

# Providing Relief to Those in Pain: A Retrospective on the Scholarship and Impact of the Mayday Project

Sandra H. Johnson

Scholarship has intrinsic value, of course; but when good scholarship can stimulate change for the better in an area as fundamental to human dignity as health care and the relief of suffering, there is a special satisfaction. This has been our experience since 1996, when the first of now four special issues of this journal focused on legal, regulatory, ethical, professional, and financial issues in medical treatment for pain.

With the generous and steadfast support of the Mayday Fund, the American Society of Law, Medicine & Ethics (ASLME) has generated a significant body of scholarship published in the *Journal of Law, Medicine & Ethics (JLME)*. This research has proven absolutely essential in changing public policy to support better care for those who suffer pain.

Over these years, the Mayday Project at ASLME has tackled many of the real and perceived barriers to effective pain relief. In pain management, both real and perceived obstacles can have a powerful negative effect. If physicians and health care institutions believe, even wrongly, that they cannot do what needs to be done for their patients — for example, because the providers believe that they will be at risk for discipline or prosecution or because payment will be denied — it seriously decreases the likelihood that patients will receive the care they need. The Mayday Project at ASLME began by listening to health care providers — in surveys, in the literature, and at meetings — talk about why pain is undertreated and what obstacles they experienced in their own practices. The research, then, mapped out the characteristics of these obstacles and always with an eye toward identifying what reflected reality, what was merely perceived, and what could be done in either case to remove barriers to pain relief.

The Mayday-funded research appearing in the four symposia of *JLME* has addressed racial and gender bias and cultural influences in the treatment of pain;<sup>1</sup> payment for medical care for the relief of pain;<sup>2</sup> the appropriate standards for liability for inadequate care, including criminal prosecution for decisions made in the care of patients at the end of life;<sup>3</sup> interprofessional issues, focusing especially on the role of pharmacists;<sup>4</sup> and, of course, the medical and ethical boundaries of pain management.<sup>5</sup>

The standards, policies, and practices relating to medical licensure and discipline have been a special emphasis of the project and formed the focus of the first symposium issue.<sup>6</sup> It is in this area that we have seen the greatest change in public policy during the course of the Mayday Project at ASLME.

When we began with the first grants in 1995,<sup>7</sup> we decided to examine issues in medical licensure and discipline, an obstacle that physicians claimed deterred them from treating their patients in pain most effectively.<sup>8</sup> The reason we chose that area was in part because it represented a confluence of medical, ethical, and legal issues and thus was well suited to ASLME's strength in providing a forum for interdisciplinary research and education in health care.

Furthermore, the distance between the standards used by the state medical boards at that time and what medical research on the use of controlled substances for relief of chronic pain had revealed was symbolic of so many of the obstacles to effective pain relief. Most medical board members are themselves physicians; and the disconnect between customary medical practice as reflected in the standards applied by the boards and improved research-based practices demonstrated the difficulties and the lag inherent in the diffusion of new clinical knowledge into medical practice. The presumptions and attitudes exhibited by medical board members reflected larger social issues as well. These larger social

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issues included a distrust of patients in pain and, at times, of the physicians who treated them as well as the influence of the national antidrug campaign of the previous decades. As authorities in identifying the appropriate standards for medical practice, the opinions and practices of the medical boards mattered — whether or not the number of physicians actually disciplined was quite small (as was actually the case) or quite large (as was the perception).<sup>9</sup>

Because the boards are dominated by professionals with medical expertise who are committed to improving health care for the public, an approach for reform that focused on changing the standards used by medical boards offered great promise that they would move away from an enforcement system that operated under the influence of the “war on drugs” and saw diversion as the major evil, and move toward a more balanced approach that would prioritize effective pain relief as a central goal of their work in this area. Before that could be done, however, a question had to be answered: Was there really a problem in the policies and practices of the medical boards in relation to physicians who treated patients for pain with controlled substances; or did the doctors simply misunderstand the situation, at best; or, at worst, were they using their expressed fears of medical board action as a scapegoat for other unarticulated reasons motivating their undertreatment of patients in pain?

The first *JLME* symposium on pain relief included the results of research on disciplinary actions against physicians and state intractable pain statutes,<sup>10</sup> as well as a case study of Texas legislation and regulations,<sup>11</sup> a state that had taken a leadership role in changing the customary disciplinary practices, and a description of how educational efforts with the state medical boards could effect change.<sup>12</sup> In a later issue, the executive director of a state medical board, one of the first Mayday Scholars, analyzed the ethical issues in treating pain from the perspective of how a state medical board could contribute to improving pain management practices,<sup>13</sup> and two officers of the American Academy of Pain Management wrote urging a sense of balance in the application of regulatory guidelines and in the use of the intractable pain statutes.<sup>14</sup>

Many organizations, including the Pain & Policy Studies Group, the American Pain Society, the American Academy of Pain Management, and others, were working to improve the public policy environment for physicians treating patients in pain. The Mayday Project of the American Society of Law, Medicine & Ethics took a leadership role in this effort. In 1996, the Society’s National Meeting on Legal, Ethical, and Institutional Issues in Pain Relief convened the leadership of each of these groups, government officials from state attorney general offices and the state medical and pharmacy boards, pain patients, patient advocates, practicing physicians, nurses, health care administrators, and pharmacists. The grants supported the attendance of fifty policymakers and patient advocates, and this allowed pharmacists to speak with physicians and nurses; attorneys general to speak with

patient advocates; and medical board leaders to meet directly with the doctors who feared them. The workshops were enlightening, and the people in attendance were in a position to make a change.

The research published in the 1996 *JLME* issue, which followed the national meeting, documented that the standards used by medical boards at that time did not recognize the best practices in pain management and that the processes themselves had a negative impact on care. The issue also included a proposal for the Pain Relief Act.<sup>15</sup> At the time the issue was published, only ten states had statutes that addressed the prescription of controlled substances for the treatment of intractable pain and only six of those addressed the concern of disciplinary action.<sup>16</sup> Only six more states had guidelines or regulations on the subject.<sup>17</sup>

The proposed Pain Relief Act departed from the statutes and practices then in effect in significant ways. First, the proposed statute extended coverage beyond physicians to include other health care providers, such as pharmacists, nurses, and physician assistants. The early statutes protected physicians only.<sup>18</sup> Second, the Act required that the state medical board support any decision to discipline a physician with expert testimony proving that the physician violated current national standards in his practice. In most states, medical boards are not required to produce expert testimony to support their decisions in every case.<sup>19</sup> Finally, the proposed statute clearly stated that its protection applied to the care of patients who were chemically dependent. While most of the statutes in existence at that time did not specifically prohibit physicians from treating chemically dependent patients with controlled substances for pain relief, the statutes included a specific limitation relating to the treatment of such patients that was very commonly misunderstood to either prohibit or discourage the treatment of such patients for pain.<sup>20</sup>

Shortly after the 1996 conference, the Federation of State Medical Boards, which is the national organization of state medical boards,<sup>21</sup> established a task force to address the standards that medical boards should use in reviewing a physician’s prescribing practices. The Federation included ASLME as a participant in the task force. After several months of work and review, the task force produced new guidelines for state medical boards, which the Federation’s House of Delegates adopted as policy in 1998.<sup>22</sup>

The new Model Guidelines for the Use of Controlled Substances for the Treatment of Pain made three very significant policy statements that responded directly to concerns that had been expressed in the published research. First, the Model Guidelines unequivocally stated that “controlled substances, including opioid analgesics, may be essential in the treatment of acute pain ... and chronic pain.” Second, the Model Guidelines stated that the legitimacy of the physician’s treatment of the patient would not be judged by “the quantity and chronicity of prescribing,” as had been the previous prac-

tice and one of the serious problems that had been identified in the Mayday Project research. Finally, like the Pain Relief Act, the Model Guidelines explicitly recognized that physicians may treat chemically dependent patients for pain with controlled substances.

There are always disputes over whether the legislature or the state medical board is in the better position to stimulate positive change in disciplinary standards and processes.<sup>23</sup> After all, legislatures are political bodies, not experts in medicine or professional discipline. On the other hand, medical boards, like other professional entities, can be resistant to departing from well-established custom. There is merit to both of these positions, of course. The balance between them is inherent in the structure of administrative law, with its division of power and roles between legislature and agency. In some cases, the simple threat of legislative action can effect change by stimulating an immediate response on an administrative level. In any case, the shared goal in such an effort, whether structured as statute or agency rule or policy, is to position the boards to bring their standards in line so that physicians in compliance with the best practices in pain management, rather than merely the customary practice of undertreatment in pain management, are safe from disciplinary action.

The number of states with legislation addressing concerns over the risk of discipline for the treatment of patients in pain has more than doubled since 1996. At least twenty-three states now have statutes providing legislative guidance or a mandate for the development of written guidelines on the part of the state medical board in its monitoring of physician prescribing practices in the treatment of pain.<sup>24</sup> Almost all of these statutes provide at least physicians with immunity from any disciplinary action that does not fall within the statutorily established boundaries for medical board action.<sup>25</sup>

The influence of the Pain Relief Act is apparent among the new statutes and amendments passed since 1996. For example, the New Mexico Pain Relief Act, effective in 1999, is nearly identical to the Pain Relief Act as first proposed in *JLME*.<sup>26</sup> West Virginia's statute, enacted in 1998, adopts the major provisions of the statute, including coverage that extends to nurses and pharmacists, protection for health care providers who can demonstrate substantial compliance with an "accepted guideline," and a clear statement that physicians may treat chemically dependent individuals with controlled substances for pain relief.<sup>27</sup> Nebraska amended its statute in 1999 and extended its coverage to include nurses;<sup>28</sup> and Texas amended its statute in 1997 to state that its protections extend to physicians treating chemically dependent patients for pain.<sup>29</sup> A few of the new state statutes take a different approach, some of which could cause difficulties. For example, the Ohio statute, enacted in 1997, requires evaluation of the patient by a specialist.<sup>30</sup> Such a requirement could operate as a barrier to patients and a discouragement to physicians.

An additional substantial effect is observable in the activity among the medical boards themselves. In 1996, only twelve states had written policies or regulations to govern cases of disciplinary action against physicians for their prescription of controlled substances for patients in pain.<sup>31</sup> The Pain & Policy Studies Group now reports that at least forty states had adopted policy statements, guidelines, or regulations as of the end of 2002.<sup>32</sup> The influence of the Federation's Model Guidelines is clear, as most of these adopt or parallel what was recommended by the Federation, as an article by researchers with the Pain & Policy Studies Group in this issue demonstrates.<sup>33</sup> However, as with the legislation enacted over the past several years, medical board guidelines are not all created equal and the guidelines under which the boards operate vary in quality.<sup>34</sup>

Enacting even the best legislation or adopting the most effective guidelines or policies does not necessarily mean that there has been any change in practice or attitudes on the part of the regulators. There is always the chance that all the paper in the world won't effect any real change at all. Fortunately, this does not appear to be the case here. Real change in the culture of the medical boards around this issue is documented in Diane Hoffmann and Anita Tarzian's article in this symposium.<sup>35</sup>

The effort to change public policy toward improving the treatment of patients in pain cannot declare victory at this point. The challenges for public policy in health care generally, and in pain management in particular, are cyclical. New research and emerging practices in the use of opioids for the treatment of chronic noncancer pain changed the fundamental assumptions on which the disciplinary activity of the boards had been based. New learning in regard to pain treatment is bound to create serious gaps again. The resident challenge for medical licensure and discipline is its ability to distinguish "good" doctors from "bad" doctors and to rehabilitate or remove the bad doctors without driving the good doctors into defensive "safe zones" of practice that do not serve patients well.

"Sentinel events" on the national scene can significantly shift the center of emphasis in policymaking as well. For example, when the Pain Relief Act was published and the Federation's Model Guidelines were adopted, Oregon had just enacted the first statute to legalize physician-assisted suicide.<sup>36</sup> Rather than making policymakers more fearful of "drugs" and "narcotics" for the treatment of pain, however, the movement to legalize assisted suicide stimulated a nationwide focus among the states on improving the quality of care and pain relief for terminal patients, with a largely beneficial side benefit to patients in chronic pain. This certainly created a policymaking environment on both the legislative and administrative level that was receptive to the Pain Relief Act and to the Model Guidelines. More recently, however, the experience with the abuse of OxyContin threatened to shift the balance away from pain relief and toward severe restriction of access to an effective pain treatment.<sup>37</sup>

Although central to its activity, the Mayday Project did not focus solely on medical licensure, and neither does this symposium. Like the earlier "Mayday" issues, this issue of *JLME* includes a range of articles in addition to the article on medical boards by Hoffmann and Tarzian. First, David Brushwood examines electronic monitoring systems for prescriptions for controlled substances.<sup>38</sup> These systems are in place in some states and are being considered in several others. The question Brushwood addresses is whether these systems will have an adverse or positive effect on the care of patients in pain. Research had indicated that the earlier "triplicate" paper-based prescription monitoring systems resulted in physicians' being hesitant to prescribe controlled substances for their pain patients even when the medications were clinically indicated.

Lars Noah then presents an analysis that explains the interaction between the two federal behemoths in regulating, either directly or indirectly, the availability of effective pain medication.<sup>39</sup> He concisely identifies the crux of the public health issues that the Food and Drug Administration and the Drug Enforcement Administration confront and how their definition of their roles determines what they can do.

Next, Stephen Ziegler and Nicholas Lovrich, Jr., have generated new data to respond to physicians' fears of legal penalty for treating patients in pain.<sup>40</sup> Their survey of local prosecutors in four states taps into the attitudes of the individuals who make the final decision as to whether or not to prosecute.

Finally, Jean Lazarus and Wendy Downing write about the issues presented to boards of nursing as they confront the same concerns about prescribing practices that the medical boards have been confronting.<sup>41</sup> Their focus on the role of monitoring the prescribing practices among nurse practitioners highlights a particular issue in that effort.

The Mayday Project at ASLME has had a significant influence on the debates surrounding treatment of patients in pain because of the publication of the special issues of the *Journal of Law, Medicine & Ethics*. But the impact of the Mayday Project extends further than that of these special issues and will persist even longer. In 1997, the Mayday Project established the Mayday Scholars Program. This program had one primary goal: to create a cadre of scholars in law, ethics, finance, and the social sciences who would turn their considerable talent, creativity, and effort toward the plight of persons in pain. We thought that once individuals of their caliber had spent some substantial time researching a particular issue that negatively affected access to effective pain relief, they would "catch fire" and continue to work in the field. This has certainly been the case. Most of the Mayday Scholars have continued to research and publish on these issues, include them in their teaching, and provide critical expertise and support to individuals and institutions trying to effect change. Several of the Mayday Scholars have undertaken very significant projects with substantial funding to

change current practices within particular states.<sup>42</sup> It has been a privilege to work with them and to see that there is a deep reserve of expertise and commitment that will continue to improve the situation of persons in pain.

As this issue of the *Journal of Law, Medicine & Ethics* is published, another season of the national pastime has just begun. First base, second, third, and home plate. With this fourth special symposium issue on pain management, the *Journal of Law, Medicine & Ethics*, the American Society of Law, Medicine & Ethics, and the Mayday Fund have reached home plate. Although the Mayday Scholars Program has reached its final year, the Mayday Project at ASLME continues. ASLME, again with the support of the Mayday Fund, will be convening a national conference in 2004 and a fifth special issue of *JLME* will be published, this time with a new emphasis on pain management in the emergency department. It has been a championship season, and we are ready to begin the cycle again.

#### ACKNOWLEDGMENTS

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6. Project on Legal Constraints on Access to Effective Pain Relief, “The Pain Relief Act,” *Journal of Law, Medicine & Ethics*, 24, no. 4 (1996): 317–18; S. Johnson, “Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act,” *Journal of Law, Medicine & Ethics*, 24, no. 4 (1996): 319–27; D. Ralston, “Pain Management: Texas Legislative and Regulatory Update,” *Journal of Law, Medicine & Ethics*, 24, no. 4 (1996): 328–37; C. Hyman, “Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment,” *Journal of Law, Medicine & Ethics*, 24, no. 4 (1996): 338–43; D.E. Joranson and A.M. Gilson, “Improving Pain Management through Policy Making and Education for Medical Regulators,” *Journal of Law, Medicine & Ethics*, 24, no. 4 (1996): 344–47.

7. The first two years of the project were also supported by the Emily Davie and Joseph S. Kornfeld Foundation.

8. F.J. Skelly, “Fear of Sanctions Limits Prescribing of Pain Drugs,” *American Medical News*, August 15, 1994, at 19; R.K. Portenoy, “Opioid Therapy for Chronic Non-Malignant Pain: A Review of the Critical Issues,” *Journal of Pain and Symptom Management*, 11 (1996): 203–17, at 204; New York Public Health Council, *Breaking Down the Barriers to Effective Pain Management, Recommendations to Improve the Assessment and Treatment of Pain in New York State* (January 1998).

9. Johnson, *supra* note 6, at 321.

10. Johnson, *supra* note 6.

11. Ralston, *supra* note 6.

12. Joranson and Gilson, *supra* note 6.

13. Martino, *supra* note 5.

14. Haddox and Aronoff, *supra* note 5.

15. Johnson, *supra* note 6.

16. Hyman, *supra* note 6, at 340.

17. *Id.* at 341.

18. See *id.* at Table 1. As of 1996, California, Missouri, Nevada, North Dakota, Oregon, and Texas had enacted statutes with provisions preventing disciplinary action against physicians and/or osteopathic physicians. None of these statutes provided disciplinary protection for other health care professionals.

19. B. Furrow et al., *Health Law*, Practitioner Treatise Series, 2nd ed. (St. Paul: West Publishing Co. 2000): § 3-23(a).

20. See, e.g., Mo. Rev. Stat. § 334.106 (1995) (“The provisions of ... this section shall not apply to those persons being treated by a physician for chemical dependency because of their use of controlled substances not related to the therapeutic purposes of treatment of intractable pain.”). See also N.D. Cent. Code § 19-03.3-05 (1995) (“This chapter does not authorize a physician to prescribe or administer controlled substances to a person the physician knows is using controlled substances for nontherapeutic purposes.”).

21. The Federation of State Medical Boards is composed of medical boards from the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands, and thirteen state boards of osteopathic medicine. Along with the National Board of Medical Examiners, the Federation created and administers uniform testing for medical licensing. The Federation also developed and administers assessment tools for evaluation of ongoing clinical performance and maintains the Federation Data Center, a nationally recognized system for collecting, recording, and distributing to state medical boards and other appropriate agen-

cies data on disciplinary actions taken against physicians and physician assistants by the boards and other governmental authorities. The Federation’s mission is the continual improvement in the quality, safety, and integrity of health care through the development and promotion of high standards for physician licensure and practice. Federation of State Medical Boards, *About Us*, at <[http://www.docinfo.org/alp\\_about\\_us.htm](http://www.docinfo.org/alp_about_us.htm)> (last visited February 7, 2003); Federation of State Medical Boards, *FSMB Facts*, at <<http://www.fsmb.org/aboutus.htm>> (last visited February 7, 2003).

22. Federation of State Medical Boards, *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* (Euleess, Texas: Federation of State Medical Boards, 1998), available through <<http://www.fsmb.org>>.

23. Federation of State Medical Boards, *Position of the Federation of State Medical Boards in Support of Adoption of Pain Management Guidelines* (Euleess, Texas: Federation of State Medical Boards of the United States, 2000), available at <<http://www.medsch.wisc.edu/painpolicy/domestic/FSMBwp.htm>>. (“The Federation promotes a non-legislative approach in improving the regulation of physicians prescribing controlled substances in the treatment of pain. Legislative action may hinder the appropriate management of pain by physicians through unnecessary requirements and could supplant the authority of state medical boards to improve the quality of care available to patients within their jurisdictions. Thus, state medical boards should be proactive in the promotion of pain management policy initiatives to preclude legislative intervention.”).

24. Ariz. Rev. Stat. § 13-3412.01 (2002); Cal. Bus & Prof Code § 2241.5 (2003); Colo. Rev. Stat. §§ 12-36-117, 18-18-308 (2002); Fla. Stat. § 458.326 (2002); Mass. Gen. Laws ch. 94C § 9 (2003); Mich. Comp. Laws §§ 333.16204a, 333.16204b, 333.16204c, 333.16204d (2002); Minn. Stat. § 152.125 (2002); Mo. Rev. Stat. §§ 334.105–334.107 (2002); Neb. Rev. Stat. §§ 71-2418, 71-2419 (2002); Nev. Rev. Stat. §§ 630.3066, 630.135 (2002); N.H. Rev. Stat. Ann. § 318-B:10 (2002); N.M. Stat. Ann. §§ 24-2D-1 to 24-2D-6 (2002); N.D. Cent. Code §§ 19-03.3-01 to 19-03.3-06 (2002); Ohio Rev. Code Ann. § 4731.052 (2002); Okla. Stat. tit. 63 § 2-551 (2003); Or. Rev. Stat. §§ 127.800–127.897 (2001); R.I. Gen. Laws §§ 5-37.4-1 to 5-37.4-3 (2001); Tenn. Code Ann. §§ 63-6-1101 to 63-6-1109 (2002); Tex. Rev. Civ. Stat. Ann. § 4495c (2002); Va. Code Ann. § 54.1-3408.1 (2002); Wash. Rev. Code § 69.50308 (2002); W. Va. Code §§ 30-3A-1 to 30-3A-4 (2002); Wis. Stat. §§ 961.001 and 961.38 (2002). See also Pain & Policy Studies Group, University of Wisconsin Comprehensive Cancer Center, *Data-base of State Laws, Regulations and Other Official Governmental Policies*, at <<http://www.medsch.wisc.edu/painpolicy/matrix.htm>> (last updated November 5, 2002).

25. *Id.* See, e.g., Ohio Rev. Code Ann. § 4731.052 (2001) (“A physician who treats intractable pain by managing it with dangerous drugs is not subject to disciplinary action by the board under section 4731.22 of the Revised Code solely because the physician treated the intractable pain with dangerous drugs. The physician is subject to disciplinary action only if the dangerous drugs are not prescribed, furnished, or administered in accordance with this section and the rules adopted under it.”).

26. Johnson, *supra* note 6; Project on Legal Constraints on Access to Effective Pain Relief, *supra* note 6; N.M. Stat. Ann. §§ 24-2D-1 to 24-2D-6 (2002).

27. W. Va. Code §§ 30-3A-1 to 30-3A-4 (2002).

28. Nebr. Rev. Stat. §§ 71-2418, 71-2419 (2002).

29. Tex. Rev. Civ. Stat. Ann. § 4495c (2002).

30. Ohio Rev. Code Ann. § 4731.052(C) (2002).

31. Hyman, *supra* note 6, at 341.

32. Pain & Policy Studies Group, *supra* note 24.

33. A.M. Gilson, D.E. Joranson, and M.A. Maurer, "Improving State Medical Board Pain Policies: Influence of a Model," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 119-29; See also D.E. Joranson et al., "Pain Management, Controlled Substances, and State Medical Board Policy: A Decade of Change," *Journal of Pain and Symptom Management*, 23, no. 2 (2002): 138-47, at 144.

34. *Id.*

35. D.E. Hoffmann and A.J. Tarzian, "Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 21-40.

36. Or. Rev. Stat. §§ 127.800 to 127.897 (1995).

37. Two of the articles in this symposium address the OxyContin issue. See Hoffmann and Tarzian, *supra* note 35; L. Noah, "Challenges in the Federal Regulation of Pain Management Technologies," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 55-74.

38. D.B. Brushwood, "Maximizing the Value of Electronic Prescription Monitoring Programs," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 41-54.

39. Noah, *supra* note 37.

40. S.J. Ziegler and N.P. Lovrich, Jr., "Pain Relief, Prescription Drugs, and Prosecution: A Four-State Survey of Chief

Prosecutors," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 75-100.

41. J.B. Lazarus and B. Downing, "Monitoring and Investigating Certified Registered Nurse Practitioners in Pain Management," *Journal of Law, Medicine & Ethics*, 31, no. 1 (2003): 101-18.

42. For example, ASLME, Ben Moulton, and Mayday Scholar Diane Hoffmann conducted the Connecticut Statewide Pain Management Study, a two-year project funded by the Donaghue Medical Research Foundation. The purpose of the study was to develop baseline data on the adequacy of pain treatment in the state of Connecticut and to use the data as a basis for generating interventions and recommendations for further research to address the problem of undertreatment of pain in the state. Based on the findings from the Donaghue grant, the following were published: A. Tarzian, S. David, and D. Hoffmann, "Management of Cancer-Related and Noncancer-Related Chronic Pain in Connecticut: Successes and Failures," *Connecticut Medicine*, 66 (2002): 683-89; D. Hoffmann, Z. Lazzarini, and B. Moulton, "Constraints to Prescribing Medications for Pain Treatment in Connecticut: Part I," *The Pain Clinic*, 4 (2002): 28-35; D. Hoffmann and A. Tarzian, "Third Party Reimbursement Practices and Their Influence on Pain Management in Connecticut: Part I," *The Pain Clinic*, 4 (2002): 11-16.

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