

# In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?

Ann M. Martino

A decade ago, conventional wisdom in the medical establishment was that physicians treating chronic pain with opioid analgesics were at a substantial risk of being sanctioned for overprescribing by state medical regulatory boards.<sup>1</sup> Dozens of articles written since have alluded to this risk as an obstacle to effective pain relief.<sup>2</sup> In the early 1990s, a number of high profile cases in which physicians were disciplined by regulatory boards for overprescribing to patients with chronic pain were reported in the press. Although the board actions in many of these cases were eventually overturned by state judiciaries, the publicity heightened practitioners' sensitivity to the regulatory risks associated with prescribing opioids.<sup>3</sup>

A review of the available data on state medical board actions nationwide for the period from 1990 to 1996 reveals that the perception of regulatory risk far exceeds the reality. Indeed, relatively few (less than 5 percent) of the disciplinary actions taken for overprescribing by state medical boards in any given year directly concern the treatment of chronic pain—malignant or nonmalignant—in patients.<sup>4</sup> Nonetheless, as the question of how to manage chronic pain more effectively received greater attention in the popular press and professional journals, many state policy-makers made efforts to institute policies that further reduce what is, despite perceptions to the contrary, already a minimal regulatory risk.<sup>5</sup>

Between 1988 and 1997, thirty-three states enacted laws (intractable pain treatment acts (IPTAs)), adopted administrative rules, and/or established guidelines for the use of narcotic analgesics for the treatment of chronic pain. These mechanisms vary considerably in nature and substance,<sup>6</sup> though all were designed to provide physicians

with some measure of regulatory relief by reducing the real and perceived risks of being subjected to regulatory sanctions for treating pain with opioids.

Most state IPTAs establish that opioid analgesics have legitimate, therapeutic uses for the treatment of chronic pain; some also provide physicians who prescribe these drugs for pain with immunity from disciplinary action as long as there is a legitimate, therapeutic reason for the prescription. By contrast, the administrative rules and/or regulations adopted by state medical boards take the form of a practice standard, or a set of requirements, that a physician who prescribes opioids for chronic pain *should* meet to avoid board sanctions or to comply with the provisions of a state's IPTA. Guidelines generally serve similar purposes, although they often allow more flexibility and provide fewer guarantees, because they do not have the legal force of statutes, rules, or regulations.

Initially, these efforts to achieve regulatory relief received high praise. But today, second-guessing has begun, particularly among those who study chronic pain management, and with good reason: the early data—both hard and anecdotal—strongly suggest that fear of regulatory reprisal continues to be the reason physicians most frequently cite for not providing adequate treatment for chronic pain.<sup>7</sup>

Why has regulatory relief—the chronic pain laws, guidelines, and administrative rules instituted by state medical boards in the last decade—failed to alter significantly the perception of risk?<sup>8</sup> It may be, as Sandra Johnson has observed, because there is at least a minimal risk of being disciplined by a state medical board for overprescribing and no risk for being sanctioned for underprescribing.<sup>9</sup> Physicians are sometimes sanctioned, albeit in small numbers, for overprescribing. However, there are no cases on record, by any state or federal medical regulatory entity, in which a physician has been subject to medical board disci-

*Journal of Law, Medicine & Ethics*, 26 (1998): 332–49.

© 1998 by the American Society of Law, Medicine & Ethics.

pline for underprescribing.<sup>10</sup>

The absence of disciplinary actions for underprescribing has not gone unnoticed. Last year, Kirk Robinson, president, and Kathryn Tucker, director of legal affairs, for the Oregon-based organization Compassion in Dying, sent a memorandum to every medical board in the United States arguing that dying patients have a right to adequate pain medication. Although the focus of the memorandum was end-of-life care, Compassion in Dying outlined a series of steps for each state medical board to follow to address the perceived risks for overprescribing and the absence of any risk—real or imagined—for underprescribing to any patient experiencing pain. For example, the memorandum urged that underprescribing be adopted as a ground for discipline. In addition, Compassion in Dying put the boards and the public on notice that it was willing to assist chronic pain patients and their families in making complaints and/or in filing suits against practitioners who fail to provide adequate pain relief by underprescribing.<sup>11</sup>

As will be discussed in the final section of this article, Compassion in Dying has made good on this promise, but to no avail. Indeed, a year after it distributed the memorandum, not a single medical board has reported taking a disciplinary action against a licensee based on an allegation that a patient received inadequate treatment with opioid analgesics.

In short, the conventional wisdom still holds: the regulatory risks associated with overprescribing are perceived by most physicians to be real and far greater than those associated with underprescribing. Regulatory relief has not changed this perception and might have strengthened prevailing norms.<sup>12</sup> As one physician noted in an interview:

Doctors are asking for reassurance, not more rules or laws. Even the best intentioned of them [laws and rules], create only more fears in the minds of doctors trying to do their best, and place more ammunition in the hands of lawyers and regulators! Doctors will avoid the treatment of pain, so as not to take the chance of “not being in compliance” with some minor detail in a law or guideline that is supposed to encourage the treatment of pain.<sup>13</sup>

This view persists because it reflects what will be described later as an ethic of “underprescribing,” an ethic that is multi-level, multifaceted, and remarkably resilient to change.

### **The causes of underprescribing**

While these Drugs (opioids) are safe and effective if taken as directed, they can be misused beyond the level prescribed, if they are taken more frequently or for a longer period than recommended. Misuse or abuse of these drugs can produce a variety of unto-

ward health consequences including drug dependence, overdose and death.<sup>14</sup>

The regulatory relief effort of the last ten years, although undeniably flawed,<sup>15</sup> was built on the premise that undertreatment of pain is a public health problem. As an extension of this premise, there is growing consensus that the reluctance of health care practitioners to use narcotic analgesics fully for therapeutic purposes has exacerbated the scope and impact of the undertreatment problem.

So much has been written and said about the underutilization of narcotic analgesics for the treatment of chronic pain that underuse is taken as a given. For example, a routine search of the holdings of a major state university library, conducted in conjunction with this study, located over 125 journal and periodical articles and eighteen books dealing with the topic. A content analysis of all the articles and fifteen of the books revealed a widely shared and growing consensus in the medical and scientific communities,<sup>16</sup> the law, social sciences, and humanities,<sup>17</sup> and the popular press<sup>18</sup> that inadequate treatment of chronic pain is the rule in the United States and most developed nations.<sup>19</sup> This view is so pervasive that professional journal articles supporting a more cautious/conservative approach to the use of narcotic analgesics—for example, law enforcement and addiction specialists—generally acknowledge that inadequate pain treatment is a problem, but the scope of the problem has been overstated.<sup>20</sup>

There is also an impressive body of literature, which includes a significant number of clinical studies, that provides compelling evidence that opioid analgesics can and should be used to treat chronic pain.<sup>21</sup> Though some disagreement exists about how liberally these drugs should be prescribed,<sup>22</sup> studies now being published suggest that it is appropriate to prescribe opioid analgesics to most patients experiencing pain (malignant and nonmalignant),<sup>23</sup> even if the patients have a history of drug abuse in some instances.<sup>24</sup>

Given the overwhelming evidence in the literature that inadequate pain management is empirically verifiable, it would follow that the patterns of underprescribing opioid analgesics should be changing. Why opioids are not used more liberally to treat pain has thus become the focus of much of the recent work written. There is now an extensive list of the causes for underprescribing, covering a broad range of issues—from societal (for example, cultural values about pain); to institutional (for example, education, treatment, reimbursement, and regulatory policies related to pain management within the health care system); to professional (for example, practice patterns, standards, and the ethos of physicians, pharmacists, nurses, and allied health care practitioners); to the individual or personal preferences and biases of practitioners and patients (for example, fears of regulatory reprisal and drug addiction). Some work in this area focuses narrowly on a specific,

concrete cause (for example, regulatory barriers and obstacles,<sup>25</sup> health care reimbursement policies,<sup>26</sup> or inadequate education in pain management/drug addiction<sup>27</sup>), while other work emphasizes the more ethereal aspects of the human condition that affect the ability to cope effectively with pain (for example, how people express pain,<sup>28</sup> prevailing conceptions of pain in medicine or the so-called “medical model” of pain,<sup>29</sup> and cultural norms about pain relief and patients’ rights,<sup>30</sup> physician-assisted suicide (PAS),<sup>31</sup> and end-of-life care<sup>32</sup>). Most provide valid and reliable empirical data, illustrating how one cause or another has led or contributed to the inadequate treatment of pain.

Figure 1 summarizes the various reasons most often identified in the literature and by practitioners interviewed for this and several other studies for underprescribing opioid analgesics.<sup>33</sup> They are organized according to the probable source, from individual to societal. The sheer number of causes in each category suggests why recent efforts at regulatory relief focusing on one or several of the alleged culprits for underprescribing may not be sufficient to change prevailing treatment practices for chronic pain patients. Indeed, when taken together, the causes set out in Figure 1 are an expression of a far more complex phenomenon: an ethic of underprescribing that sets the parameters of, and the rewards for, appropriate prescribing to pain patients. In order for medical boards to alter existing prescribing practices for the treatment of chronic pain, they must, first, develop an understanding of the role of the ethic of underprescribing and, second and more important, institute policies and procedures that will alter the system of rewards that reinforces its core principles. It is my view that, as long as the system rewards underprescribing, current practices in the treatment of chronic pain will probably endure.

### The ethic of underprescribing

Undertreatment for pain in the medical setting has sources that run far deeper than a reluctance to provide adequate pain medication.<sup>34</sup>

How is an ethic formed and what is the basis for its central principles? An *ethic* refers to a body of principles about what is appropriate, good, or just conduct. As defined here, a *practice* is any cooperative human activity that has its own ethic—or rules of conduct—that anyone engaged in the activity must uphold. In this case, the activity or practice is the management of chronic pain.

Applied ethicists argue that there are multiple duties or responsibilities in any given ethic.<sup>35</sup> For example, physicians have an obligation to serve patients’ interests, to uphold professional standards, to adhere to the rules of the institutions that deliver and finance health care, and to obey the laws of the jurisdiction that has granted the privilege or right to practice. Variations in the scope of respon-

sibilities at each level may create conflicts as a matter of course.<sup>36</sup> Again, using physicians as an example, it is not uncommon for a doctor to be confronted with the dilemma of undertaking a course of action that, although clearly in the patient’s best interest, is inconsistent with the rules of a health insurer or some deeply held personal value. According to philosopher Alasdair MacIntyre, there is a complex set of internal and external rewards that significantly influences the choices members of a practice make when faced with these kinds of conflicting responsibilities.<sup>37</sup>

The core principles of practice determine whether particular behaviors or acts are good for the practice (internal rewards) or good because of the consequences they bring (external rewards).<sup>38</sup> Internal rewards are generally attained only by meeting the obligations central to a particular practice. The sense of accomplishment or inner satisfaction that follows from having done a job well, from fulfilling one’s obligations to a patient, from upholding the principles of the practice, and/or from doing no harm typifies rewards internal to a practice. External rewards, such as money, prestige, and status, are derived from sources secondary to the practice, even though they may be essential for its perpetuation.<sup>39</sup> Income, peer respect, and the ability to practice without restraint and to make choices about and have input into the work environment are some examples of the rewards external to a practice. MacIntyre contends that to understand the nature of an ethic, it is more important to focus on the nature of these rewards and how they are valued, than on the acts practitioners take or their eventual outcomes, both of which may be the same.

In chronic pain management, physicians may not prescribe opioids for patients because they adhere to the medical model that construes pain as a symptom of a condition rather than as one that warrants treatment. In this instance, eliminating or moderating the pain with drugs without first fulfilling the obligation to isolate its cause would be a breach of the standards of the practice and cause the denial of internal rewards—for example, the sense of having abdicated rather than having met one’s obligation to the patient. By contrast, another physician may be unwilling to prescribe opioids, even though that physician believes he/she has an intrinsic obligation to treat a patient’s pain, for fear that doing so would result in the loss of external rewards—for example, reimbursement from an insurer or a board investigation that will affect licensure status or practice privileges—necessary to perpetuate the practice.

MacIntyre notes that when faced with competing responsibilities in the practice setting, the preferred course of action is often the latter. Most practitioners will choose the course of action that preserves external rewards, even if the goods internal to the practice are sacrificed in the process.<sup>40</sup> In other words, the probability that practitioners will abandon principles appears to increase in instances where the perceived risk of losing external rewards is high.<sup>41</sup>

**(1) Personal/Individual**

*(A) Health Practitioners*

- Risks of being disciplined for overprescribing by federal or state regulators.
- Fear of being accused of physician-assisted suicide (PAS) or becoming a party to euthanasia, particularly with respect to seriously ill and dying patients.
- Fear that use of drugs for pain will lead to addiction.

*(B) Patients and Family Members*

- Misconception that opioid analgesics will cause mental confusion, disorientation, personality change, and various kinds of drug-seeking behavior.
- Underreporting of pain because of a desire to be “good patient.” Do not want to distract physician from primary task of treating the disease or to admit to increase in pain because that suggests progression of disease.
- View that admitting to pain and taking narcotics to relieve pain are signs of personal weakness.
- Fear that use of pain medications will lead family, friends, and colleagues to view patients as “druggies”.
- In terminally ill patients, concern that high doses of opioid analgesics will lead to death and that family members would appear guilty of euthanasia or physician of assisted suicide.

**(2) Group/Profession**

- Desire to avoid pain patients because of difficulties and frustrations inherent in certain types of pain management.
- Fear of being duped by a “drug-seeking” patient or being considered a “prescription doctor” by colleagues.
- General lack of knowledge about the differences between pain management, patient sedation, hastening death through administration of drugs, euthanasia, and PAS.
- Lack of awareness about the extent to which pain can be managed with opioid analgesics.
- High level of unawareness about developments in pain relief medications and technology evident across specialties.
- General inability to differentiate between and understand risks of physical dependence and addiction resulting from long-term use of opioid analgesics.
- Excessive concern about the side-effects of opioid analgesics—including nausea, constipation, insomnia, and so forth. Concerns about such are grossly misplaced when treating patients who are otherwise unable to function at all or are dying.
- Long held, and empirically invalid, belief that patients are poor judges of the scope and severity of their pain.
- Conventional wisdom that pain medication should be reserved for patients with moderate-to-severe pain only.
- Failure to conduct, as sound medical practice, thorough and frequent reevaluations of patients’ pain status.

**(3) Organizational/Institutional**

*(A) Health Care Finance and Delivery*

- Hospitals operate on disease-oriented model that does not encourage or reward pain management or innovations that improve pain treatment more generally.
- Pressure to keep health care costs down by denying potentially expensive pain treatments to patients who are terminally ill in both acute care and nursing home facilities.
- Inadequate coordination of care, particularly for treatment of nonmalignant pain outside treatment centers; same for terminally and seriously ill patients unless in a hospice setting.
- Reimbursement policies of health insurers centering on assumptions about “medical necessity” have resulted in inadequate or uneven coverage for long-term pain treatment.
- Malpractice insurance policies that create disincentives for the practice of pain medicine.

*(B) Regulators*

- Closed system of accountability established around distribution that provides for registration, record-keeping, and enforcement that enables regulatory agencies to identify the manufacturer, distributor, physician, or pharmacist who diverts controlled substances for illicit use.
- Concerns over possible abuse or diversion have caused many pharmacies to limit stocks of narcotics. Availability also varies greatly by regions of the United States and the presence of large academic medical centers.
- Prescribing of Schedule II drugs—the class into which most opioid analgesics fall—among the most carefully scrutinized by the Drug Enforcement Agency. (Schedule II drugs have high potential for abuse.)
- Multiple copy prescription forms required by state regulators to prescribe opioid analgesics outside of the hospital are cumbersome to complete and are frequently unavailable in an office or clinical practice setting.
- Several state agencies—for example, various health professional boards and government drug enforcement agencies—have overlapping and sometimes competing jurisdictions over prescribing practices.
- Investigative techniques of regulators that tend to intimidate practitioners under suspicion for overprescribing, that frequently use aggregate number of prescriptions, dosage units, and length of treatment as measures of appropriate prescribing, and that often use practitioners who do not treat pain patients as peer reviewers and/or expert witnesses.
- Public rankings of regulatory board effectiveness that present the aggregate number of disciplinary actions taken involving prescribing practices without differentiating between underlying causes—for example, indiscriminate prescribing, self-prescribing or diversion, and overprescribing are lumped together.

*(C) Health Care Professionals and Education*

- Inadequate medical school and post-graduate training in pathophysiology of acute and chronic pain. Woeful undertraining in most aspects of palliative care and of clinical pharmacology of opioid analgesics—that is, which drugs are appropriate in which circumstances for particular patients with particular kinds of pain.
- Perpetuation of an outdated, mechanistic model that characterizes pain as a neurophysiological impulse or response to disease.

- Scopes of practice of various health professions involved in pain management are viewed as distinct or separate. Cross-training of practitioners and sharing knowledge bases are the exceptions rather than the rule.
- (4) Cultural/Societal**
- Idea that pain builds character.
  - Fear of pain and death and resulting unwillingness to engage in political dialogue about appropriate policy.
  - Opiophobia or general fear of drugs, including legitimate use of narcotics that is an unintended consequence of U.S. War on Drugs—for example, the Just Say No campaign.
  - Federal and state controlled substance laws and policies that restrict access to and the amount of narcotics that can be prescribed in a set period to a specific number of dosage units.

**Figure 1. Causes for Underprescribing.**

*The ethic of underprescribing applied*

The works of applied ethicists provide a useful framework for understanding how an ethic is formed. With this in mind, the goals in this section are twofold:

- to identify the key principles in the ethic of underprescribing; and
- to assess to what extent the ethic of underprescribing has been altered by recent efforts at regulatory relief.

Meeting these goals requires taking a step inside the practice of chronic pain management and examining the experiences of both patients and health care professionals. To this end, the following analysis draws on the findings of several published studies as well as the statements of patients and health care practitioners who participated in focus groups or who were interviewed at length as part of this project. Comments made by a diverse group of health professionals in two different forums held in March 1998—a national forum on chronic pain management held by the Federation of State Medical Boards (FSMB), in Dallas, Texas, and a symposium on chronic pain sponsored by the Mayday Foundation and the Iowa Board of Medical Examiners (IBME), in Ankeny, Iowa—are also incorporated.

The focus groups involved health care practitioners (physicians, nurses, and pharmacists), patients and their families, and various other stakeholders. The focus groups were conducted by an independent research firm in January 1998, in Des Moines, Iowa, as part of this project. Follow-up interviews with focus group participants took place over the next several months. Data from nationally based studies that support focus group and interview findings are cited, where appropriate.

*The principles*

The principles or rules of conduct that set the standards for judging behavior in a practice ethic, while unique to it, are not formed in a vacuum. They tend to develop slowly, over time from a variety of sources.<sup>42</sup> The three principles to be discussed here are drawn from the causes for underprescribing presented in Figure 1 and from the statements of practitioners.

Each principle discussed concerns a facet of the practice of pain management. Because the principles at the root of an ethic are not tangible things, narrative statements made by those who participate in and are affected by the practice of chronic pain management are woven together throughout to help us interpret and understand what they mean. The first principle, Just Say No, pertains to narcotics and drug addiction; the second, Grin and Bear It, focuses on what society makes of pain; and the third, Avoid Risks, centers on issues in the practice setting. The simple slogans or labels assigned to the three principles are primarily rhetorical; they are commonplace sayings that evoke, in a two or three word phrase, an understanding of the complex set of beliefs at the core of the ethic of underprescribing. However, it is the narrative statements about how chronic pain is and should be treated that best explain the nature and purpose of the ethic of underprescribing.

**Principle 1. Just Say No: drug addiction and abuse harm individuals and society**

Among the barriers to effective pain relief most often cited in the literature is a generalized fear of narcotics, defined here loosely as mood-altering substances. In some respects, the entire system of U.S. laws that has been established to control access to and the distribution of drugs rests on two extensions of this fear: (1) any chemical substance that distorts reality has the potential to be abused; and (2) persons who abuse or are addicted to these substances are likely to engage in conduct that threatens the social order.

The fear of opioid addiction is so pervasive that a term—“opiophobia”—has been coined to distinguish it from concerns about illegal drug use.<sup>43</sup> Opiophobia has been heightened in recent years by the rhetoric accompanying government’s War on Drugs. One of the central tactics in the War on Drugs has been to focus broadly on the horrors of addiction in media campaigns and antidrug and prevention programs, without drawing distinctions between drug dependency and abuse or types of addictive drugs. It is thus not surprising that many patients fear that taking any drug in large doses for relatively long periods of time will cause addiction. Consider the following comment made by a woman who, by her own account, was dependent on opioid analgesics to control intractable low back pain:

When I realized that without the medication I could not function, I felt like a “druggie” ... no better than a crack-head. My husband pleaded with me to stop [taking the prescribed medication] for the sake of our family... He harassed me and the doctor. I was forbidden to mention that I took the drugs even to my closest friends. After a while, I started to act like a drug addict. I hid my medications from him and from everyone else. I drove miles to have my prescriptions filled at drugstores where no one knew me. No one ever explained to me that it was “okay” to need my medications ... that needing drugs to take away pain is different [from] being a druggie. So I stopped and the pain nearly killed me. I wanted to start up again, but the doctor who treated me before said no, not after all the trouble, even though I got divorced... He [the doctor] was afraid I’d lose him his prescribing [privileges].<sup>44</sup>

Several studies examining patient concerns about narcotics suggest that the sentiments expressed above are not unique.<sup>45</sup> What is most telling in this quotation, however, is how the patient’s fears of addiction influenced the practitioner’s actions. Even for the physician who is willing to prescribe opioids, the possible loss of a valued external reward (prescribing privileges) may provide a strong incentive to say no.

The extent to which opiophobia has shaped and been reinforced by the ethic of underprescribing cannot be overstated, particularly as it relates to the norms of the health care professionals who treat pain patients. As one doctor notes:

From the minute I entered medical school to the day I finished my residency, I had it drilled into my head that narcotics should be used sparingly (if ever). We spent hours listening to professors describe how patients will do anything to get their doctors to prescribe narcotics and not more than a minute or two discussing their therapeutic uses. My experience as a resident confirmed this view. Most of the patients who came into the ER [emergency room] complaining about pain were addicts or drug seekers. Many a young resident got duped. It’s not an experience you forget ... [it] probably affects my thinking still.<sup>46</sup>

Reinforcing the idea that saying no is its own just reward is once again the very real concern that saying yes will draw the notice of the organizations that regulate prescribing, administering, dispensing, and ordering of narcotics—the Drug Enforcement Agency (DEA), state drug enforcement bureaus, and the boards of medicine and pharmacy. A physician assistant explains:

It took years for [physician assistants] to convince

the legislature to give us prescribing privileges for Schedule IIs. Frankly, I don’t need or want the responsibility. I worked with a doctor in a small town family practice for years. [He] was a good doc ... kept up with the research ... believed that he could manage chronic pain patients. He only had one or two chronic pain patients, both elderly gents. It was a small town, with only one pharmacy. He was reported by a pharmacist friend to both the pharmacy and medical boards because he [the pharmacist] thought the number of doses per [pre]script[ion] was supposedly too high. Next it was the DEA. Nothing happened, no action was taken. But, the investigation was enough. He took early retirement. It destroyed him, and for what? Two patients who were dying felt better for awhile and died anyway. Now the town is out one very good doc.<sup>47</sup>

Although substantial empirical evidence indicates that regulators seldom take punitive action in cases like the one above, the likelihood that an investigation will be conducted on an allegation of overprescribing is high. Avoiding an investigation is yet another incentive to underprescribe.

The standards for prescribing drugs are not monolithic, however. In certain circumstances, prescribing high doses of drugs is generally considered to be legitimate. For example, the general public and health care practitioners accept that it is appropriate to prescribe drugs to curtail the symptoms of certain illnesses and injuries, as well as to comfort terminally-ill patients suffering in pain.<sup>48</sup> As one physician noted about the latter:

Mood-altering drugs are reinforcing. Their chemical make-up creates a need for more, which is why addicts do anything to get their hands on them. Cancer patients are different... With dying patients, even if they do become addicted and want more, there’s no harm done. It’s only a problem if you kill the patient before his time in the process. Then you cross the line into physician-assisted suicide or, worse, euthanasia.<sup>49</sup>

Legitimate uses are largely confined, thus, to circumstances in which there is a marginal harm or no potential for “the continued craving to use an opioid and the need to use the opioid for effects other than pain relief.”<sup>50</sup> However, even when prescribing opioids to terminally ill patients, the potential arises for the loss of external rewards. Some of the opioid analgesics prescribed for dying patients can slow respiration and, in doing so, hasten death. In virtually every state in the United States, laws on the books impose stiff criminal sanctions on health care practitioners who are suspected of crossing what is generally agreed to be a very ambiguous line. The threat of prosecution, the

possibility of being labeled another Kevorkian, and the risk of losing prescribing or practice privileges are all strong incentives to say no, even in instances where the use of high doses of opioids is not only the legitimate, but also the most humane course of action.

In sum, strong rewards, both internal and external to the practice of chronic pain management, reinforce the principle in the ethic of underprescribing to say no. A practitioner who accepts that addiction is harmful and that assisting or hastening death is a wrong has a duty to prescribe drugs in a manner that will not result in either. Federal and state prescribing laws, societal norms about the dangers of drugs, and board rules and regulations reward practitioners who underprescribe by making saying yes a risky proposition—to practitioners' livelihood, reputation, and status in the practice community and under the law.

### Principle II. Grin and Bear It: pain happens

The principles of the ethic of underprescribing derive from a wide array of sources, including religion, history, science, and popular culture. David Morris argues that the view of pain in the United States is one in which pain is often indistinguishable from suffering. Suffering, in turn, is conceived of as a moral good: pain builds character, reflects intelligence, adds strength, and enhances pleasure. Morris goes on to say that this conception of pain has greatly influenced thinking about how people in pain should deal with it.<sup>51</sup> The comment of a young man, whose father has agonized with chronic headaches for over a decade, makes the point:

I couldn't understand why my father was so embarrassed by [his] inability to withstand his pain until I started to study religion and history in high school. Christians believe it was necessary for Jesus to suffer the physical pain of crucifixion to redeem mankind from sin. Because of this, people who bear lots of [physical] pain in the name of God are turned into saints and martyrs. People who take pain in the name of country are given medals.... The real heroes in our society know ... it's best to suffer in silence. And if Jesus is the standard, you know the bar is going to be set pretty high.<sup>52</sup>

Implicit in the notion that it is ennobling to suffer is the idea that avoiding or attempting to relieve pain is a sign of weakness. This idea is reflected in norms about how chronic pain patients should be treated. As a pharmacist notes:

Drug control laws essentially say that pain ... is part of the natural order of things.... [W]hat we really should be worried about [are] the things that make

pain go away. I agree. I am a [scientist]. I know that there are only a limited range of things anybody can do to make pain go away and there are so many things that can cause it. To borrow a phrase, "pain happens." We have to be careful not to make too much of pain. It's my job to alert the proper authorities [when a doctor] gets carried away with a patient's complaints and prescribes morphine or some other narcotic at levels that hurt more than help.... Some serious pain in life is just unavoidable. Morphine or hydrocodone or whatever other narcotic is *de rigueur* at a given moment might control pain, but they won't stop the fact that we'll all suffer harsh pain at some point. It is misleading, and probably unethical and illegal, for any [health care practitioner] to suggest otherwise.<sup>53</sup>

As this quotation intimates, avoiding pain, while not inherently wrong, is suspect—so much so that society has adopted substance control laws, rules, and regulations that reward practitioners who uphold the principle Grin and Bear It by choosing to underprescribe.

In many respects, the principle Grin and Bear It reinforces the internal rewards that follow from the principle Just Say No. A physician suggests how the two principles may function in tandem:

We develop the drugs to take pain away and then we turn around and pass laws that stigmatize their use. This has nothing to do with controlling pain; it's about controlling drug [distribution] and the addicts who use them. In some ways, it makes sense to me. But I still resent it that the U.S.A. had to get to the point where we needed to pass laws that say it's okay to use opioids for therapeutic purposes. If it really were okay, we wouldn't [need] the laws. Chronic pain patients are difficult enough to treat without having to worry about "big brother" looking over your shoulder. The DEA, the boards ... [they] don't trust doctors to be able to distinguish between a patient who needs medication for pain and a patient who is seeking drugs. I resent it and I'm not about to jeopardize my livelihood because of it. I refer almost all of my chronic pain patients these days.<sup>54</sup>

The important role both principles play in the ethic of underprescribing is clarified further in the statement of a pharmacist, who works for a large drugstore chain in the Midwest:

It would be total chaos if we gave [pre]script[ion]s to everyone suffering from chronic pain. America would grind to a halt. That's how powerful these drugs are. Everybody thinks the pain they're feeling at this mo-

ment is the worst pain ever. There's no guarantee that opioids will make the quality of life better for patients in pain. Sure, they reduce pain, but they dull [patients'] senses ... too. This is why CSAs [controlled substance acts] are necessary. We all have a stake in pain management too. Can you imagine what would happen to American productivity if everyone who claimed to have chronic pain was treated with [opioids]?<sup>55</sup>

And last, the revealing sentiments of a registered nurse, who practices in a hospice setting:

The patients with metastatic cancer or HIV [human immunodeficiency virus] who suffer needlessly ... the people who don't want to get out of bed and face another day because of pain in the occipitocervical area [in the spine at the back of the neck] or the lumbar [lower back], we [health care professionals] make them heroes by forcing them to endure pain that is treatable. We do it supposedly because the risk of addiction ... is supposed to be so high. Every day each and everyone of us does things where the real risk of a bad outcome is much higher—crossing a busy city street, for example. The real reason we underprescribe for pain, though, is that we don't know any better. We don't learn about the pathophysiology of pain when we are trained. And we are afraid—afraid some board or narcotics agent will sweep down and accuse us of wrong-doing and we'll lose everything.<sup>56</sup>

Despite the considerable range of opinions about whether it is appropriate to prescribe high doses of narcotics to chronic pain sufferers, practitioners agree that it is a risky venture to do so, which highlights once again what powerful inducements external rewards can be in influencing pain treatment.

In a practice dominated by an ethic of underprescribing—one that conceives of pain as an inevitable part of the human condition, of suffering as a moral good, and of drugs as harmful or bad—some patients say they have considered taking their own lives rather than endure the unrelenting pain and the social stigma of not being able to cope:

I'd had pain before, though not like this. No one I went to could figure out why. At first, I thought I'd die and then I wanted to [die]. I was actually relieved when the doctor finally found the tumor. At least then I knew it wasn't all in my head. Things are better now. Back then for awhile, I really did think about going the Kevorkian route though.<sup>57</sup>

As the recent U.S. Supreme Court decision in *Vacco v. Quill* implies, the far less onerous option of treatment with

opioid analgesics may not be any more viable or socially acceptable than PAS for some pain sufferers.<sup>58</sup> Morris points out that it will require a revolution in what society makes of pain—in the values of what he describes as the culture of pain—to change the patterns of underprescribing that have made PAS an option even worth considering.<sup>59</sup>

The external rewards reinforcing the principle Grin and Bear It are many and powerful. Indeed, although it is hard to imagine that anyone who regularly engages in the practice of chronic pain management would purposefully deny relief to a patient experiencing unrelenting pain, the available empirical evidence clearly shows that it happens all the time. The reason underprescribing persists may well be that many health care practitioners believe that their duty to comply with laws and societal norms allowing pain to happen outweighs their responsibility to provide relief to patients. Yet, a more likely explanation for continued patterns of underprescribing is that practitioners take a look at the legal landscape and seek out alternative methods for fulfilling their responsibility. It is ironic that, in a society where the consumer has access to literally hundreds of over-the-counter drugs that promise a quick fix to pain, those with a real need are left to endure. The fact of the matter is that, as wary as we are of pain, we are more leery of anyone or thing that takes it away.

### Principle III. Avoid Risks: it ensures no harm done

As indicated in Figure 1, most of the major health care institutions reward underprescribing. According to organizational theorists, institutions are instrumental entities that, by their very nature, are geared toward achieving organizational goals and to perpetuating the status quo. As such, they tend to be risk averse.<sup>60</sup> Inasmuch as the practice of pain management is taught, delivered, financed, and regulated by organizations, it makes sense that avoiding risks is a guiding principle in the ethic of underprescribing. Avoiding risks is a means not only of ensuring that practitioners do no harm (internal reward), but also of securing income, power, prestige, job security, and status—these are all external rewards distributed by all the major organizations and institutions in the American health care system.

Insurance providers have become the central players in the drive to contain health care costs. One of the ways they attempt to minimize costs is by basing reimbursement policies on determinations of medical necessity and on analyses of the average cost of treating certain diseases or performing particular procedures within a patient population. Pain, because it is so subjective, and chronic pain treatment, because it is so case specific, do not lend themselves to such cost-control measures. A physician explains how the reimbursement policies of insurers may create disincentives for deviating from the status quo of underprescribing:

Unless you're in a pain clinic, it's an unbelievable ordeal to obtain third-party payment for pain treatment with [opioids]. Every time it's the same. I call; the patient calls. Then I ask for a review, if the plan hasn't already. After suffering that indignity, reimbursement is denied a third time. If, by the fourth appeal, the payment still isn't forthcoming, there's a decent chance that either or both of us will be kicked from the plan. How and what they [insurers] reimburse is another mystery. Same plan, same coverage, same pain, same treatment, different day ... different payment. What's always the same ... [is that on] every pain patient I take [on], I lose money.<sup>61</sup>

In short, the procedures established by insurance providers to achieve cost control—an organizational goal—have skewed the distribution of external rewards in a manner that creates a financial risk for chronic use of opioids.

The goal of regulatory organizations also centers on avoiding risks. Regulators use a command and control—"do this or else"—approach that creates risks for engaging in particular kinds of behavior. The effectiveness of this approach hinges on whether the target population believes regulators have the legitimate authority to command compliance. Said one physician:

I follow the guidelines on prescribing narcotics because, as a licensed doctor, I have an obligation to play by the rules, whether they're set by the boards or the DEA ... whoever. I do it because I believe that they're [laws, regulations, rules, and so forth] there for a legitimate purpose, be it to protect patients from some harm or threat or some such. I have duty to respect that, even if I disagree.<sup>62</sup>

In turn, the scope of compliance depends on how much the group regulated fears or values the "or else" to be denied. In the following, an investigator for a state medical board identifies the nature of the regulatory risks confronting a physician if investigated or disciplined for overprescribing:

Say the board investigates a doctor for possible overprescribing after a pharmacist reports the doctor was prescribing opioids at doses above the accepted standard. I investigate the case the same way I would any other alleging inappropriate prescribing. I can't assume that, because the patient has a chronic pain condition, the doctor's actions were right. That's for the board to decide. If the board decides to take a [disciplinary] action, even a minor slap, there will be lasting consequences. The action will be reported [to the National Practitioner Data Bank]. Insurance companies and hospitals will use that data bank report to

keep a doctor from getting privileges and on [insurance] plans. The hospitals and insurers do what they're going to do, regardless of what the board says. I know of a case where the doctor lost his hospital privileges just because the board ordered him to take a course in appropriate prescribing. That is not fair. Still I don't think the board should be making decisions based on ... how discipline will affect practice privileges. That protects doctors and it's our job to protect the public.<sup>63</sup>

The following comments, made by a nurse, consider the impact of the same regulatory risks from the vantage point of health care practitioners:

It doesn't take all that much to protect yourself [from licensure discipline] or an investigation by the [DEA]. Good documentation of why you prescribed the drugs, regular follow-up, that sort of thing ... things we should do when treating any patient. These days, the cost of being accused is nearly as high as [that of being] convicted. Even when no discipline results, other docs who know about the investigation might think you were duped by a patient. And it only takes one case and, before you know it, everyone thinks you're a [pre]script[ion] doc.<sup>64</sup>

As these statements suggest, failure to avoid the risks established by regulators may have a ripple effect on the distribution of the external rewards that make practice possible and profitable.

To be investigated or sanctioned by a board could result in a loss of stature, reputation, institutional privileges, or access to insurance panels, even if no restrictions or limitations are imposed on the license to practice. In fact, loss of these other external rewards—all of which are essential to maintain a successful practice—may have the same effect as the most onerous sanction a board can take: license revocation. Thus, the regulatory imperative to avoid risks strongly reinforces the ethic of underprescribing.

In some respects, the goal of the educational institutions that train health care professionals is to teach practitioners how to fit in or to become members of the health care establishment. As such, these institutions socialize practitioners to avoid risk-taking. Before a group of health care professionals concerned about chronic pain, an anesthesiologist specializing in pain management stated:

For the better part of the last century, schools of medicine especially, but all health professional schools, have taught a medical model of pain which presents pain as a neurobiological manifestation of a disease or illness rather than [as] a problem warranting treatment itself. [As a result], pain management just hasn't

been part of the core curriculum in most professional schools until of late.<sup>65</sup>

According to another physician, these institutions have, however, apparently gone to great lengths to teach the value of avoiding risks:

The training in the pathophysiology of pain and in the use of opioid analgesics when I was a resident was nil. Until recently, physicians and pharmacists who didn't adhere to the medical model had to train themselves, or keep moving, to get the training and experience needed. In the fifteen years since I finished my clinical training, I've met a few physicians from my generation who regularly use opioids to treat chronic pain, but only two I would call successful doctors ... who have lucrative practices and are respected in the community. Many of the rest are outcasts, who had to fight long to get privileges, reimbursements, and partners ... and even harder to shake the reputation for being soft on pain.<sup>66</sup>

Studies show that for many mid-career physicians underprescribing of opioid analgesics is the status quo.<sup>67</sup> This complacency likely will continue as long as health education institutions base clinical teaching on an outdated model of pain that creates internal rewards for avoiding risks and that emphasizes the potential loss of external rewards for prescribing opioids.

The risk avoidance principle also overlaps with the other two central principles of the ethic of underprescribing. In the words of one physician:

Any doctor worth his salt knows the research about the [therapeutic uses] of opioids for treating chronic pain. There is such ignorance out there about addiction ... such concern about the regulators, the narcs, the board—the [pre]script[ion] cops ... such misunderstanding about narcotics and what they can do for this kind of pain. All the talk isn't going to change the reality that most doctors and patients don't think of pain as the problem. Instead, it's drugs [that] are the problem or disease [that] is the problem. That kind of thinking will be around until we do something to make the professionals understand that there is nothing to be gained from thinking and acting as if chronic pain and patients who have it can be wished away.<sup>68</sup>

The comment of a member of a state medical board suggests even more clearly why the ethic of underprescribing endures:

Are we talking about changing an entire way of do-

ing things because doctors are afraid the board or DEA or patients will turn on them? The board only disciplines physicians in the most egregious cases ... the same is true for the other enforcement agencies. They're [the few physicians sanctioned for overprescribing] the exception that proves the need for the rules. We just don't see cases in which allegations involve underprescribing. If it's as common as some of these docs and nurses say, why isn't [it] being reported to the board?<sup>69</sup>

The answer to the question posed by this physician is, simply enough, that underprescribing is the norm or the prevailing standard rather than an aberration.

### *The impact of regulatory relief*

There are essentially two ways of stripping an ethic of its relevance: to establish new principles or to alter the system of rewards supporting existing principles. Recent efforts at regulatory relief—IPTAs, chronic pain regulations, rules, and guidelines—although a step in the right direction, were not designed with either goal explicitly in mind. Moreover, as alluded to earlier, an ethic is a complex phenomenon. The system of principles or standards of conduct that are at its core evolves gradually, over time as the practice itself develops. Hence, enacting laws or implementing policies that liberalize the chronic use of opioids will not undermine the relevance of a practice ethic unless they also fundamentally change the nature of the practice itself. The following statement by a physician illustrates the point:

I am licensed to practice in five states. Everyone of them has adopted a chronic pain rule or law of some kind in the last couple of years. While I think these new laws are well intentioned, I don't expect them to change prescribing practices anytime soon. In the first place, hardly any physicians know about them and the physicians [who] do know about them [physicians who regularly treat pain patients] don't need them: they already know what to do. In the second place, you cannot undo what it took a generation to create just like that. Even my colleagues [who] know about the board's new rules have a wait and see attitude. They haven't let the fact the board hardly ever disciplines physicians for chronic pain prescribing dissuade them in the past. No reason to believe the new rules will change that. It's all in perception.<sup>70</sup>

If this physician's thinking is correct, regulatory relief might change the actual standards or rules of the practice, but it will not alter the perception that there are few risks and fairly substantial external rewards for underprescribing.

Can the IPTAs, rules, and guidelines on chronic pain

management become the basis of a new ethic for pain management? Several researchers argue that regulatory relief has created an implicit risk for underprescribing by establishing a new standard that legitimizes the long-term use of opioids for therapeutic purposes in the treatment of certain kinds of pain.<sup>71</sup> But, as the comment above suggests, an implicit risk may not be enough to strip the ethic of underprescribing of its relevance. For the risk to become explicit, it is necessary to develop external rewards that directly reinforce the standard on appropriate prescribing at the center of regulatory relief. Ironically, the most immediate means of establishing these external rewards may not be regulatory relief, but more regulation.

### **Establishing a new ethic: the role of medical boards**

It is illegal in all fifty states for a physician to practice without a license. A physician with a license that has been restricted or limited as a result of a board sanction, while legally authorized to practice, may find it difficult to do so. As noted in the section on avoiding risks, it is not uncommon for hospitals to curtail the privileges of physicians by placing their licenses on probationary status. Similarly, malpractice insurers may raise premiums or deny coverage to physicians who have been disciplined. Health insurers and managed care organizations (MCOs) frequently make it a policy to exclude or deselect physicians with encumbered licenses from health care plans. Limitations on prescribing privileges imposed by a board can result in sanctions by DEA and state pharmacy boards. Changes in licensure status can also affect less tangible rewards. Prestige and reputation in the health care community and within a specialty area are valued external rewards that vary in accordance with a physician's licensure status. To the point, as the entities that authorize physicians to practice, state medical boards are uniquely positioned to affect the distribution of external rewards throughout the health care system.

### *The options: what medical boards can do*

As yet, no state medical board has created a risk for underprescribing that takes advantage of this unique position. This may be a function of the fact that medical boards tend to be reactive rather than proactive. However, medical boards can create risks in three ways, if only indirectly: by investigations, rule-making, and administrative adjudication.

Most boards only initiate investigations after receiving a complaint or a report of an allegation. Despite the fact that the majority of boards are authorized to initiate an investigation on their own—that is, without first receiving a complaint or report—doing so can render a board vulnerable to criticism for being overzealous or biased against a particular practitioner or area of practice. Also,

boards generally do not have the financial and human resources required to conduct routine compliance checks of licensees or to survey patient satisfaction with particular treatments or procedures. Moreover, state medical board investigations and sanctions tend to be aimed at physicians who deviate from *prevailing* clinical practice and conduct standards. As the discussion on the ethic of underprescribing suggests, the undertreatment of chronic pain with opioids *is* the standard—the prevailing clinical practice.

In discussions with medical board executives conducted between November 1997 and January 1998, only one board (California) of the thirty-six represented had received a complaint or report explicitly alleging underprescribing in the treatment of chronic pain.<sup>72</sup> Several executives indicated that they had received complaints from prison inmates alleging that certain medications had been denied by prison officials as a form of punishment,<sup>73</sup> but they noted that most were generally not pursued as underprescribing cases. The data on board actions indicate that, even in states that have adopted IPTAs and/or chronic pain guidelines, investigations involving the treatment of chronic pain continue to focus broadly on patterns of inappropriate prescribing. This may be the case because the medical experts and consultants the boards rely on to review investigative materials and to serve as witnesses in prescribing cases seldom have training in chronic pain management. As well, there appears to be consensus among medical board administrators that it would be both improper and impolitic to seek out underprescribing cases without first adopting formal rules or standards establishing grounds for disciplinary action.

Second, medical boards set formal standards and related policies about such matters by rule. Rule-making often occurs in response to national trends (for example, chronic pain and regulatory relief), changes in the science or technology that have an impact on the profession (for example, telemedicine acts and rules), or problems that surface repeatedly in complaints under investigations or under prosecution (for example, scope of sexual misconduct). The process of adopting a rule or regulation in most states is a democratic one, in which all interested parties are invited to participate. Proposed regulations are generally published or noticed for public comment for a set period of time; public hearings may also be held at some point; and, in virtually every state, proposed regulations are reviewed by a standing committee of the legislature and/or an executive branch council before a board can move for final adoption. Active and intense opposition to a regulation by a single party or a coalition of opponents can effectively derail efforts to adopt a rule at any stage in this process. Consequently, a medical board may not be able to adopt a formal policy on underprescribing through a rule if licensees, the public, or their representatives deem it unnecessary or potentially burdensome.

To date, no state medical board has adopted a formal policy or standard that treats underprescribing as an explicit ground for disciplinary action, and only one is considering doing so—IBME. The persistence of the ethic of underprescribing may be one of the reasons why medical boards are so reluctant to invest the capital necessary to build support for a rule on underprescribing.

And, third, standards of practice and professional conduct are also set through the administrative adjudicative process when boards render final decisions. It is difficult to assess with any accuracy the extent to which any one factor is the major cause for discipline. As a practical matter, most of the cases that result in a disciplinary action involve many factors, categorized broadly under headings such as *unprofessional conduct*, *professional incompetence*, or *substandard care*. Depending on how the grounds for disciplinary action are defined in a state's medical practice act or a particular state board's administrative rules, sanctions imposed for underprescribing could be reported under one of these general grounds.

Final decisions in the adjudicative option would have to be made on a case-by-case basis in response to complaints made by patients alleging underprescribing. However, as noted earlier, state board executives report receiving few complaints specifically alleging underprescribing or undertreatment of pain. As the public becomes more aware of this issue over time, the number of complaints may increase. Even if they do, boards will still have several obstacles to overcome. For example, it may be difficult to convince prosecutors to pursue charges in an area in which there is little legal precedent and the standards of practice are ambiguous and vulnerable to broad legal challenges. Similarly, boards may not be able to locate expert witnesses willing to support publicly a charge that underprescribing is substandard care, given prevailing practices among physicians in most states. In the short term, it is unlikely that boards will be able to establish a risk for underprescribing on a case-by-case basis through the administrative adjudication process. Again, the data bear this out: in interviews with state medical board administrators, not one of the thirty-six who participated could identify a pending case that could become the basis for a standard on underprescribing.

### *Making the transition to a new ethic of prescribing*

The most direct way of creating an explicit risk is the second—rule-making or standard-setting—because it allows boards to affect directly the direction of external rewards. A review of the practice acts and administrative rules enforced by state medical boards reveals that all have a law or rule on the books establishing the parameters for appropriate prescribing that alludes to or implies that risks for overprescribing exist.

The following is a representative sample of provisions on appropriate prescribing now in effect across the states:

The promiscuous or indiscriminate prescribing, ordering, administering, or dispensing of controlled substances for other than therapeutic purposes.

Prescribing, selling administering, distributing, ordering or giving to an habitué or addict or any person currently or previously drug dependent any drug legally classified as a controlled substance or recognized as a dangerous, addictive or illegal drug unless indicated as part of a therapeutic regime for chronic pain management approved by the board.

Prescribing, dispensing, or administering any controlled substance, prescription-only drug, or an illegal drug, or controlled substance for other than accepted therapeutic purposes.

Prescribing, dispensing or furnishing any prescription drug without prior examination and medical indication therefor.

Possessing, using, prescribing for use, or distributing controlled substances or legend drugs [controlled substances] in any way other than for legitimate or therapeutic purposes, diverting controlled substances or legend drugs, violating any drug law, or self-prescribing controlled substances.<sup>74</sup>

Altered to address underprescribing, a rule could take the following form in a state with an IPTA or chronic pain regulations or guidelines:

Option 1: Prescribing, ordering, administering, or dispensing of controlled substances in violation of the standard for chronic pain management established in [IPTA or board rule] unless good cause is shown for failure to adhere to the requirements set forth therein.

As a more direct approach, a medical board could adopt the following rule as a ground for disciplinary action:

Option 2: Failure to adequately prescribe, order, administer, or dispense controlled substances, including opioid analgesics, for the relief or modulation of chronic pain in accordance with accepted knowledge and prevailing clinical practice for pain treatment and the standard for chronic pain management established in [IPTA or rule].

A more cautious board would add the caveat:

Nothing in this subrule shall be construed to be an advocacy of the imprudent or improper use of opioid analgesics. Further, this subrule shall not relieve a licensee of the obligation to comply with state and federal laws governing the lawful prescribing, ordering, administering, or dispensing of controlled substances.<sup>75</sup>

Adopting any of these rules would authorize a medical board to scrutinize vigilantly physician practices for evidence of both underprescribing and overprescribing opioids. A medical board would then have the authority to take a disciplinary action on the above rather than on some broader ground—be it substandard care, professional incompetence, unprofessional conduct, and so forth—if a physician were found to have failed to prescribe appropriately for pain relief. The true difficulty arises in attempting to determine what constitutes “appropriate” prescribing. As the public entities responsible for regulating the practice of physicians, state medical boards are obligated to do no less.

The environment in which most medical boards operate will make meeting this obligation difficult. Medical boards do not function in a vacuum. Proposing a rule establishing underprescribing as a ground for discipline does not ensure that it will be adopted or, if adopted, readily enforced.

First, embittered by both their experience with national health care reform and the restrictions imposed on physicians by MCOs, medical associations have been particularly wary of government rules or policies in the last several years that could in any way further encroach on the clinical decision-making authority of practitioners.<sup>76</sup> The perceived regulatory risks associated with overprescribing are of concern to professional associations and societies. Yet, in the current political climate, state medical societies may well view regulations establishing a risk for underprescribing for what it is—more regulation. A statement made by the president of one state medical society exemplifies this way of thinking about regulations on underprescribing:

We will do whatever it takes to avoid another set of guidelines or rules that make physicians vulnerable to malpractice lawyers or board lawyers. Our goal is to get the board off doctors' backs, not to give the board another reason to look over our shoulders. A rule on underprescribing will go a long way toward assuring that no physician in their right mind ... who is not practicing in a pain center ... will go anywhere near a pain patient. What we need is less board regulation ... less looking over our shoulders ... not more. The medical society will look very carefully at anything else.<sup>77</sup>

If this perspective represents medical associations na-

tionwide, state medical boards will have an uphill battle when trying to adopt formal policies on underprescribing. Ultimately, success will hinge on boards' abilities to rally public support and to persuade a skeptical medical community that establishing a risk for underprescribing will serve the long-term interests of patients and professionals.

Second, enforcing a policy on underprescribing may require medical boards to change fundamentally the way they investigate prescribing cases. As noted earlier, boards initiate investigations in response to complaints and reports alleging inappropriate prescribing. Boards rely on expert consultants and peer reviewers to examine patient charts and prescribing data gathered from pharmacies during the investigation and to determine whether the appropriate standard has been met. Most often, these experts are board certified specialists in the same area of medicine as the physician under investigation.

Board executives indicate that the majority of complaints boards receive involve physicians in primary care (family practice, internal medical, obstetrics and gynecology, pediatrics, and so forth) and surgical specialties.<sup>78</sup> Because studies show that training in pain management in these areas of medicine has not been widespread, one of the greatest challenges confronting boards will be locating consultants and reviewers with sufficient experience in pain management to serve as credible witnesses. Boards seeking to enforce a policy on underprescribing may have to work together and pool experts across state lines and specialties. In the short term, boards may have no option other than to ask experts explicitly to consider whether undertreatment of pain is a problem when they review cases.

Third, the effectiveness of a policy on underprescribing will also hinge on whether board members, licensees, and the public change how they think about prescribing issues. As one board member explains:

While the idea of establishing a policy against underprescribing makes good sense, guidelines or rules are not alone going to change behavior. Board members and licensees have to change the way they think about prescribing to chronic pain patients. Eventually, the patients too will have to be more aware. The board just doesn't get complaints about under-prescribing because most patients in serious pain, particularly those [who] are terminal, don't think about continuing pain as being a prescribing problem. Board members, like most doctors outside pain clinics, do the same ... by focusing on the underlying organic problem, rather than [on] pain management as a problem.<sup>79</sup>

As this comment suggests, not only must board members alter how they approach prescribing for chronic pain, but patients will also have to be more aware of the therapeutic uses of opioids.

Can boards do anything to raise the consciousness of patients and physicians on this issue without undertaking a massive education campaign? The following suggests, perhaps so:

We [board members] could start the process today, even before a single complaint [is filed] or the regulation [is adopted]. When we review cases where pain is an issue ... we could ask ourselves and our [expert] reviewers to look at the prescribing of drugs from the vantage point of “was it appropriate” and mean [was it] enough instead of only [was it] too much. If we do this as a matter of course, we really wouldn’t need the regulation. It’s best still to have a policy in print or on the books so that doctors will know that we mean business if we find prescribing wasn’t enough.<sup>80</sup>

Again, the challenge a board faces in choosing this course is determining the parameters of appropriate prescribing.

#### *Underprescribing as inappropriate prescribing: a tale of two boards*

In the last several months, at least two state boards have confronted this challenge. I recount their experiences below. The state boards are referred to as State Board A and State Board B. I do not identify the boards to protect the patients and to hold confidential the investigative materials provided to me by the boards.

State A is generally considered to be one of the leaders in the regulatory relief movement. It was among the first to adopt an IPTA; and the chronic pain management guidelines adopted by State Board A have been used as a model by many other states. Despite the state’s reputation for being progressive in chronic pain treatment, State Board A does not have a law or regulation specifically addressing underprescribing practices. It is thus not surprising that Compassion in Dying would find State A to be an appropriate test site for an underprescribing case.<sup>81</sup>

According to Ms. Tucker, a decedent’s daughter contacted Compassion in Dying to request help in pursuing a complaint against a physician who failed, in her view, to provide adequate pain relief medication to her father during his final days in home-hospice care. The patient was apparently dying from inoperable cancer; sources indicate that he left the hospital before a formal diagnosis of his condition was made. According to the daughter’s account, the treating physician significantly reduced the level of opioid analgesics prescribed for her father once he left the hospital. Compassion in Dying sought out an independent review of the physician’s prescribing practices from an oncologist practicing in the same community. After reviewing the medical records at length, the oncologist determined

that the pain care provided by the treating physician was inadequate and substandard. On the basis of this review, the daughter, with the help of Compassion in Dying, sent a complaint to State Board A, alleging that her father had received inappropriate treatment.

As would most medical boards, State Board A investigated the complaint as an allegation of inappropriate prescribing. State laws prohibiting disclosure of investigative information make it difficult to ascertain how the complaint was investigated or what issues influenced the board’s thinking when reviewing the results of the investigation. However, most board’s conduct lengthy interviews with the physician and complainant at the investigative phase and then seek out a medical expert or consultant to review the relevant medical records and to render an opinion before the board makes a determination in quality of care/prescribing cases. Generally, medical consultants and reviewers are selected for their expertise in a particular specialty. For example, if the physician under investigation is an internist, then the board will seek consultants who are board certified in internal medicine to conduct reviews.

Although there is limited public information available about State Board A’s reasoning in this case, this much is known. Sources familiar with the case report that, after reviewing the results of the investigation, State Board A determined that the physician’s actions, though negligent, did not rise to the level required by law to file a formal charge (or charges) for inappropriate prescribing. A representative of the decedent’s daughter claims that State Board A issued the physician a letter, essentially warning him that any future reports of underprescribing opioid analgesics to a patient would likely result in the filing of formal charges.

The daughter made her dissatisfaction with State Board A’s decision known to the media and interested public officials, to little effect. The board has no plans to revisit its decision, but remains firmly committed to pursuing any complaints alleging underprescribing that it receives. Indeed, in finding merit in a complaint alleging underprescribing, State Board A has taken a significant step in establishing a risk for inadequate pain treatment. As yet, State Board A has not found sufficient cause to carry out its threat or to make the risk a legal reality.

In contrast, chronic pain issues have not been high on the political or public policy agenda of State B. State Board B did adopt a rule establishing chronic pain treatment guidelines, but was otherwise inactive. Currently, only one or two organizations are active on chronic pain issues in State B, and neither anticipates any progressive changes in public policy in this area in the near future.

As in the case before State Board A, State Board B received a complaint from a family member who was deeply upset by the quality of care provided to a dying patient in home-hospice care. In this instance, there was a clear diagnosis that the patient was terminally ill. However, it is

questionable whether the patient or his family had come to accept the diagnosis or that he was receiving noninterventionist, palliative care. When the patient began to fail at home from a lack of sustenance, his family sought to have him admitted to a hospital. The patient's family alleges that the treating physician was agitated when the patient was admitted and, as a consequence, was unwilling to honor wishes to initiate extraordinary life-saving measures. The family contends that the treating physician chose only, either out of incompetence or malice, to administer potassium chloride and at levels that may have actually hastened the patient's death. The family's outrage was compounded by the treating physician's decision to override the request to resuscitate the patient in the event that he arrested.

Public information on the investigation of this case by State Board B is limited. If handled in a routine manner, staff would have first conducted an in-depth investigation of the complaint; if the board found reason for concern in the investigative materials, the relevant medical records would have been referred to experts in the field. According to public statements made by the decedent's family, after considering the results of the investigation and the findings of the panel of expert reviewers, State Board B concluded that the physician's conduct met the prevailing standard of care. The board apparently determined that the decision to administer potassium chloride was appropriate. Sources familiar with the case indicate that at no time did State Board B or its panel of reviewers consider whether it was substandard for the physician not to prescribe opioid analgesics to the patient in sufficient doses to relieve his pain or to enhance his ability to take nourishment. State Board B reportedly also found that the physician had not adequately explained to the decedent's family the patient's status and his rationale for issuing a do-not-resuscitate order. As a result, a confidential letter was sent by the board advising the physician to pay more attention to the concerns of patients and their families. The decedent's family has repeatedly denounced the State Board B's decision in the press and in other public forums. By all accounts, State Board B remains confident that it made the right decision.

Yet, for State Board B, the conclusion of the case marked a new beginning. The controversy surrounding the final decision prompted members to question whether they had adopted the appropriate approach to the case. Of concern was the board's failure to consider the prescribing issues in greater detail. State Board B determined that the prudent course of action in future quality of care/prescribing cases is for investigators to obtain materials that allow consultants and peer reviewers to assess the adequacy of pain treatment. As a result of this decision, State Board B has actively sought out experts in chronic pain management to assist in evaluating inappropriate prescribing cases. Staff of the board has been directed to study the scope of the

underprescribing problem and to develop strategies that will improve State Board B's ability to detect and deter inadequate pain treatment. Further, at least three underprescribing cases are now under review by State Board B, in which formal charges on the grounds of inappropriate prescribing are likely to be filed in the near future. To put licensees on notice of this change in approach, State Board B is preparing to notice an amended rule that explicitly includes underprescribing as a ground for discipline.

## Conclusion

Although they have taken very different routes, State Board A and State Board B are both in a position to establish meaningful risks for underprescribing. In time, perhaps they will do so. At present, there is compelling evidence that the ethic of underprescribing, though wounded, has not fallen. For example, the U.S. Senate narrowly defeated the Lethal Drug Abuse Prevention Act,<sup>82</sup> which would expand the grounds for the suspension or revocation of a physician's DEA certificate if it were determined that a prescription for controlled drugs had hastened a patient's death. The legislation is expected to resurface in the next session, however. Since May 1, 1998, the number of formal overprescribing charges issued by state medical boards has actually risen by 10 percent over the past six month period.<sup>83</sup> Few of the states that have not participated in the regulatory relief efforts to this point report that they are planning to do so. And, as yet, not a single case is on record in which a medical board has taken a formal disciplinary action against a physician for underprescribing.

## References

1. See J.H. Von Roenn et al., *Physician Attitudes and Practice in Cancer Pain Management: A Survey from the Eastern Cooperative Oncology Group* (Washington, D.C.: American Health Council, Jan. 1998); R.K. Portenoy, "Opioid Therapy for Chronic Nonmalignant Pain: Clinicians' Perspective," *Journal of Law, Medicine & Ethics*, 24 (1996): 296-309; and D.E. Joranson et al. "Opioids for Chronic Cancer and Non-Cancer Pain: A Survey of State Medical Board Members," *Federation Bulletin: The Journal of Medical Licensure and Discipline*, 79 (1992): 15. Although I am primarily concerned with the practices and policies of state medical boards, several studies have focused on the barriers to effective pain relief posed by other regulatory entities, chiefly state pharmacy boards and drug enforcement agencies, as well as the Drug Enforcement Agency and federal and state controlled substance laws. See, for example, C.S. Hill, "The Negative Influence of Licensing and Disciplinary Boards and Drug Enforcement Agencies in Pain with Opioid Analgesics," *Journal of Pharmaceutical Care in Pain and Symptom Control*, 1 (1993): 43-62.
2. See sources cited *supra* note 1. See also C.N. Shealy, "Opioids and Controlled Substances in Chronic Benign Pain: A Survey of State Medical Board," *American Journal of Pain Management*, 1 (1997): 10-14; C.S. Hyman, "Pain Management and

Disciplinary Action: How Medical Boards Can Remove the Barriers to Effective Treatment," *Journal of Law, Medicine & Ethics*, 24 (1996): 338-43 and S.H. Johnson, "Disciplinary Actions and Pain Relief: An Analysis of the Pain Relief Act," *Journal of Law, Medicine & Ethics*, 24 (1996): 319-27.

3. See, for example, *Hoover v. Agency for Health Care Administration*, 676 So. 2d 1380 (Fla. Dist. Ct. App. 1996). Sandra Johnson provides a review of several other relevant cases. See S.H. Johnson, "Removing Legal Constraints on Effective Pain Relief," *ABA Bioethics Bulletin*, 5, no. 3 (1997): 9-10.

4. As part of my research, a review of the aggregate actions for the state medical boards reported to the Federation of State Medical Board's (FSMB) data bank was conducted for the reporting years 1990 to 1996. The available data as well as anecdotal reports from board administrators indicate that sanctions imposed for overprescribing are the exception rather than the rule, particularly with respect to chronic pain. Indeed, the data show that most disciplinary actions related to prescribing are a result of self- or indiscriminate prescribing by practitioners.

5. See D.E. Joranson and A.M. Gilson, "State Intractable Pain Policy: Current Status," *APS Bulletin*, 7, no. 2 (1997): 7-9.

6. David Joranson and Aaron Gilson, see *id.*, provide an excellent analysis of the distinctions between these various approaches—that is, laws versus rules versus guidelines—and identify the benefits and risks associated with each. They also point out that several states have laws, rules, and guidelines—for example, Texas. See The Intractable Pain Treatment Act, Tex. Rev. Civ. Stat. Ann. art. 4495c (West 1996); and Tex. Admin. Code tit. 22, §§ 170.1-3 (1996).

7. See Johnson, *supra* note 3.

8. During a focus group of health professionals (physicians, pharmacists, and nurses) in January 1998 and a symposium in March 1998, both held in Iowa in conjunction with this project, fear of regulatory reprisal was cited as a major reason for underprescribing in clinical decision making on pain management. The Iowa Board of Medical Examiners (IBME) formally adopted an administrative rule on chronic pain management in early 1997; the rule had been noticed for comment six months earlier. In addition, IBME had established the guidelines as policy in a decision in a widely publicized case in late 1995. IBME's policy clearly states it recognizes that effective pain management can be achieved through the use of high dosages of narcotic analgesics and then sets guidelines, based on those adopted by California in 1994, for prescribing to chronic (nonmalignant) pain patients. See Cal. Bus. & Prof. Code § 2241.5 (West 1998).

9. See Johnson, *supra* note 2; and Johnson, *supra* note 3.

10. A review of the available data on disciplinary actions taken by state medical boards from 1989 to 1997 reveals that no actions were reported to FSMB's data bank or to the National Practitioner Data Bank (NPDB) in which the ground or cause for action was identified as underprescribing. For a broader and more in-depth study of administrative, civil, and criminal actions that yielded similar findings, see Johnson, *supra* note 2.

11. See Memorandum "Improving End-of-Life Pain and Symptom Management," from B.K. Robinson et al., Compassion in Dying, to All State Medical Boards and the Federation of State Medical Boards (Jan. 12, 1998) (on file with author).

12. See Joranson and Gilson, *supra* note 5; Johnson, *supra* note 2; and Johnson, *supra* note 3.

13. Statement of Hospice Physician, Focus Group, Ankeny, Iowa (Jan. 6, 1998) (on file with author) (responding to the question: "Has the chronic pain management policy adopted by the Board [Iowa Board of Medical Examiners] eliminated or

reduced your concerns about facing disciplinary action for inappropriate prescribing?").

14. American Medical Association, *Code of Ethics* (Chicago: American Medical Association, 1990): at 36.

15. For a more in-depth discussion of the problems with most of these efforts, see Joranson and Gilson, *supra* note 5. In general, the focus of the criticism is that a long, and often detailed, list of procedures, which a physician must follow when treating a chronic pain patient to avoid disciplinary action, creates a barrier itself. This defensive format is similar to that used in practice parameters as protection against malpractice. Physicians tend to view practice parameters as a necessary evil that limits their clinical decision-making discretion.

16. See, in particular, P. Rousseau, "Do Terminally Ill Patients Receive Adequate Pain Management?," *Drugs and Aging*, 8 (1996): 233-36; L.S. Hitchcock, B.R. Ferrell, and M. McCaffrey, "The Experience of Chronic Nonmalignant Pain," *Journal of Pain and Symptom Management*, 5 (1994): 312-18; R.K. Portenoy and R. Payne, "Acute and Chronic Pain," in J.H. Lowinson, P. Ruiz, and R.B. Millman, eds., *Comprehensive Textbook of Substance Abuse* (Baltimore: Williams & Wilkins, 1992): 695-721; K.M. Foley, "The Treatment of Cancer Pain," *N. Engl. J. Med.*, 313 (1985): 84-95; C.S. Hill and W.S. Fields, eds., *Advances in Pain Research and Therapy* (New York: Raven Press, Vol. 11, 1989); and R.L. Daut and C.S. Cleeland, "The Prevalence and Severity of Pain in Cancer," *Cancer*, 50 (1982): 1913.

17. See D. Morris, "Pain's Dominion: What We Make of Pain," *Wilson Quarterly*, 3 (1994): 10; N.L. Cantor and G.C. Thomas, "Pain Relief, Acceleration of Death and Criminal Law," *Kennedy Institute of Ethics Journal*, 2 (1996): 107-28; K.M. Foley, "Controlling the Pain of Cancer," *Scientific American*, Sept. (1996): 164-65; L.F. Post et al., "Pain: Ethics, Culture, and Informed Consent to Relief," *Journal of Law, Medicine & Ethics*, 24 (1996): 348-59, and N.J. Marcus and J.S. Arbeiter, *Freedom from Chronic Pain* (New York: Simon & Schuster, 1994).

18. See, for example, J.M. Schrof, "Caught in Pain's Vicious Cycle," *U.S. News & World Report*, Mar. 17, 1997, at 55-57, 60-65; S. Brownlee, "Effective Pain Treatments Already Exist: Why Aren't Doctors Using Them?," *U.S. News & World Report*, Mar. 17, 1997, at 55-57, 60-65; M. Batten, "Take Charge of Your Pain," *Ms. Magazine*, Jan.-Feb. (1995): at 35-37, 80-81; V. Brower, "A World of Hurt," *Utne Reader*, July-Aug. 1996, at 20-21; and D. Stehlin, "The Challenge of Relieving Pain," *FDA Consumer*, Sept. (1991): 30-35.

19. The point that inadequate pain management is a global problem is made in R.T. Angarola and D.E. Joranson, "International Efforts Underway to Provide Adequate Medication for Pain Control," *APS Bulletin*, 5, no. 6 (1995): 9-10, 23.

20. See, for example, T. Parran Jr., "Prescription Drug Abuse: A Question of Balance," *Alcohol and Substance Abuse*, 81 (1997): 967-78.

21. The Mayday Pain Resource Center has compiled a comprehensive index of the publications in this area. See *Mayday Pain Resource Center Materials* (Duarte: City of Hope National Medical Center, Nursing Research & Education, Dec. 1997). See also Portenoy, *supra* note 1; R.K. Portenoy, "Chronic Opioid Therapy in Nonmalignant Chronic Pain," *Journal of Pain and Symptom Management*, 5 (1990): S46-S62; and references cited *supra* notes 13-17.

22. David Morris argues, for example, "that drugs alone cannot control the wide range of pain syndromes." Morris, *supra* note 17, at 10. See also Parran, *supra* note 20.

23. Jacob Sullum explores this notion. See J. Sullum, "No Relief in Sight," *Reason*, Jan. (1997): 22-28.

24. See, for example, A. Trachtenberg, ed., "Treatment of

Pain in Addicts and Others Who May Have Histories of Dependence" (Washington, D.C.: Center for Substance Abuse, U.S. Public Health Service, Unpublished Monograph, Mar. 1998) (presenting findings of experts before the Office of Pharmacological and Alternative Therapies).

25. See, for example, Sullum, *supra* note 23; Johnson, *supra* note 2; Hill, *supra* note 1; and R. Nowak, "Cops and Doctors: Drug Busts Hamper Pain Therapy," *Journal of NIH Research*, 4 (1992): 27-28.

26. See R.T. Angarola and D.E. Joranson, "Healthcare Reimbursement Policies: Do They Block Acute and Cancer Pain Management?," *APS Bulletin*, 4, no. 5 (1994): 7-9; and B. Ferrell, "Cost Issues Surrounding the Treatment of Cancer Related Pain," *Journal of Pharmaceutical Care in Pain & Symptom Control*, 1 (1993): 1, 9-23.

27. See R. Carter, "Giving a Drug a Bad Name...," *New Scientist*, Apr. 6, 1996, at 14-15; M. Zenz, "Morphine Myths: Sedation, Tolerance and Addiction," *Postgraduate Medicine Journal*, Supp. 81, no. 2 (1991): 100-02; C. Tucker, "Acute Pain and Substance Abuse in Surgical Patients," *Journal of Neuroscience Nursing*, 6 (1990): 339-49; and D.P. Friedman, "Perspectives on the Medical Use of Drugs of Abuse," *Journal of Pain and Symptom Management*, 5 (1990): S2-S5.

28. See R. Selzer, "The Language of Pain," *Wilson Quarterly*, 3 (1994): 28-33.

29. See Morris, *supra* note 17.

30. See Batten, *supra* note 18.

31. See Cantor and Thomas, *supra* note 17.

32. See Portenoy, *supra* note 1; and Foley, *supra* note 16.

33. As indicated earlier, as part of the research for this study, a series of focus groups was held involving Iowa physicians in January 1998. Lengthy interviews were also conducted with physicians and other health care providers practicing in Iowa and other states who are concerned about chronic pain management, from August 1997 to March 1998.

34. Morris, *supra* note 17, at 10.

35. For an overview of applied ethics, see W. Frankena, *Ethics* (Englewood Cliffs: Prentice-Hall 1973); and A. MacIntyre, *After Virtue* (Notre Dame: Notre Dame University Press, 2nd ed., 1984): at 181-225.

36. For elaboration of this argument, see Morris, *supra* note 17; A. Goldman, *The Moral Foundations of Professional Ethics* (Towata: Rowman and Littlefield, 1980): 70-74; and P. Masden and J. Schafritz, "Introduction," in P. Masden and J. Schafritz, eds., *Essentials of Government Ethics* (New York: Meridian, 1992): 1-16.

37. See MacIntyre, *supra* note 35.

38. In the lexicon of philosophy, the former is referred to as a deontological and the latter as a teleological argument. For an elaboration of the distinctions between the two, see L. Strauss and J. Cropsey, eds., *The History of Political Philosophy* (Chicago: University of Chicago Press, 3rd ed., 1987).

39. For an elaboration of Alasdair MacIntyre's arguments on internal and external rewards in ethical systems, see T. Cooper, "Hierarchy, Virtue and Practice: A Perspective for Normative Ethics," in Masden and Schafritz, *supra* note 36, at 286-91.

40. See *id.*

41. See MacIntyre, *supra* note 35.

42. See Masden and Schafritz, *supra* note 36.

43. See J.P. Morgan, "American Opiophobia," *Alcohol and Substance Abuse*, 5 (1986): 163-73.

44. Statement of Participant, Pain Patients and Consumers Focus Group, Des Moines, Iowa (Jan. 7, 1998) (on file with author).

45. See Schrof, *supra* note 18; and Brownlee, *supra* note

18.

46. Pediatrician, Remarks at Iowa Board of Medical Examiners Chronic Pain Symposium, Ankeny, Iowa (Mar. 27, 1998) (on file with author).

47. Interview with Physician Assistant, in Ankeny, Iowa (Mar. 26, 1998) (on file with author).

48. See survey results presented in Von Roenn et al., *supra* note 1. See also Schrof, *supra* note 18; Brownlee, *supra* note 18; and Joranson and Gilson, *supra* note 5.

49. Statement of Iowa Physician, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (on file with author).

50. The definition of addiction was adopted by the American Pain Society. See Batten, *supra* note 18, at 37.

51. See Morris, *supra* note 17.

52. Interview with the Son of the Chronic Pain Sufferer, Pain Patient and Consumers Focus Group, in Des Moines, Iowa (Mar. 19, 1998) (on file with author).

53. Statement of Licensed Pharmacist, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (on file with author).

54. Statement of Internist, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (on file with author).

55. *Id.*

56. Statement of Hospice Nurse, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (on file with author).

57. Statement of Cancer Victim, Focus Group, Des Moines, Iowa (Jan. 7, 1998) (on file with author).

58. *Vacco v. Quill*, 117 S. Ct. 2293 (1997). For a useful discussion of the argument made in the decision, see R.A. Burt, "The Supreme Court Speaks—Not Assisted Suicide, but a Constitutional Right to Palliative Care," *N. Engl. J. Med.*, 337 (1997): 1234-36.

59. See Morris, *supra* note 17, at 8.

60. See Masden and Schafritz, *supra* note 36, on the nature of organizational goals.

61. Interview with Missouri Physician, in Dallas, Tex. (Mar. 17, 1998) (noting that the physician had decided to cease treating chronic pain patients) (on file with author).

62. Interview with Internist, Iowa Board of Medical Examiners Chronic Pain Symposium, in Ankeny, Iowa (Mar. 27, 1998) (noting that the long-term prescribing of opioids is a potential violation of prescribing laws) (on file with author).

63. Interview with Investigator of a Southern Medical Board, Federation of State Medical Boards Chronic Pain Management Symposium, in Dallas, Tex. (Mar. 17, 1998) (on file with author).

64. Comment of Floor Nurse, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (noting regulatory risks) (on file with author).

65. Richard Rosenquist, M.D., University of Iowa Department of Anesthesiology, Keynote Address at Iowa Board of Medical Examiners Chronic Pain Symposium, Ankeny, Iowa (Mar. 27, 1998) (on file with author).

66. Statement of Board Certified Family Practitioner at Iowa Board of Medical Examiners Chronic Pain Symposium, Ankeny, Iowa (Mar. 27, 1998) (on file with author).

67. See Von Roenn et al., *supra* note 1.

68. Statement of Pain Clinic Internist, Focus Group, Des Moines, Iowa (Jan. 8, 1998) (on file with author).

69. Statement of Physician of a Southern Medical Board, Iowa Board of Medical Examiners Chronic Pain Symposium, Ankeny, Iowa (Mar. 25, 1998) (noting the physician's reaction on learning that IBME was considering adopting a rule establishing underprescribing as substandard care) (on file with author).

70. Statement of Pain Clinic Internist, *supra* note 68.

71. This argument was first developed in H.W. Clark and K.L. Sees, "Opioids, Chronic Pain, and the Law," *Journal of Pain and Symptom Management*, 5 (1993): at 304.

72. Every year, the organization representing medical board executives—Administrators in Medicine—holds regional meetings in the United States. About twenty-one board executives were interviewed as part of this study at the Central–Western Regional Meeting, in Phoenix, Arizona, in October 1997, and at the Eastern–Southern Regional Meeting, in Raleigh, North Carolina, during the same month. Between November 1997 and January 1998, telephone interviews were conducted with fifteen additional board executives.

73. Although some of these complainants claimed to be chronic pain sufferers, for reasons that are not entirely clear, board officials did not consider the complaints to be about underprescribing per se.

74. This is a small sampling of medical board rules pertaining to prescribing practices based on a search of state medical board web pages. See Ad Hoc Task Force on Regulatory Issues, Council on Licensure, Enforcement and Regulation, *Uniform Grounds for Disciplinary Actions: Resource Brief* (Lexington: CLEAR, No. 95-3, 1995): at 4. See also AIM, *DocFinder* < <http://www.docboard.org> > (visited Dec. 8, 1998).

75. IBME has considered each of these variations. IBME voted on November 17, 1998, to file a notice to adopt the direct approach (option #2) with the conservative caveat.

76. Numerous articles have made this point. See, for example, J.H. McArthur and F.D. Moore, "The Two Cultures and the Health Care Revolution: Commerce and Professionalism in Medical Care," *JAMA*, 26 (1997): 985–89; and V.R. Fuchs, "Economics, Values and Health Care Reform," *American Economic Review*, Mar. (1996): 1–24.

77. President of a Mid-Western State Medical Society, Address at Iowa Board of Medical Examiners Chronic Pain Symposium, Ankeny, Iowa (Mar. 27, 1998) (on file with author).

78. See Interviews with Medical Board Executives, in Phoenix, Ariz. (Oct. 1997) (on file with author); Interviews with Medical Board Executives, in Raleigh, N.C. (Oct. 1997) (on file with author); and Telephone Interviews with Medical Board Executives (Nov. 1997–Jan. 1998) (on file with author).

79. Statement of Medical Board Member, Federation of State Medical Boards Annual Meeting, Orlando, Fla. (Apr. 30, 1998) (commenting on the administrative rule on underprescribing proposed by IBME) (on file with author).

80. *Id.*

81. For a full account from the perspective of Compassion in Dying, see S.G. Stolberg, "Amid Calls for Pain Relief, New Calls for Caution," *New York Times*, Oct. 13, 1998, at F7.

82. See Lethal Drug Abuse Prevention Act, S. 2151, 105th Cong. (1998).

83. This figure is based on a search of NPDB and FSMB's data base.