conceptualized

"I am haunted by a monster inside me. I live in fear of waking the beast. When raging, it jabs spikes into my spine, and wraps stinging tentacles around my waist and down my leg. It's come close to breaking me in half, more than once. I hate the thing. And I fear it will stay forever, eating me like a parasite, for the rest of my days."²³

"Pain has plagued mankind since the beginning of time—it is one of the universal human experiences."²⁴ Pain is both universal and deeply personal. Everyone has experienced pain. No one has experienced my particular pain.²⁵ Providers encounter patients of all ages in pain and in literally every healthcare setting from the emergency department to long-term care.²⁶ Pain is the primary or most common complaint in many patient encounters.²⁷ Literally every provider treats patients in pain. In fact, pain may be the only patient complaint that every provider has also experienced. Yet, the reference is of mixed value because of the unique quality of pain. A

²³ Richard Johnson, PAIN EXHIBIT (artist statement of work symbolizing his pain) (on file with author).

²⁴ MARGO MCCAFFERY, *supra* note 4, at 3.

²⁵ See, e.g., Thomas Moore, *Foreword* to SCOTT FISHMAN & LISA BERGER, *THE WAR ON PAIN*, (2000). ("Each person in pain experiences that pain in a particular way that to him has a special meaning . . . it tends to be experienced as narrative.")

²⁶ See, e.g., NATIONAL PAIN CARE POLICY ACT OF 2009, H.R. REP. NO. 111-47, at 2 (2009) ("Pain is the most common reason Americans access the health care system and is a leading cause of disability and a major contributor to health care costs . . . one in every four Americans, have suffered from pain that lasts longer than 24 hours and millions more suffer from acute pain.")

²⁷ The three most common reasons given by adults for visiting the emergency department are stomach and abdominal pain, chest pain, and headache. CDC & NAT'L CTR. FOR HEALTH STAT., HEALTH, UNITED STATES, 2008: WITH SPECIAL FEATURE ON THE HEALTH OF YOUNG ADULTS 62 (2008), available at [http://www.cdc.gov/nchs/data/08.pdf](http://www.cdc.gov/nchs/data/hus/08.pdf).

provider will undoubtedly use their own individual pain experience to (possibly inaccurately) reference the patient's pain experience.

Because pain is multidimensional and multifaceted, an accurate and comprehensive definition of pain is elusive. Nonetheless, there are some general descriptions and definitions that have helped to categorize pain. The International Association for the Study of Pain defines pain as "[a]n unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."²⁸ Pain is also described temporally, such as whether it is acute or chronic; by the source of pain, such as cancer pain or neuropathic pain; or by a combination of these and other qualities.²⁹ Acute pain is sometimes said to be associated with acute or potential tissue damage while chronic pain has lost its biological function.³⁰ Yet, any perfect definition of pain is somewhat elusive. According to Jean Jackson, "the abundance of definitions, classifications and the disagreements contained in the writings of pain experts enlighten us best on just how difficult defining . . . pain is."³¹

Of the various concepts of pain, Margo McCaffrey's is robust because it acknowledges the experiential, subjective and multi-dimensional nature of pain. According to McCaffrey, "pain is whatever the experiencing person says it is, and exists whenever he says it does."³² Although every nurse trained in the last four decades can recite this concept at will, the reality of pain treatment illustrates the chasm between clinical knowledge and clinical practice.³³ For

²⁸ *Pain Terms*, INT'L ASS'N FOR THE STUDY OF PAIN, <http://www.iasp-pain.org/Content/NavigationMenu/GeneralResourceLinks/PainDefinitions/default.htm> (last visited Aug. 22, 2013).

²⁹ See, e.g., *Pain: Hope Through Research*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE http://www.ninds.nih.gov/disorders/chronic_pain/detail_chronic_pain.htm (last visited Jan. 25, 2013).

³⁰ See, e.g., Jean A. Jackson, *After a While No One Believes You: Real and Unreal Pain*, in *PAIN AS HUMAN EXPERIENCE: AN ANTHROPOLOGICAL PERSPECTIVE* 138, 140 (Mary Jo Delvecchio Good et al. eds., 1992).

³¹ *Id.* at 141.

³² MARGO MCCAFFREY, *NURSING MANAGEMENT OF THE PATIENT WITH PAIN* 11 (1979) (citing to her 1968 edition at p. 95). The definition, first coined in 1968, was the first to describe pain as more than a simple biological variable or symptom of tissue damage.

³³ Margo McCaffery, *Nurses' Knowledge of Pain Assessment and Management: How Much Progress*

providers to take patients' reports of pain as seriously as McCaffrey suggests, they must be able to accurately process the information provided and empathize with the patient. As Vence Bonham explained, "[p]eople interpret and react to health symptoms, including pain, based on their life experiences and cultural norms."³⁴ Thus, providers' interpretations are formulated through the lens of their own backgrounds, values, experiences and interpersonal coping strategies.

Additional skill and thoughtfulness is required of providers when they encounter patients in pain, as they must rely almost completely on the patient's descriptions rather than on more objective measures.³⁵ They must be aware of and prepared to evaluate the experiences that frame their reaction. Yet, many providers do this every day. As Lous Heshusius explains of her many experiences with providers in describing her pain, "telling the same story to different doctors . . . led to helpful treatment . . . not because they heard something others had not but because they looked through different lenses themselves, listening to the same story with a different understanding of illness and healing."³⁶

In addition, patients must be able to adequately express their pain experience to providers. Yet, using words to express the experience of pain is a recurrent difficulty reported by patients.³⁷ According to one patient in chronic pain, "[i]n spite of working in the medical field for almost 25 years, I found it very difficult to express how my pain feels to anyone . . . [s]ometimes there are no words to

Have We Made?, 14 J. PAIN SYMPTOM MGMT. 175, 175-76 (1997). In fact, McCaffrey noted in a 1997 article that in the 1970s she believed the problem was attributable to a lack of education but later acknowledged that education had not corrected the problem of neglect of treatable pain.

³⁴ Vence Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and the Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS, 52, 52 (2001).

³⁵ See generally Eric Cassell, *The Nature of Suffering and the Goals of Medicine*, 306 NEW ENG. J. MED. 639 (1982); JODI HALPERN, *FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE* (Oxford Univ. Press 2001).

³⁶ LOUS HESHUSIUS, *INSIDE CHRONIC PAIN: AN INTIMATE AND CRITICAL ACCOUNT* 46 (ILR Press 2009).

³⁷ See, e.g., Heather Davulcu, *Eye of the Storm*, PAIN EXHIBIT ("My pain and isolation could not be expressed through words.") (on file with author).

explain.”³⁸ Another explained, “a subjective experience, physical pain . . . cannot be adequately communicated by traditional language.”³⁹

Further, many have acknowledged the need to carefully present themselves and their stories to providers in an attempt to adjust for the impact of the providers’ own perceptions and biases. Lynne Greenberg explains her rehearsed presentation and narrative, stating, “I realized the importance of my descriptions for the diagnosis and the cause of my pain . . . [I] had a legion of carefully crafted, nearly scientific narratives to explain my condition.”⁴⁰

The treatment of pain likely suffers from difficulties attendant in communicating and understanding the patient’s experience. However, patients and providers must continue to address the barriers of this matter of public health and ethical concern.

B. Pain Relief as an Ethical and a Public Health Issue

As a pain patient, I do not need my doctor to be my psychotherapist. However, a genuine attentiveness to my problems, a sense of empathy for what I am going through, a readiness to hear me—the things that my few fine doctors do for me—is that too much to ask for?⁴¹

The adequate treatment of pain implicates quality of life, health care outcomes, costs, and worker productivity. “Pain is a significant public health problem. Chronic pain alone affects at least 116 million U.S. adults. Pain reduces quality of life [and] affects specific population groups disparately.”⁴² Based on prevalence alone, pain is a matter of public health. It is the “most common reason Americans access the health care system and is a leading cause of disability and major contributor to health care costs.”⁴³ The adequate treatment of pain has value that extends far beyond the patient. Clinical practices

³⁸ See Christine Feterowski, *Artist Statement*, PAIN EXHIBIT (on file with author).

³⁹ See Deborah Gottheil Nehmad, *Artist Statement*, PAIN EXHIBIT (using random pain scale numbers in art work to communicate his frustration at the attempt to apply the objective scale to the pain experience) (on file with author).

⁴⁰ LYNNE GREENBERG, *THE BODY BROKEN: A MEMOIR* 42 (2009).

⁴¹ HESHUSIUS, *supra* note 36 (emphasis omitted).

⁴² INST. OF MED., *supra* note 9, at 5.

⁴³ Nat’l Pain Care Policy Act of 2009, H.R. REP. NO. 111-47, at 2 (2009).

in pain treatment have implications for public health and policy. "The total financial cost of pain to society . . . ranges from \$560 to \$635 billion."⁴⁴

"Effective pain management is a moral imperative, a professional responsibility, and the duty of people in the healing professions."⁴⁵ Clinical decisions that unnecessarily deprive a patient of adequate pain relief cause harm to the patient.⁴⁶ When providers do not treat a patient's pain adequately, it is a deviation from professional standards and obligations, by causing harm without a countervailing ethical justification.⁴⁷ That harm typically extends beyond the physical experience of pain to the psychological, emotional, and social realm, as well as to the community.⁴⁸

Scott Fishman has discussed the harm that some providers may cause by doing nothing or far too little to treat pain. "[W]hen someone is in pain, there is no risk-free option—including doing nothing. . . . [S]ome doctors still allow a patient to languish in pain, believing that on balance, such an experience isn't detrimental to the patient's health and well being."⁴⁹ David Morris has described undertreating pain as "dangerously close to the act of willfully inflicting it."⁵⁰

Whether or not providers can truly provide relief to the patient, they have an ethical obligation to be fully present with the patient, to display appropriate empathy, and to allow the patient to be heard.

⁴⁴ INST. OF MED., *supra* note 9, at 302-03 (evaluating costs based on two components: "(1) the incremental costs of medical care due to pain, and (2) the indirect costs of pain due to lower economic productivity associated with lost wages, disability days, and fewer hours worked." Estimates are in 2010 U.S. dollars.).

⁴⁵ *Id.* at 3.

⁴⁶ Scott M. Fishman, *Clinical Commentary* to LOUIS HESHUSIUS, *INSIDE CHRONIC PAIN: AN INTIMATE AND CRITICAL ACCOUNT* 135-36 (2009) (noting that "doing nothing" and "allowing someone to remain in pain has risks" of pain, and "there is usually something, if not many things, we can do when someone is in pain that has less risk than allowing them to remain in pain").

⁴⁷ *Id.* (noting that the "fundamental philosophy in medicine" of "first do no harm" may be violated by allowing a patient to unnecessarily remain in pain).

⁴⁸ *See id.* at 132.

⁴⁹ Fishman, *supra* note 46, at 135.

⁵⁰ DAVID MORRIS, *THE CULTURE OF PAIN* 191 (1991).

This is too rarely emphasized as a clinical and ethical obligation. According to Scott Fishman, “[i]n a medical world more committed to solving the crime than comforting the afflicted, the individual in pain confronts a system that has wandered far from its fundamental promise to patients of curing when we can, but always treating suffering.”⁵¹

Expecting providers to work to be fully present, empathize with their patients, and treat suffering is a worthwhile and reasonable goal for which writers such as Eric Cassell, Jodi Halpern, and John Abbott Worthley have advocated.⁵² According to Halpern, “[t]o empathize more accurately, physicians need to strive to be self-aware, thus avoiding projecting their own unacknowledged emotions onto patients.”⁵³ Halpern describes “empathy in terms of a listener using her emotional associations to provide a context for imagining the distinct experiences of another person.”⁵⁴ This requires effort by the provider and a commitment to engage in the interaction. Yet, Halpern explains, “missing important emotional cues from patients wastes time, leading to missed diagnoses, inadequate treatment adherence, and inadequate understanding of patients’ values in the face of tough medical decisions.”⁵⁵

To truly impact the health of patients, providers must strive to be fully present not only during the dramatic scenarios of which bioethics case studies are made. Instead, providers must strive to be attentive and present in their ordinary day-to-day interactions with patients. As Worthley has advanced, the seemingly small judgments, decisions, and statements of providers can profoundly impact the suffering of patients.⁵⁶ This is particularly true for patients

⁵¹ Fishman, *supra* note 46, at 131–32.

⁵² See, e.g., JODI HALPERN, FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE (2001); ERIC CASSELL, DOCTORING: THE NATURE OF PRIMARY CARE MEDICINE 162 (1997); ERIC CASSELL, THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE (Oxford Univ. Press 2nd ed., 2004); JOHN ABBOTT WORTHLEY, THE ETHICS OF THE ORDINARY IN HEALTH CARE (1997).

⁵³ HALPERN, *supra* note 52, at XV.

⁵⁴ *Id.*

⁵⁵ *Id.* at XIV.

⁵⁶ WORTHLEY, *supra* note 52 (contending that “ethics is largely, although by no means exclusively, a micro phenomenon in the daily ordinary routine of healthcare professionals . . .

suffering with pain.⁵⁷ Usually pain can be accurately evaluated and appropriately treated.⁵⁸ Even when little can be done for a patient in pain, a provider who is fully present and empathetic can reduce the associated suffering.⁵⁹

Untreated or undertreated pain often causes harm beyond the patient to her family and support system. The consequences of the inadequate treatment of pain can be devastating to their families. For Kakima's family, "the pain of her illness and the apparent aloof indifference of the medical practitioners had left an indelible impression."⁶⁰

Ultimately, neglect of treatable pain implicates public health concerns.⁶¹ According to Scott Fishman, "[s]ociety is clearly saying—and rightfully so—that we've got a public health crisis of undertreated pain. Patients are demanding care, and doctors are being pushed to the frontline of this problem."⁶² How providers behave in treating patients in pain has implications that ripple far beyond the patient alone. Yet, there is continued evidence that treatable pain is undertreated and neglected.⁶³

C. Providers Continue to Neglect or Minimize Treatable Pain

"While the future will be full of more weapons against pain, they will only be as valuable as our shared commitment to utilize them. The

. that requires active reflection and skillful analysis").

⁵⁷ See, e.g., ARTHUR FRANK, *THE WOUNDED STORYTELLER* 8 (1997) ("Years after her hospitalization and treatment, she can still describe what happened in exquisite detail: she calls the hurt caused by a nurse's casual comment as if it had been spoken yesterday.").

⁵⁸ See, e.g., CASSELL, *supra* note 52, at 162 ("The pain may be subjective, but the report of pain is a thing that can be evaluated.").

⁵⁹ See, e.g., HESHUSIUS, *supra* note 36, at 61 (describing a certain patient's perspective of an interaction with his doctor: "He had nothing to offer, and I felt badly for him...I know you don't have the answers either," I said. He quietly responded, 'But I can listen.' Immediately, I experienced a certain calmness. I felt relieved. Here was a doctor acknowledging that, indeed, he did not have the answer either. But he spoke the truth. He would listen. And he did.").

⁶⁰ Komesaroff, *supra* note 1, at 196.

⁶¹ See INST. OF MED., *supra* note 9, at 5.

⁶² Fishman, *supra* note 46, at 142.

⁶³ See Megan Crowley-Matoka et al., *Problems of Quality and Equity in Pain Management: Exploring the Role of Biomedical Culture*, 10 PAIN MED. 1312, 1313 (2009).

enemy in the war on pain is not just disease but also indifference.”⁶⁴

Evidence of inadequate treatment exists for patients of all ages in both acute and chronic pain. According to Tait et al., “an abundant literature attests to the clinical difficulties faced by patients with pain; . . . health care providers tend to under-assess, underestimate, and undertreat their symptoms. These patterns . . . have been found across a range of settings . . . [and] across a range of painful conditions.”⁶⁵ For example, a 2007 expert consensus statement revealed that up to 50% of older adults have chronic pain but that pain is “often overlooked, under-assessed, and misassessed, especially among seniors with dementia.”⁶⁶ Pain treatment in children of all ages remains suboptimal according to the American Pain Society.⁶⁷ Problems with inadequate pain management are evident across the general health care system and within the Veteran’s Affairs Health System.⁶⁸

The undertreatment of pain cuts across provider groups as well. A nurse described the problem in Tilda Shalof’s memoir this way: “the patient under-complains, the doctor under-prescribes the nurse under-administers—it all adds up to pain control worth diddly-squat.”⁶⁹ Physicians tend to undertreat as well as underestimate pain.⁷⁰ Surgeons underestimated the patient’s subjective reports of pain in one study in more than two-thirds of patients.⁷¹ Studies of patterns of nursing administration have demonstrated a tendency of

⁶⁴ SCOTT FISHMAN & LISA BERGER, *THE WAR ON PAIN* 268 (2000).

⁶⁵ Tait et al., *supra* note 9, at 11–12.

⁶⁶ Thomas Hadjistavropoulos et al., *An Interdisciplinary Expert Consensus Statement on Assessment of Pain in Older Persons*, 23 *CLINICAL J. PAIN* S1, S1 (2007).

⁶⁷ Am. Pain Soc’y & Am. Acad. of Pediatrics Position Statement, *The Assessment and Management of Acute Pain in Infants, Children and Adolescents* (2001), available at <http://pediatrics.aappublications.org/content/108/3/793.full> (last visited Mar. 1, 2013).

⁶⁸ See Crowley-Matoka et al., *supra* note 63, at 1313.

⁶⁹ TILDA SHALOF, *A NURSE’S STORY: LIFE, DEATH AND IN-BETWEEN IN AN INTENSIVE CARE UNIT* 327 (2004).

⁷⁰ See, e.g., Ying Xue et al., *Pain Attitudes and Knowledge Among RNs, Pharmacists, and Physicians on an Inpatient Oncology Service*, 11 *CLINICAL J. ONCOLOGY NURSING* 687, 692 (2007) (finding physicians tended to believe their patients over-reported pain).

⁷¹ Shahrokh C. Bagheri et al., *Comparison of Patient and Surgeon Assessments of Pain in Oral and Maxillofacial Surgery*, 36 *CAL. DENTAL ASS’N* 43, 50 (2008).

nurses to under-medicate their patients. In one study, 21% of nurses would begin treatment by administering a lower dose of pain medication than *even the lowest ordered dose*.⁷² Even emergency services workers, such as emergency medical technicians, tend to underestimate pain.⁷³

The continuing problem of inadequate treatment of pain persists despite decades of pervasive clinical research and education that should have empowered providers to optimally treat pain. Yet, in this area, knowledge does not align with the realities of clinical practice. While progress has certainly occurred, there is consistent evidence that providers continue to minimize and even disbelieve patient reports of pain, fear regulatory and licensure actions, and disparately treat pain based on a number of biases. Further, there is some evidence that increased professional experience tends to decrease provider's empathy for and trust of patients reporting pain.⁷⁴ Despite decades of research and education, pain remains undertreated for patients of all ages and in all settings.

Of course, the reasons for the continued inappropriate treatment of pain are multifactorial, complex, and context-dependent. Many interconnected barriers to adequate pain treatment have been identified and range from simple mistaken knowledge to ingrained racial, gender, or cultural biases and may originate from providers, institutions, or even the patients themselves.⁷⁵ Barriers that originate from providers include bias to, disbelief of, or mistrust of patients, and are well demonstrated in the literature.⁷⁶ These barriers have

⁷² Debra B. Gordon et al., *Nurses' Opinions on Appropriate Administration of PRN Range Opioid Analgesic Orders for Acute Pain*, 9 PAIN MGMT. NURSING 131, 139 (2008) (emphasis added); but see Ruth A. Griffin, et. al., *Stereotyping and Nurses' Recommendations for Treating Pain in Hospitalized Children*, 30 RES. NURSING & HEALTH 655 (2007) (finding nurses rated pain consistent with children's reports and advocated for aggressive pain management).

⁷³ See Thomas J. Luger et al., *Acute Pain is Underassessed in Out-of-Hospital Emergencies*, 10 ACAD. EMERGENCY MED. 627, 629 (2003).

⁷⁴ See, e.g., Benita Wilson & Wilfred McSherry, *A Study of Nurses' Inferences of Patients' Physical Pain*, 15 J. CLINICAL NURSING 459 (2006); Ingrid Bergh et al., *Worst Experiences of Pain and Conceptions of Worst Pain Imaginable Among Nursing Students*, 61 J. ADVANCED NURSING 484 (2007).

⁷⁵ See, e.g., Carmen Green et al., *Disparities in Pain: Ethical Issues*, 7 PAIN MED. 530, 530 (2006).

⁷⁶ See, e.g., Megan Crowley-Matoka et al., *supra* note 63, at 1312.

been identified, studied, and where possible, addressed. Yet, the reality is that some patients continue to suffer.

The focus of this article is on those barriers originating from or furthered by providers. *It is an open secret that most providers find dealing with patients in pain, especially patients with chronic pain, difficult.*⁷⁷ Although provider attitudes have improved in the last forty years,⁷⁸ the simple reality is that providers sometimes make choices that contribute to the needless pain and suffering of patients.

Providers must rely on the clinical encounter and interactions with patients to evaluate pain. Sometimes to the detriment of patients, the provider's version of the medical encounter "becomes the one against which others are ultimately judged true or false, useful or not."⁷⁹ Judgments about pain occur mostly within the scope of patient-provider context interactions and "fall under the umbrella of social cognition: the study of how people make sense of other people and themselves."⁸⁰ A wide range of factors may influence and moderate how providers make judgments about their patients. These factors are generally "related to one of the three elements that are involved in an interaction . . . the observer who is making the judgment (provider), the target of the judgment (patient), and the situational features of the context within which the interaction occurs (clinical encounter)."⁸¹ Moral disengagement is a social cognitive process that operates in these three domains by focusing on the provider, the patient, or the situation.

At the same time, providers generally ascribe to personal and professional ethical norms that embrace the relief of suffering and the

⁷⁷ See, e.g., GAWANDE, *supra* note 19, at 117-118 (Picador 2002); see also THE PAIN COALITION, http://www.letstalkpain.org/pain_coalition/coalition.html ("healthcare professionals tell us they have serious concerns when treating pain, such as: whether they will be able to help manage the patients' pain appropriately; fears about contributing to substance abuse and addiction in society; and concerns about regulatory scrutiny. All of these concerns can affect the care and management of their patients who are in pain.").

⁷⁸ See, e.g., McCaffrey, *supra* note 32, at 5 ("[T]he patient with chronic pain was called a skilled manipulator, hostile, and both emotionally and financially unrewarding. It was also said that this type of patient tries to make the physician suffer pain.").

⁷⁹ See Frank, *supra* note 57, at 5.

⁸⁰ See Tait et al., *supra* note 9, at 13 (internal quotations omitted).

⁸¹ *Id.* at 14.

minimizing of harm.⁸² This article presupposes that providers want to help their patients by recognizing their dignity, minimizing harm and maximizing benefit. Yet, in some areas such as pain treatment, providers often fall short of those goals despite education, evidence, and policy efforts. The mechanisms of moral disengagement may provide a partial explanation.

III. MORAL DISENGAGEMENT THEORY

“The concept of moral disengagement was developed to help explain how people excuse themselves for inflicting suffering upon others.”⁸³ First described by Bandura, it is a social cognitive theory that describes the self-regulatory process used to reconcile conflicts between an individual’s internal moral standards and her conduct.⁸⁴ It allows individuals to maintain their own self-image as moral persons and to justify their otherwise harmful acts or omissions.⁸⁵ Moral disengagement also frees the actor from associated guilt or self-sanctions. According the Bandura, “people do not usually engage in harmful conduct until they have justified, to themselves, the morality of their actions.”⁸⁶ In fact, moral disengagement predicts unethical decision making.⁸⁷ Further, some people are simply more predisposed to moral disengagement.⁸⁸

Moral disengagement has been examined in a variety of settings.⁸⁹ For example, high levels of moral disengagement have

⁸² See, e.g., AM. MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml>; see also AM. NURSES ASS’N, Code of Nursing Ethics, available at http://nursingworld.org/ethics/code/protected_nwcoe629.htm#1.1.

⁸³ A. L. McAlister, *Moral Disengagement and Tolerance for Health Care Inequality in Texas*, MIND SOC. 25, 26 (2010).

⁸⁴ See, e.g., BANDURA, *supra* note 16, at 194.

⁸⁵ See, e.g., McAlister, *supra* note 83, at 26.

⁸⁶ Bandura, *supra* note 16, at 194.

⁸⁷ Detert et al., *supra* note 14, at 374.

⁸⁸ *Id.*

⁸⁹ A few articles have considered the role of moral disengagement in medical care surrounding extreme acts of inhumanity such as capital punishment, treatment of terrorists

been correlated with cyber bullying;⁹⁰ tolerance for inequities for access to healthcare;⁹¹ lying in an online environment;⁹² and as a precursor to antisocial behavior.⁹³ Although the theory has not yet been applied to the provision of health care, according to Detert, “moral disengagement tactics seem particularly applicable to organizations where individuals feel compelled to 1) follow the orders of authority figures and 2) where responsibility for harmful outcomes is often diffused to organizational teams.”⁹⁴ The description is particularly fitting for health care delivery systems where care is delivered by a hierarchy of professionals, each with particular authority to order and execute treatments but all working both individually and as “team members.”

Although the theory has not been extensively studied in day-to-day situations, according to Bandura, “it is by no means confined to extraordinary circumstances.”⁹⁵ Instead, moral disengagement

and apartheid. See Paul Gready, *Medical Complicity in Human Rights Abuses: A Case Study of District Surgeons in Apartheid South Africa*, 6 J. OF HUM. RTS. 415 (2007); Singh, *supra* note 18, at 15. A greater body of work applied moral disengagement to settings completely removed from health care. See, e.g., Baker et al., *supra* note 18 (examining the individual correlates of moral disengagement in adults including locus of control and perspective taking ability); Detert et al., *supra* note 14, at 374; Haney, *supra* note 18 at (applying moral disengagement to the processes of jurors in death penalty cases); Jennings, *supra* note 18 at 573–602; Judges, *supra* note 18; Kelly, *supra* note 18; Stavros P. Kirakidis, *Moral Disengagement: Relation to Delinquency and Independence from Indices of Social Dysfunction*, 52 INT’L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 571 (2008); Celia Moore, *Moral Disengagement in the Process of Organizational Corruption*, 80 J. BUS. ETHICS 129 (2008); Scott Vollum et al., *Moral Disengagement and Attitudes about Violence toward Animals*, 12 SOC’Y & ANIMALS 209 (2004) (analyzing survey research of Texas residents on attitudes toward animal violence under a framework of moral disengagement).

⁹⁰ See Chrise D. Pomari & Jane Wood, *Peer and Cyber Aggression in Secondary School Students: The Role of Moral Disengagement, Hostile Attribution Bias and Outcome Expectancies*, 36 AGGRESSIVE BEHAV. 81, 88–89 (2010).

⁹¹ Alfred L. McAlister, *Moral Disengagement and Tolerance for Health Care Inequity in Texas*, 9 MIND SOC. 25 (2010).

⁹² Charles E. Naquin et al., *The Finer Points of Lying On-line: Email Versus Pen and Paper*, 95 J. APPLIED SOC. 387 (2010).

⁹³ Luke W. Hyde et al., *Developmental Precursors of Moral Disengagement and the Role of Moral Disengagement in the Development of Antisocial Behavior*, 38 J. ABNORMAL CHILD PSYCHOL. 197 (2010).

⁹⁴ Detert et al., *supra* note 14, at 374.

⁹⁵ Bandura, *supra* note 16, at 205.

operates “in *everyday situations* in which decent people routinely perform activities that bring them profits and other benefits at injurious costs to others.”⁹⁶ Moreover, the process of moral disengagement is not all or nothing. Instead, individuals gradually disengage by initially performing mild acts that with repetition elicit less and less self-censure. Eventually, “acts originally regarded as abhorrent can be performed with little personal anguish or self-censure.”⁹⁷ The health care setting may be the perfect catalyst for day-to-day repetition of moral disengagement surrounding unethical behavior.

Moral disengagement theory is described in terms of three primary mechanisms: 1) sanitizing the act (cognitive reconstruction); 2) sanitizing the actor (minimizing the actor’s role in the harm); and 3) sullyng the target (focusing on the target of the act as unfavorable or deserving).⁹⁸ These mechanisms act in concert with one another to allow individuals to commit acts they would otherwise regard as unethical or immoral. Each of these mechanisms and sub-mechanisms are discussed below.

1. *Sanitizing the Act*

The first primary mechanism in moral disengagement is cognitive reconstruction of the act or sanitizing the act. Through this mechanism, the actor deflects culpability by reconstructing or reframing the act itself. Sanitizing the act is achieved through: a) moral justification, b) euphemistic labeling, and c) advantageous comparison.⁹⁹

a. **Moral Justification**

Moral justification focuses on the use of moral, social, or economic rationale to sanctify the behavior. In this process, “detrimental conduct is made personally and socially acceptable by

⁹⁶ *Id.* (emphasis added).

⁹⁷ *Id.*

⁹⁸ See Bandura, *supra* note 16, at 209.

⁹⁹ *Id.* at 194–96.

portraying it as serving socially worthy or moral purposes.”¹⁰⁰ Immoral acts can also be justified by economic value.¹⁰¹ “Viewing harmful activities as serving worthy ends not only eliminates any self-censure for performing them, but can even beget pride for doing them well.”¹⁰²

The classic, although extreme, example of moral justification is found in military conduct in combat. Killing is redefined, and violence is morally justified as necessary to preserving cultural values, fighting ruthless oppressors, preserving peace, or honoring country.¹⁰³ In a less extreme example, one study assessed moral justification in the tolerance for health care disparities with the statement: “too much government help makes people less willing to help themselves.”¹⁰⁴ In that case, the immorality of depriving health care to the economically disadvantaged was reframed as a social good for their benefit. In a 2009 study by White et al., the authors cite examples from chemical, lead, and tobacco industry of moral justification of corporate wrongdoing. For example, in addressing individual health concerns associated with chemical use on food, one company responded that “feeding the world will depend on the use of chemicals. . . . Chemicals are important for both protection and production of food.”¹⁰⁵ Harm to individuals is justified based on the greater good, necessity, or benefits in other areas.

b. Euphemistic Labeling

Euphemistic labeling uses sanitized language, passive style, or specialized jargon to make harmful conduct seem innocuous.¹⁰⁶ Sanitizing language is illustrated in the military through the terms

¹⁰⁰ *Id.* at 194.

¹⁰¹ Jenny White et al., *Moral Disengagement in the Corporate World*, 16 ACCOUNTABILITY IN RES. 41, 47 (2009) (“Moral, social and economic justifications are used to sanctify injurious products and practices and to challenge regulations.”)

¹⁰² *Id.*

¹⁰³ Bandura, *supra* note 16, at 195.

¹⁰⁴ Alfred McAlister, *Moral Disengagement and Tolerance for Health Care Inequities in Texas*, 9 MIND SOC. 25, 27 (2010).

¹⁰⁵ White, *supra* note 101, at 49.

¹⁰⁶ Bandura, *supra* note 16, at 195.

“waste” rather than “kill” and “collateral damage” rather than “civilian deaths.”¹⁰⁷ One tobacco company used the term “pharmacological satisfaction” instead of “addiction.”¹⁰⁸

Language can also serve to remove the agent from the act and exonerate the agent.¹⁰⁹ In one example, a driver who hit a telephone pole described it this way: “[T]he telephone pole was approaching. I was attempting to swerve out of its way, when it struck my front end.”¹¹⁰

Specialized jargon can also be used to sanitize an act. For example, during the Watergate scandal, criminal conspirators were “team players” engaged in a “game plan” rather than a conspiracy.¹¹¹ Together, these mechanisms work to cleanse acts of their immoral qualities.

c. Advantageous Comparison

Advantageous comparison uses a more egregious example to sanitize the act. Viewing conduct relative to more reprehensible acts exonerates the actor.¹¹² “The more flagrant the contrasting inhumanities, the more likely it is that one’s own destructive conduct will appear benevolent.”¹¹³ For example, the tobacco industry used advantageous comparison when addressing the dangers of secondhand smoke. Executives at one company recommended that secondhand smoke danger be favorably compared to more dangerous chemicals found in food pesticides and contaminated water.¹¹⁴

According to Bandura, the mechanisms involved in sanitizing the act, taken together, are the “most powerful set of psychological

¹⁰⁷ Albert Bandura, *Selective Moral Disengagement in the Exercise of Moral Agency*, 31 J. OF MORAL EDUC. 101, 104 (2002).

¹⁰⁸ White, *supra* note 101, at 50.

¹⁰⁹ Bandura, *supra* note 107, at 105.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Bandura, *supra* note 16, at 196.

¹¹³ *Id.*

¹¹⁴ White, *supra* note 101, at 51.

mechanisms for disengaging moral control.”¹¹⁵ Through these mechanisms, actors give moral purpose to their harmful acts, divest themselves of censure, and employ self-approval of their immoral actions.

2. *Sanitizing the Actor*

The second primary mechanism of moral disengagement is sanitizing the actor. Under this mechanism, the actor avoids culpability for the act by minimizing her own role in the harm. This is accomplished by: a) displacing or diffusing responsibility for the act(s), and b) disregarding or distorting the consequences of the act(s).¹¹⁶

a. **Displacing or Diffusing Responsibility**

Whenever acts are characterized as necessary because of organizational or regulatory requirements, responsibility is displaced. Individuals do not feel personally responsible for their actions when they see the act as required by authorities.¹¹⁷ This is illustrated by the notorious Milgram experiments in which some participants agreed to inflict harm on others as long as the researcher agreed to take responsibility for the acts.¹¹⁸ An extreme example is the willingness of Nazis to commit atrocities under the guise of “just following orders.”¹¹⁹

Diffusion of responsibility can take several forms, all of which allows diminished personal accountability. Diffusion can be achieved by a division of labor, group decision making, and collective action.¹²⁰ When labor is divided, “people shift their attention from the morality of what they are doing to the operational details and efficiency of their specific job.”¹²¹ Group decision making allows

¹¹⁵ Bandura, *supra* note 16, at 196.

¹¹⁶ Detert et al., *supra* note 14, at 374, 375.

¹¹⁷ Bandura, *supra* note 16, at 196.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.* at 198.

¹²¹ *Id.*

“everyone” and, therefore, “no one” to be responsible for immoral conduct.¹²² Collective action allows any particular harm to be attributed to others.¹²³

b. Disregarding or Distorting the Consequences

Disregarding or distorting consequences allows individuals to disengage from their immoral acts. If the harm inflicted can be ignored, distorted, or disbelieved, self-censure is not activated.¹²⁴ “It is easier to harm others when their suffering is not visible and when injurious actions are physically and temporally remote from their effects.”¹²⁵ For example, a customer may not report a monetary error in her favor because the big company won’t be affected by a relatively small amount of money.¹²⁶ The tobacco, mining, and lead industries all engaged in distorted and disregarding consequences of the harm of chemicals in their respective industries by denying the ill effects, discounting the science involved, and calling for further studies.¹²⁷ In organizations, the hierarchical structures facilitate this mechanism of disengagement. Those in the middle of the structure have the easiest time disengaging because they “neither bear responsibility for the decisions nor do they carry them out and face the harm being inflicted.”¹²⁸

3. Sullyng the Victim

Finally, sullyng the victim is achieved by: a) dehumanizing, disparaging, or denigrating the victim; and b) attributing blame to the victim because of her behavior, psychosocial, or biological differences.¹²⁹ “The strength of moral self-censure depends on how

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.* at 199.

¹²⁶ Detert et al., *supra* note 14, at 376.

¹²⁷ White et al., *supra* note 101, at 56–61.

¹²⁸ Bandura, *supra* note 16, at 199.

¹²⁹ Detert et al., *supra* note 14, at 376; Bandura, *supra* note 107, at 108.

the perpetrators regard the people they mistreat.”¹³⁰

a. Dehumanizing the Victim

“[Perceiving] another in terms of common humanity activates empathetic emotional reactions through perceived similarity and a sense of social obligation.”¹³¹ Causing harm to another viewed as fully human will illicit guilt and self-sanctions. Conversely, viewing someone as less than fully human makes it easier for individuals to harm them. “It is easier to brutalize people when they are viewed in low animal forms, as when Greek torturers referred to their victims as ‘worms.’”¹³² Referring to others in non-human terms such as “gooks,” “savages,” and “degenerates” is also a form of dehumanization.¹³³ According to Bandura, in concentration camps, victims had to be degraded as subhuman “so that those who operated the gas chambers would be less burdened by distress.”¹³⁴ Even more alarming, combining diffused responsibility with dehumanization results in greater willingness of actors to behave punitively.¹³⁵

b. Attributing Blame to the Victim Based on Differences

Viewing immoral acts provoked or compelled by the victim allows individuals to, often self-righteously, avoid culpability. Blaming the victim allows perpetrators to view themselves as faultless and “driven to injurious conduct by forcible provocation; . . . [v]ictims then get blamed for bringing suffering on themselves.”¹³⁶ Differences can serve as the basis for such disengagement by working in synergy with out-group membership and us-versus-them thinking.¹³⁷ Harm is more likely when “others have been cast as

¹³⁰ Bandura, *supra* note 107, at 108.

¹³¹ Bandura, *supra* note 16, at 200.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.* at 203.

¹³⁷ See Detert et al., *supra* note 14, at 376.

worthy of derogation or even lacking in human qualities.”¹³⁸

IV. MORAL DISENGAGEMENT AND PATIENTS IN PAIN

“The nurse has considerable power and responsibility with respect to the treatment of pain. In her position of power, the nurse may facilitate or inhibit the treatment of pain.”¹³⁹

To date, no research has focused on the possible role of moral disengagement in the inadequate treatment of pain. However, when viewed through the lens of the mechanisms of moral disengagement, both existing research in pain and public accounts point to the possible moral disengagement of providers from actions that cause further harm to patients in pain.

A. Sanitizing the Act of Undertreating Pain

Providers can disengage from their act of inadequately treating pain by sanitizing the act itself. This can be achieved through moral justification, euphemistic labeling, and advantageous comparison.

Moral justification frames the actions as serving greater moral, societal, or economic purposes. Areas possibly implicated in pain control are the concerns surrounding addiction and diversion of prescription drugs. Provider actions in depriving patients of adequate pain medication may be framed as founded in the need to save the patient from addiction or save society from the ills of drug diversion or abuse. While there are legitimate reasons for concern about diversion and addiction, these concerns are often overblown and used to justify the irrational denial of relief to patients in pain.¹⁴⁰

¹³⁸ *Id.* at 376.

¹³⁹ McCaffery, *supra* note 4, at 6.

¹⁴⁰ There are, of course, real concerns surrounding diversion and addiction that I do not attempt to minimize by also claiming that those concerns are sometimes used as an excuse or justification to deprive patients of pain relief. For example, there is concern surrounding the rise in deaths resulting from the misuse of opioids. See, e.g., Morbidity and Mortality Weekly, *Quickstats: Number of Poisoning Deaths Involving Opioid Analgesics and Other Drugs or Substances-United States*, 59 CENTER FOR DISEASE CONTROL & PREVENTION 1026 (1999-2007) Aug. 20, 2010. These concerns, however, must be balanced with the need to continue to adequately treat patients in pain. See, e.g., PAIN & POLICY STUDIES GRP., *ACHIEVING BALANCE IN STATE PAIN POLICY, A PROGRESS REPORT CARD*, 2008, available at

Physicians report that concerns surrounding diversion results in fewer prescriptions, lower doses, and fewer refills of pain medication for patients with either cancer or non-cancer-related pain.¹⁴¹

Some physicians and pharmacists express unfounded concerns about addiction or drug abuse despite adequate information about disease process.¹⁴² There is also a general overestimation of addiction among providers.¹⁴³ Sometimes providers even fail to adequately manage cancer pain because of “needless fears of addiction.”¹⁴⁴ It is not uncommon in practice for providers to prematurely take patients in pain off of opioids and justify it as better than allowing the patients to develop tolerance or addiction.¹⁴⁵

Patients in pain tell stories of difficulties in treatment being justified based on societal or moral reasons. One patient in pain tells a story of having to repeatedly reschedule her appointments for the “benefit of others.” She explained “each time I call my doc for help . . . she puts me off and makes me set a new appt . . . we have to make room for patients with acute illness . . . my depression and anxiety are getting worse and I feel my doc doesn't care.”¹⁴⁶ Another describes being denied his baseline dosage of pain medications for moral reasons in the hospital. “I was living on 25% of normal meds after the bladder surgery. My pain Dr. (sic) is on staff of that hospital. . . . He fought to get me what I needed but between the urologist and the nurses I was

www.painpolicy.wisc.edu.

¹⁴¹ See, e.g., PAIN & POLICY STUDIES GRP., *supra* note 140, at 10; see also Jenny J. Lin et al., *Physician Attitudes Toward Opioid Prescribing for Patients with Persistent Noncancer Pain*, 23 CLINICAL J. OF PAIN 799 (2007) (finding internists were more likely to be concerned about illegal diversion, addiction and inability to prescribe a correct dose than geriatricians).

¹⁴² PAIN & POLICY STUDIES GRP., *supra* note 140, at 10; Lin et al., *supra* note 141.

¹⁴³ PAIN & POLICY STUDIES GRP., *supra* note 140, at 10; Lin et al., *supra* note 141.

¹⁴⁴ See, e.g., Aaron M. Gilson, *The Concept of Addiction in Law and Regulatory Policy Related to Pain Management*, 26 CLINICAL J. PAIN 70 (2010); R.J. Moore et al., *Communicating Suffering in Primary Stage Head and Neck Cancer*, 13 EUR. J. CANCER CARE 53, 60 (2004).

¹⁴⁵ This was a common practice in my experience even with patients who had just undergone major surgeries. One physician with whom I worked had a set rule for type and amount of pain medication that could be prescribed that was enforced regardless of patient background, type of surgery, size or other contextual factors.

¹⁴⁶ See Micke Brown, *Pain 101: An Introduction to Pain for Patients and Caregivers*, question from Trebclf1011, AM. PAIN FOUND., <http://www.painfoundation.org/learn/library/chat-transcripts/pain-101.html> (last visited Apr. 12, 2010) (emphasis added).

still not given what I need. *Everybody in that hospital had to say that they thought it was wrong for me to be on so much meds.*"¹⁴⁷

Others describe either fear of or actually being taken off of effective pain medications indiscriminately by doctors who believe doing so is justified by larger concerns unsupported by the pain literature. For example, one patient described the experience this way: "I don't tell people anything. They say 'how's your pain?' and I say 'I've learned to live with it' . . . only those doctors that I now know I can trust would I ever even discuss what I do to manage my pain. . . ." ¹⁴⁸ Another said, "I don't tell my family doctor because when I told him he said "[g]et off that garbage."¹⁴⁹

Patients in acute pain often have their pain needs relegated to other health concerns that may not be justified. For example, one patient recalled a refusal to treat by a provider in the emergency room who said, "We can't treat you for pain because we would be treating the symptom rather than the problem."¹⁵⁰ Regarding some of his first experiences as a provider in the emergency room, Paul Austin recalled watching an experienced resident, Kyle, treat a patient's injuries while ignoring his pain. He explained:

Mr. Meyers grunted, still hurting. Kyle didn't seem to notice. . . . I envied [Kyle's] casual confidence, but wondered how he could be so oblivious to the man's pain. . . . Kyle had known exactly what to do. . . . But damn, he'd seemed so callous. I wondered if he had been like that before he started, or if medical school and internship had done it to him. And if med school could change people that much, did I really want to go?¹⁵¹

From the patient perspective, Lynne Greenberg recounts her first memories after a car accident, enduring multiple procedures without even topical anesthetic:

¹⁴⁷ AM. PAIN FOUND., chat room, post by bwilliams, transcript on file with author (emphasis added).

¹⁴⁸ April Vallerand & LuAnn Nowak, *Chronic Opioid Therapy for Nonmalignant Pain: The Patient's Perspective. Part I – Life Before and After Opioid Therapy*, 10 PAIN MGMT. NURSING 165, 169 (2009).

¹⁴⁹ *Id.*

¹⁵⁰ INST. OF MED., *supra* note 9, at 32.

¹⁵¹ PAUL AUSTIN, SOMETHING FOR THE PAIN: COMPASSION AND BURNOUT IN THE ER 33 (W.W. Norton & Company, Inc. 2008) (emphasis added).

I awoke to a torture chamber of cures. A team of doctors was cleansing and stitching up my wounds. Screaming, I tried to writhe away from the several nurses who were holding me down. The doctors . . . would not give me pain medication, even a topical numbing agent, until they had identified my injuries. The doctors took for granted that I should endure my leg being sewn back together—the prick and shudder of thread as it sliced through my skin—at the same time as they gouged pieces of glass out of my face and set my two shattered arms with no anesthesia, manipulating and yanking the bones into alignment. It was the night I first learned the many faces of pain, his different guises, sensations, and methods, and how clever he is at shape-shifting.¹⁵²

Also prevalent in clinical care is euphemistic labeling, another mechanism of moral disengagement that sanitizes the act. Euphemistic labeling uses sanitized or passive language or specialized jargon to cloak immoral acts. An example of passive language comes from *Inside Chronic Pain*, by Lous Heshusius. The author described a physician's reaction after he caused her serious pain with an unannounced, unnecessary, and rough examination. The physician's passive apology was, "Sorry I *had* to hurt you,"¹⁵³ rather than, "I'm sorry that hurt." Language surrounding lowering pain doses, changing, or stopping medication is often sanitized. For example, patients are "weaned" or "tapered" rather than "taken off" medications. Patients are "transitioned" to other drugs. Physicians who under-prescribe may insist they are engaging in "responsible prescribing" or "risk mitigation."¹⁵⁴

Advantageous comparison uses a more egregious example to sanitize the act. For example, the physician who lowers a patient's medication dosage might say, "At least I didn't completely discontinue your medications like Dr. X did." Providers who under-prescribe might expect patients to be grateful that they do not deny them drugs altogether, like many other providers. Several nurses I worked with were fond of depriving patients of pain relief, even in the acute phase of injury, on the premise that it would better prepare them for the realities of the rehabilitation setting.

¹⁵² LYNNE GREENBERG, *THE BODY BROKEN: A MEMOIR*, xii (Random House 2009).

¹⁵³ HESHUSIUS, *supra* note 36, at 71.

¹⁵⁴ See Aaron M. Gilson, *The Concept of Addiction in Law and Regulatory Policy Related to Pain Management, A Critical Review*, 26 *CLINICAL J. PAIN* 70, 75 (2010).

B. Sanitizing the Provider who Undertreats Pain

The second primary mechanism of moral disengagement is sanitizing the actor. Here, the provider is able to disengage by minimizing her own culpability for the immoral act. This is accomplished by either displacing or diffusing responsibility or by distorting the consequences of the act.

Whenever acts are characterized as necessary because of organizational or regulatory requirements, responsibility is displaced. For example, physicians who refuse to provide effective opioid therapy may displace responsibility for their actions to the law or regulatory agencies, such as the DEA or state licensing boards. Sandra Johnson writes, “[b]laming the law is a particularly powerful source of control because it diverts attention from the real decision maker. . . . It does so in a fashion that creates an assumption of both good will and powerlessness on the part of the patient's dear doctor.”¹⁵⁵ According to the Pain and Policy Studies Group at the University of Wisconsin, physicians report that they prescribe lower doses and quantities and give fewer refills because of regulatory scrutiny.¹⁵⁶ Yet all available evidence supports the idea that regulatory scrutiny is hardly a reality.¹⁵⁷ Perhaps just part of the reason that fears of regulatory scrutiny continue to take the blame for inadequate pain treatment is the exercise of moral disengagement. Displacing responsibility for these decisions to regulatory authorities simply reduces or eliminates provider culpability.

Patient accounts further support the idea that the responsibility for inadequate pain treatment is displaced to the law or regulatory requirements.¹⁵⁸ According to one patient's wife, “My husband is a (lung and brain) cancer survivor, but as a result of his treatments, he

¹⁵⁵ Johnson, *supra* note 22, at 993.

¹⁵⁶ See, e.g., Donald M. Goldenbaum et al., *Physicians Charged with Opioid Analgesic-Prescribing Offenses*, 9 PAIN MED. 737, 745 (2008). But see, Sandra H. Johnson, *Assessing Legal Risk*, 9 PAIN MED. 748 (2008) (“This consistent evidence-based message cannot compete with the grapevine and news headlines of the rare horror story.”).

¹⁵⁷ PAIN & POLICY STUDIES GRP., *supra* note 141.

¹⁵⁸ See, e.g. AM. PAIN FOUND., chat room post from October 18, 2005, on file with author (“how do you get docs to let go of litigation paranoia and personal judgments that you are only wanting drugs?”) (pain clinic capping doses of pain meds across the board).

suffers from long term chronic pain. His doctors start him out on pain meds, then quickly take him off them because they are afraid of losing their license, at which time he suffers a great deal.”¹⁵⁹ Another patient said “I have been a chronic Pain patient for many years due to numerous physical injuries . . . I am, and have been UNDERTREATED by a PM doc who must work for the DEA as every time we discuss meds, he tells me he cannot increase my meds due to their ‘oversight’.”¹⁶⁰

Nurses may displace responsibility for undertreating pain to the patient’s physician’s lack of adequate orders or may blame hospital policy for arbitrary adherence to administration of pain medication. The “I’m just a nurse” excuse can be used to exonerate the nurse of moral culpability whenever her actions are dependent, to some extent, on physician orders. Further, culpability may be displaced by hospital or health system policy. For example, a hospital with a large population of “drug-seeking” patients who asked for IV Demerol by name simply took it off of the hospital formulary.¹⁶¹ This action allowed nurses and doctors to displace the blame to the hospital for not providing the patients with the one drug that, in their opinion, provided relief.

The health care system itself is ripe for diffusion of responsibility. A patient in pain may depend on a host of professionals and paraprofessionals to execute appropriate care and treatment. For example, one patient may depend upon adequate and appropriate physician orders for pain medication and therapy, a secretary to properly record the orders, a pharmacist to accurately deliver medications, the institution to have the proper formulary of medications and supportive administrative policies, a nurse to execute the orders successfully and accurately, as well as therapists to

¹⁵⁹ Debra Sutton, Comment to *Addiction, Pain and Public Health website and the War on Docs/Pain Crisis blog*, <http://doctordeluca.com/wordpress/> (last visited June 17, 2013).

¹⁶⁰ Paul Tamaaro, Comment to *Addiction, Pain and Public Health website and the War on Docs/Pain Crisis blog*, <http://doctordeluca.com/wordpress/> (last visited June 17, 2013).

¹⁶¹ Sometime in the mid 2000s, Saint Louis University Hospital removed IV Demerol from its formulary because of the large population of patients in sickle cell crisis that requested it as the only drug that provided them with relief. The population was viewed as “drug seeking” and difficult to deal with, and taking the drug off of the formulary allowed the providers to honestly tell them that Demerol was not an option.

provide physical or occupational therapy. The modern-day structure of health care specialization, coupled with many regulatory barriers to interdisciplinary practice, often leads to diffusion of responsibility. According to one patient, "Is it too much to ask that we, the patients, no longer be bound to a system where no one professional takes responsibility for the patient—a system of unbelievable referrals with unscientific, unproven treatments (and hope) sold to the patient by each referring physician."¹⁶² When everyone can be potentially responsible, no one person need be morally responsible.

Finally, providers can sanitize the act of not relieving pain by disregarding the extent of the harm and the consequences of undertreatment. The harm of not relieving treatable pain is alleviated if providers do not really believe patient reports of pain and the associated suffering. Unfortunately, the literature supports the idea that pain is infrequently "what the patient says it is." According to a nursing faculty member, "I teach students as most faculty do, that 'pain is what the patient says it is.' But when I bring them into the clinical arena they *see in real practice that nurses and doctors disbelieve the patients' complaints and treat them as drug seekers.*"¹⁶³ In general, providers tend to underestimate pain when compared with patient reports and harbor a general tendency to disbelieve patients in pain.¹⁶⁴ One nurse described her disbelief of patients by saying, "sometimes there are people here that aren't here for a real reason. They're here because they're seeking medication. . . . [Y]ou get an understanding for who's in pain and who's not."¹⁶⁵ A few providers I knew would watch patients without their knowledge to judge whether they acted like they were "really" in pain. One patient explained her experience with disbelieving providers saying, "I have

¹⁶² INST. OF MED., *supra* note 9, at 115.

¹⁶³ *Id.* at 295 (emphasis added).

¹⁶⁴ See, e.g., Judy Watt-Watson et al., *Relationship Between Nurses' Pain Knowledge and Pain Management Outcomes for Their Postoperative Cardiac Patients*, 36 J. ADVANCED NURSING 535 (2001) (For example, only 47% of patients reporting moderate to severe pain received all of their ordered analgesia from the nurses in the study.); Lena Gunningberg & Ewa Idvall, *The Quality of Postoperative Pain Management From the Perspectives of Patients, Nurses and Patient Records*, 15 J. NURSING MGMT. 756 (2007).

¹⁶⁵ Laurie M. Lauzon Clabo, *An Ethnography of Pain Assessment and the Role of Social Context on Two Postoperative Units*, 61 J. ADVANCED NURSING 531, 535 (2007).

. . . found some practitioners who could ‘read the tea leaves,’ so to speak, and TELL ME how much pain I must be in.”¹⁶⁶ “[P]ain assessment is only the first step; it is what is done with that information that makes a difference to patients.”¹⁶⁷

As Atul Gawande explained, “When doctors encounter a patient who has chronic pain without physical findings to account for it . . . we tend to be dismissive . . . we’re apt to conclude, [it] is all in the head: not a physical pain but a different somehow less real, ‘mental’ pain.”¹⁶⁸ This concept of the “visible” and “real” pain verses invisible, less real pain is well illustrated by a story included in a study by Douglas and colleagues. A patient with both multiple sclerosis and chronic pain finds her providers more receptive to treatment when she uses a cane, or as she puts it, a “[s]ympathy stick.”¹⁶⁹ She explained, “I actually did an experiment with . . . my doctors. I have a walking stick . . . and I went in one day [without the stick] . . . and he gave me a really hard time to get a script. I went and saw him about 4 weeks later and I had my stick with me – wrote out the script no problems.”¹⁷⁰

Perhaps in no other area of clinical care has the concept of trust of the patient been more examined. Unfortunately, patients in pain often bear the burden of a presumption that they are worthy of mistrust.¹⁷¹

One patient reports, “Since 1991 I have been dealing with mistrust in motives for seeking pain care. Most doctors I encountered did not believe that my pain was severe enough to warrant more than ibuprofen.”¹⁷² According to Ben Rich, “patients . . . who seek treatment that may involve the prescribing of opioid analgesics must

¹⁶⁶ INST. OF MED., *supra* note 9, at 59 (emphasis in original).

¹⁶⁷ *Id.* at 141.

¹⁶⁸ GAWANDE, *supra* note 19, at 117–18 (Picador 2002).

¹⁶⁹ Clint Douglas et al., *Understanding Chronic Pain Complicating Disability: Finding Meaning Through Focus Group Methodology*, 40 J. NEUROSCI. NURSING 158, 163 (2008).

¹⁷⁰ *Id.*

¹⁷¹ See, e.g., Scott M. Fishman, *Trust and Pharmaco-Vigilance in Pain Medicine*, 6 PAIN MED. 392 (2005); Ben Rich, *The Doctor as Double Agent*, 6 PAIN MED. 393 (2005).

¹⁷² INST. OF MED., *supra* note 9, at 295.

convince their treating physician . . . that they are 'trustworthy.'"¹⁷³ One patient recalled "I went through a lot of doctors, as many of us have, who were either not knowledgeable enough about my condition, doubted the severity of my pain, called me a drug seeker or just plain didn't care."¹⁷⁴ In Werner's work with patients in chronic pain, "[a] common feature of many of the illness stories . . . are descriptions of their own strength (both [sic] physical, mental, and emotional) and a negative attitude to the talk of illness as 'whining and complaining'. . . . [T]hey tell how hard they have had to work to be taken seriously, believed, and understood in medical encounters."¹⁷⁵

"When someone is in pain, her or his mind and body are inextricably linked and there is at least some degree of suffering."¹⁷⁶ The harm associated with the inadequate pain treatment is not limited to continued pain and suffering. A significant delay can actually lead to the development of chronic pain syndromes, such as reflex sympathetic dystrophy or post-herpetic neuralgia.¹⁷⁷ If providers do not believe patient reports of pain, they thereby minimize the self-sanctions through moral disengagement of the harm associated with their actions.

C. Sullyng the Patient in Pain

"If I asked for prescription pain relief, I was treated like a common criminal. It was a terrible time in my life."¹⁷⁸

Moral disengagement can also succeed when the patient is sullied such that otherwise immoral actions are stripped of their moral significance. Providers may disparage, denigrate, and dehumanize the patient or attribute blame to them because of

¹⁷³ Rich, *supra* note 171, at 393.

¹⁷⁴ AM. PAIN FOUND., posted Aug. 26, 2009 (on file with author).

¹⁷⁵ Anne Werner et al., 'I am Not the Kind of Woman who Complains of Everything': *Illness Stories on Self and Shame in Women with Chronic Pain*, 59 SOC. SCI. & MED. 1035, 1038 (2004) (emphasis added).

¹⁷⁶ Fishman, *supra* note 46, at 132.

¹⁷⁷ INST. OF MED., *supra* note 9, at 296 (treatment within the first six months with nerve blocks and related therapy can prevent long-term symptoms).

¹⁷⁸ *Id.* at 142 (quotation from person with chronic pain to a committee survey).

psychosocial or biological differences.

Name calling is a very common way patients in pain are disparaged, denigrated, and dehumanized. Patients asking for better pain treatment are often called names such as babies, whiners, drug seekers, and drug addicts. It is not uncommon to hear patients referred to as “pain trolls,” a term that is dehumanizing in attributing non-human status to the patient. One patient explained it this way, “I have been told to ‘suck it up’. . . . I have been accused of being a ‘druggy.’”¹⁷⁹ Another patient described a trip to the emergency room for acute pain:

I was in such bad pain. . . . I was 100% up front about all known health issues and meds. After a [CT] and a pain shot which helped for 10 mins, I was sobbing and shaking due to pain! 3 hours later I told my nurse that something was wrong and please get [the doctor]. 45 minutes later he came in and said I was fine, [CT] “normal”. . . . I begged for [a] test to find out what was going on, Nope I must be [an] addict!! I never felt so Helpless! After 6 weeks of Horrific pain and endless test[s], I went to a surgeon who took 2 mins to pull the [CT] from [ER]! . . . My appendix full of stones, diverticulitis And a gall bladder that folded in half! . . . I have [a syndrome] which causes joint dislocations and connective tissue problems, GI issues among other things. . . . So me taking a few pains pills during the day when my joints dislocate should [not] merit not treating new complications! So now I’m worrying about pain control after surgery!¹⁸⁰

A 2010 New York Times story about the experiences of a terminally ill woman in pain included an illustrative example of how even very sick cancer patients are sometimes disparaged. “During one hospitalization . . . she had asked for intravenous Dilaudid, a strong opioid, for “10 out of 10” pain. She was labeled a “drug seeker” by the medical staff, she said—perhaps because she was asking for the drug by name—as if she were an addict craving crack.”¹⁸¹

The nursing literature has addressed to some extent the moral

¹⁷⁹ *Id.* at 59.

¹⁸⁰ broken :(, Comment to *Addiction, Pain and Public Health website and the War on Docs/Pain Crisis blog*, <http://doctordeluca.com/wordpress/comment-page-2/#comments> (last visited June 17, 2013).

¹⁸¹ Anemona Hartocollis, *Helping Patients Face Death, She Fought to Live*, N.Y. TIMES, April 4, 2010, at A1.

work of resisting, labeling, and disparaging patients. In a study by Varcoe and colleagues, several nurses reflected on these incidents saying, for example, "I see staff judging patients and saying they were addicts without any real knowledge. . . . [E]thically . . . you have to choose whether it is worthwhile to try to sort of ameliorate that discrepancy."¹⁸² Another nurse recounted giving a patient pain medication after other staff refused on the basis that the patient was "drug dependent." Thereafter, the nurse reported that both she and the patient suffered poor treatment by the other staff members.¹⁸³ Scott Fishman, among others, has addressed the tendency of physicians to label and disparage patients in pain. He explains this way:

[W]hen people feel uncomfortable and vulnerable because they don't know what to do, they may either blame themselves or blame the customer. . . . And sadly because pain elicits so many emotional reactions, it's not hard to find a reason to blame that customer, which happens time and time again. *That's why patients feel we are stigmatizing them by labeling them as either "nuts" or as seeking "secondary gain."* By labeling a patient, the person treating the patient . . . asserts his or her belief that that patient's primary complaint isn't valid and that the patient is essentially a fake. Taking such a position *makes it easy for the clinician to relinquish responsibility* to get the patient better. So when we label the patient it may say more about us than them.¹⁸⁴

Moral disengagement can also operate through sullyng the patient by attributing blame based on the patient's differences. Disparities in pain treatment based on gender, sex, age, socioeconomic status, race, and ethnicity are well established.¹⁸⁵

¹⁸² Colleen Varcoe et al., *Ethical Practice in Nursing: Working the In-Betweens*, 45 J. OF ADVANCED NURSING 316, 321 (2004).

¹⁸³ *Id.*

¹⁸⁴ Fishman, *supra* note 46, at 137-38.

¹⁸⁵ See, e.g., Diana J. Burgess et al., *Understanding the Provider Contribution to Race/Ethnicity Disparities in Pain Treatment: Insights from Dual Process Models of Stereotyping*, 7 PAIN MED. 119, 119 (2006); Miriam O. Ezenwa et al., *Racial and Ethnic Disparities in Pain Management in the United States*, 38 J. NURSING SCHOLARSHIP 225 (2006); Carmen Green et al., *Disparities in Pain: Ethical Issues*, 7 PAIN MED. 530 (2006); Carmen Green et al., *The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain*, 4 PAIN MED. 277 (2003); Janet Kaye Heins et al., *Disparities in Analgesia and Opioid Prescribing Practices for Patients With Musculoskeletal Pain in the Emergency Room*, 32 J. EMERGENCY NURSING 219 (2006); Joshua H. Tamayo-Sarver et al., *The Effect of Race/Ethnicity and Desirable Social Characteristics on Physicians' Decisions to*

Characteristics such as race or ethnicity coupled with the presence of complaints of pain on the patient's chart may trigger the anticipation of a difficult encounter for providers. Further, physicians are often less communicative, less open to patient participation, and more likely to cut the encounter short when dealing with patients who are non-white or low income.¹⁸⁶ In the end, "physicians are more likely to mislabel problems that originate in the social and economic sphere as negative characteristics of the patients themselves."¹⁸⁷

For patients in pain, this attribution of blame coupled with known biases in opioid prescribing practices puts them at a "double-disadvantage."¹⁸⁸ "[I]n the context of pain management, the particular fears surrounding opioids intersect powerfully with existing biases toward non-white patients, which may range from the blatant (as more likely to be drug addicted . . .) to more subtle (as simply less easily understood, and thus less easily trusted)."¹⁸⁹ Overall, patients are sometimes blamed for not getting better and for not trying to improve.¹⁹⁰

Providers sometimes dehumanize, denigrate, and blame patients in pain. It is possible that these actions allow them to avoid moral self-sanctions that would normally be associated with causing the harm of continued pain and suffering. Coupled with mechanisms that sanitize the provider, those that sanitize the act and sully the victim may be an expression of ongoing moral disengagement of providers to the harm caused by failing to relieve treatable pain. Overall, moral disengagement may be operating, in part, to allow the continued undertreatment of pain.

Prescribe Opioid Analgesics, 10 ACAD. EMERGENCY MED. 1239 (2003); Arvind Venkat et al., *The Impact of Race on the Acute Management of Chest Pain*, 10 ACAD. EMERGENCY MED. 1199 (2003).

¹⁸⁶ See Crowley-Matoka et al., *supra* note 63, at 1312, 1316–17.

¹⁸⁷ *Id.* at 1317.

¹⁸⁸ *Id.* at 1315–18.

¹⁸⁹ *Id.* at 1317.

¹⁹⁰ See, e.g., LYNNE GREENBERG, *THE BODY BROKEN: A MEMOIR* 43–44 (Random House 2009) ("One supremely unsympathetic neurologist, a self-proclaimed headache specialist, shook her head sadly, repeatedly proclaiming...'[y]ou really have to want to get better.' I left thinking that I had caused a hopeless situation by not trying hard enough to improve. Another neurologist . . . discounted my pain and concluded that nothing serious ailed me . . . Get a tooth mold and get out of bed.")

V. RECOMMENDATIONS

"With my fine few doctors, I have never experienced a sign of disbelief, a lack of patience, a being bored with my incurable pain."¹⁹¹

No empirical research exists on the possible connection between moral disengagement and health care delivery or the neglect of treatable pain. Nonetheless, the mechanisms of moral disengagement fit nicely within some of the patterns common to the under-treatment of pain. Thus, an empirical examination would be useful in exploring what role, if any, moral disengagement plays in the failure of some providers to neglect treatable pain.

Previous work in moral disengagement may be useful in guiding strategies to prevent further moral disengagement of providers. For example, work by Detert and colleagues revealed traits that correlate positively with a person's tendency for moral disengagement.¹⁹² They found that individuals who were more empathetic and those with strong moral identity were less likely to morally disengage. In contrast, chance locus of control (believing experiences are due to chance and forces outside their control) is positively related to moral disengagement as was trait cynicism (underlying distrust of others).¹⁹³ This research may be useful in guiding employment practices and well as shaping training and other programs. For example, education and training to enhance empathy and minimize cynicism may be particularly helpful in minimizing moral disengagement.

A 2012 study by Moore et al. introduced an adult-oriented and easy-to-administer measurement scale for the propensity to morally disengage.¹⁹⁴ In addition, the researchers compared the propensity to morally disengage with a number of other psychological constructs.¹⁹⁵ They found that moral disengagement was positively correlated with relativism and Machiavellianism and

¹⁹¹ HESHUSIUS, *supra* note 36, at 79.

¹⁹² Detert et al., *supra* note 14, at 374.

¹⁹³ *Id.*

¹⁹⁴ Celia Moore et al., *Why Employees do Bad Things: Moral Disengagement and Unethical Organizational Behavior*, 65 PERS. PSYCHOL. 1 (2012).

¹⁹⁵ *Id.* at 35.

negatively correlated with moral identity, empathy, cognitive moral development, idealism, and dispositional guilt.¹⁹⁶ The group also demonstrated that moral disengagement was a strong and consistent correlate of unethical behavior; *possibly the strongest individual difference predictor of unethical behavior to date.*¹⁹⁷

Employers and organizations may opt to use the scale developed by Moore et al. to determine those individuals most likely to disengage and develop remediation programs in response. At least some evidence suggests that moral disengagement is “malleable to external influences over time.”¹⁹⁸ In addition, organizational leaders and educators could develop a number of strategies to increase individual accountability and lessen the tendency to displace or diffuse responsibility or to assign blame to others.¹⁹⁹ These strategies could be built into specific programs directed at health care organizations and providers.

The scale developed by Moore et al., coupled with an examination of provider responses to patients in pain, may provide useful information into the operation of moral disengagement in health care and, specifically, in the treatment of pain.

Certainly, all evidence suggests that many providers remain morally engaged and present with their patients. In research by Nettleton, the primary determinant of whether a provider was good or bad was his or her attitude and manner. Patients were “extremely positive when practitioners had listened to them and appeared to accept that they were unwell and in need of ongoing support.”²⁰⁰

Patients who are suffering crave acknowledgment more than magical cures. In fact, one of the findings of the Institute of Medicine’s report on pain was the need for the health care system and providers to treat pain in context, based on the individual patient, and to develop care that is patient-centered, comprehensive,

¹⁹⁶ *Id.*

¹⁹⁷ *Id.* (emphasis added).

¹⁹⁸ *Id.* at 40 (citing Paciello et al., *Stability and Change of Moral Disengagement and its Impact on Aggression and Violence in Late Adolescence*, 79 *CHILD DEV.* 1288 (2011)).

¹⁹⁹ *Id.* at 40–41.

²⁰⁰ S. Nettleton, *I Just Want Permission to be Ill: Towards a Sociology of Medically Unexplained Symptoms*, 62 *Soc. Sci. & Med.* 1167 (2006).

and interdisciplinary.²⁰¹ Lous Heshusius explained an extremely positive encounter with a doctor who had no treatment to offer:

I know you don't have the answers either," I said. He quietly responded, "But I can listen." Immediately, I experienced a certain calmness. I felt relieved. Here was a doctor acknowledging that, indeed, he did not have the answer either. But he spoke the truth. He would listen. And he did.²⁰²

VI. CONCLUSION

This article explores moral disengagement as a contributing factor in the continued reality that clinical practices often perpetuate the inadequate treatment of pain. This may be a first step in examining the role that moral disengagement plays in the day-to-day ethical lapses that negatively impact patient care. Further empirical work is needed that examines: 1) the propensity for health care providers to morally disengage; 2) the association of that propensity with unethical behavior; and 3) the prevalence of these mechanisms. Research on the potential of individuals to alter the degree and process of disengagement and the effectiveness of remediation strategies could influence organizational and institutional approaches to prevention, education, and organizational structure. In addition, answers to these questions may require new approaches to legal and regulatory systems.

²⁰¹ INST. OF MED., *supra* note 9, at 164 ("Pain assessment should focus on soliciting a careful history of the pain experience, the impact of pain on functioning and quality of life and emotional suffering, and the patient's goals and values.").

²⁰² HESHUSIUS, *supra* note 36, at 79.