

Improving Pain Management Through Policy Making and Education for Medical Regulators

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Physician concern about regulatory scrutiny as a barrier to appropriate prescribing for pain management has been identified and studied.¹ A 1991 Pain Research Group survey demonstrated a need to provide updated information about opioids and pain management to state medical board members.² Indeed, a national survey even showed a need to provide more education about pain management to oncology physicians.³ Two approaches for responding to these concerns have been undertaken in several states by the state medical boards and the pain management community: (1) the development and adoption of administrative policies designed to bring disciplinary standards in line with clinical practice; and (2) the creation of education programs for state medical board members and staffs. Each can have a substantial impact on removing real and perceived regulatory barriers to effective pain relief.

Guidelines

State medical boards have a duty to protect the public from improper prescribing, but they also have an interest in promoting public health. Although the use of opioid analgesics to manage chronic noncancer pain is being reassessed clinically and scientifically,⁴ some state medical boards have already recognized and responded to the need to clarify their policies regarding prescribing for pain.⁵ Policy making and clarification by the boards themselves, especially when produced through collaboration with the pain management community, can significantly contribute to harmonizing clinical practice and regulatory policy.

In some instances, boards have adopted guidelines on

the use of controlled substances in pain management to address inappropriate uses of opioids and unprofessional prescriptive practices. More recently, however, some boards have begun using guidelines to address physicians' fear of board investigation or discipline for prescribing opioids for chronic noncancer pain. Indeed, respondents to the 1991 national survey of U.S. medical board members supported a call for medical boards to clarify their policies. Most members who were surveyed said, at that time, they would discourage a physician from prescribing opioids for a patient with chronic noncancer pain, and approximately one-third said they would investigate the practice as a potential violation of law.⁶

Medical board guidelines vary considerably. The attitudes of medical boards toward the use of opioids ranges from "It is generally accepted in current medical therapy that it is inappropriate to treat nonmalignant pain with narcotics on a routine basis"⁷ to "[T]he Board recognizes that opioid analgesics can also be useful in the treatment of patients with intractable nonmalignant pain especially where efforts to remove the cause of pain or to treat it with other modalities have failed."⁸

The conditions and qualifications in medical board policies on opioid use also vary considerably. The pain management community may not support some provisions, such as: a requirement that two physicians diagnose intractable pain; the recommendation or requirement of "drug holidays";⁹ the use of undefined terms such as *addict* or *habitué*; or restrictions on prescribing to the entire class of people who use drugs nontherapeutically, even if they have pain.

In 1993, the Medical Board of California (MBC) undertook a review of "malprescribing." A special task force on appropriate prescribing heard testimony that physicians avoid prescribing controlled substances, including "tripli-

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cate” drugs,¹⁰ for patients with intractable pain out of fear of discipline by MBC.¹¹ As will be illustrated, MBC then took several actions to emphasize that it supports appropriate prescribing of opioids for pain, including intractable pain.

MBC initially provided information about the then new Agency for Health Care Policy and Research clinical practice guidelines on acute and cancer pain to all state physicians and encouraged them to apply the guidelines in clinical practices. MBC cosponsored the California Summit on Effective Pain Management held in 1994,¹² which recommended that the triplicate prescription system be replaced with a less invasive and more efficient system. Further, MBC adopted a proactive policy statement, “Prescribing Controlled Substances for Pain,”¹³ and announced that it would publish guidelines to help physicians avoid investigation when they used opioids to manage intractable pain. The resulting guidelines¹⁴ were issued in 1994 and have been used as a model by other medical boards.

The new California guidelines were constructed on the fundamental principles that guide professional medical practice, as generally recognized by medical boards. The MBC guidelines do not establish specific prescribing or pain management parameters; rather, they afford California physicians a framework within which a physician may prescribe without concern about interference from regulatory agencies. Drafts of the guidelines were reviewed by medical and legal experts, adopted unanimously by MBC, and disseminated to all California physicians. The American Pain Society (APS) endorsed the California guidelines in 1995.¹⁵

Subsequent to the development of the MBC guidelines, complementary guidelines were adopted by the boards of nursing and pharmacy.¹⁶ Similar guidelines were then adopted by the medical boards in Florida,¹⁷ North Carolina,¹⁸ and Washington.¹⁹ Further guidance for state policy is contained in the recently approved “Consensus Statement on the Use of Opioids for the Treatment of Chronic Pain,” available from the American Academy of Pain Medicine and APS.²⁰ This statement was developed by a joint task force of the two organizations chaired by Dr. J. David Haddox.

Legislation

Legislative activity has also led to policy addressing pain management; it presents special risks. Some benefits might be gained from legislation in increased public and professional awareness that opioids can legitimately be used to treat chronic pain. Legislation may also help to ease some physicians’ fears of ultimate disciplinary action, though perhaps not board investigation and its attendant legal costs. However, standards of medical practice would be established by elected officials, for example, who may or may

not involve organizations that represent medicine and science in the drafting process. Opening the door to legislative consideration of medical issues must be carefully considered because this process is political and complex, and the consequences are difficult to foresee. A serious concern is whether legislatures and some regulatory boards might even further restrict rather than expand access to opioids for chronic pain management. Conversely, some policies focus exclusively on use of opioids and fail to acknowledge the legitimate use of nonpharmacological methods of pain management.

Unfortunately, some specific restrictions could create problems for good clinical practice if they are uniformly applied or enforced. These restrictions include: (1) defining medical use of opioids for intractable pain as a therapy of last resort (as is the case in many current intractable pain statutes); (2) application of intractable pain treatment acts to all intractable pain patients, including those with cancer; (3) implying that opioids may be used for pain only in cases where the cause of pain *cannot* be removed; (4) excluding pain patients who use drugs for nontherapeutic purposes; (5) requiring an evaluation of every patient by a specialist in the organ system believed to be the cause of pain; and (6) requiring a signed informed consent form in every case where controlled substances are used to relieve pain.

State legislatures will probably continue to consider intractable pain policy. With the national focus on assisted suicide likely to return to the states following the United States Supreme Court decision,²¹ state legislators may become even more interested in legislative action to improve pain management. With the development of model pain legislation by the American Medical Association,²² it is possible that state and local medical societies will become interested in such legislation. Professional pain organizations should closely monitor the development of state pain policy and provide information and assistance to their elected representatives.

Alternatively, once a particular state has identified inadequate treatment of pain as a problem, a state pain commission could be established. Such a commission could enlist the assistance of other state agencies, could produce a careful study of the problem, and could guide the development of a variety of needed responses,²³ including educational programs and administrative policy making. This process can provide a foundation for change. However, the greatest risk with government studies is the lack of funding for follow-up and implementation.

Education for medical boards

Discussions of the findings of the 1991 survey of medical board members with the Federation of State Medical Boards of the United States (FSMB) led to cooperative efforts to

sponsor educational workshops, "Pain Management in a Regulated Environment."²⁴ The workshops provided various state medical boards with an educational forum in which to review and discuss advances in knowledge and practice and to develop board guidelines concerning the appropriate medical use of opioids in pain management and related disciplinary policy. Six workshops were presented between 1993 and 1996: one for the Alabama Board of Medical Examiners in 1993, four regional workshops for board members from various state medical boards in 1994 and 1995, and one for the North Carolina Board of Medical Examiners in 1996. A total of 125 board members attended these workshops, and they represented thirty-two state medical boards and approximately 20 percent of the total number of board members. The seminars were sponsored by FSMB in cooperation with the Pain Research Group (now the Pain & Policy Studies Group). Members of APS and the American Society for Addiction Medicine served as faculty.

Such workshops may stimulate a change in policy. For example, following these workshops, the medical boards in Alabama and North Carolina developed and disseminated new guidelines for prescribing controlled substances for pain.²⁵ In most cases, the purpose of these post-seminar guidelines has been to clarify that the medical board accepts use of opioids to manage chronic noncancer pain. They also outline each board's basic expectations of prescribers.

Conclusion

Medical board guidelines, like intractable pain treatment statutes and regulations, can encourage better management of intractable pain. Guidelines vary from state to state, and some ultimately restrict appropriate prescribing. Before medical boards issue new guidelines for prescribing opioids for intractable pain, they should evaluate the situation in their state and systematically review the issues, seeking advice from experts who can provide accurate information about current clinical practice and pharmacology. New guidelines, if needed, should reflect current knowledge about pain management and permit flexibility in the management of patients with intractable pain. The present positive dialogue that is developing among medical boards, pain clinicians, and addiction specialists should be enhanced in order to ensure the development of rational and consistent intractable pain treatment guidelines at the state level.

In our experience, professional licensing boards are keenly interested in improving public health. As the demand for better pain management increases and medical boards learn about medical advances in pain management, they may revise their disciplinary policies. But these revisions should take place systematically and in consultation with members of the pain management community.

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