

# **Pain Management and Palliative Care: The Medical, Ethical and Legal Issues at the End-of-Life.**

## **Contents**

- I. INTRODUCTION**
- II. BIBLIOGRAPHY STRUCTURE**
- III. STATUTES**
- IV. REGULATIONS AND GUIDELINES**
- V. OVERVIEW MATERIAL/ RELEVANT STATUTE LISTS**
- VI. CASE LAW**
- VII. PRACTICE MANUALS/ INSTRUCTIONAL MATERIALS**
- VIII. GOVERNMENT PUBLICATIONS**
- IX. SERIALS/UPDATED PUBLICATIONS**
- X. BOOKS/PAMPHLETS**
- XI. ACADEMIC ARTICLES/ PUBLICATIONS**

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**CITATION: Arnold, JF. Pain Management and Palliative Care: The Medical, Ethical and Legal Issues at the End-of-Life. Medical University of South Carolina Institute of Human Values in Health Care: Charleston, South Carolina, August 1999 (Monograph).**

## **INTRODUCTION**

Pain relief has become a central issue in quality care of the dying and in the debate over assisted suicide. Among the chief reasons frequently noted for the inadequacy of the treatment of pain is that the legal system actually penalizes effective interventions to relieve pain while it leaves neglect of pain unthreatened.<sup>1</sup> In response, several states have acted to reduce the threat of disciplinary action against physicians who appropriately treat pain. Similarly, professional and consumer organizations have all advocated more emphasis on improved communication between the physician and patient.<sup>2</sup>

Over the past ten years, legislators and policy makers have also have paid great attention to the important issues surrounding assisted suicide and end of life care. In 1997, for example, the U.S. Supreme Court affirmed that state legislatures may decide whether or not to legalize physician assisted suicide. While the decision struck down a patient's right to receive physician-assisted suicide, the Supreme Court arguments generated substantial interest in the care and treatment of patients at the end of life. In response, several state legislatures began to explore ways in which to improve the care of the seriously ill and dying patients. By early 1998, at least 20 states had established commissions or task forces to examine end of life care issues. Most of the task forces have focused on the themes that are highlighted in this report, including addressing barriers to improving end-of-life care services, discussing factors associated with physician-assisted suicide or encouraging better pain management by physicians.

The purpose of this guidebook is to provide information about the medical, ethical and legal issues at the end of life. Since the issues surrounding end of life care are complex, however, this guidebook is intended to serve as an introduction to the topic. Toward this goal, this report summarizes and analyzes legislation on intractable pain and barriers to effective pain relief. It also highlights the major policy considerations that must be addressed in order to reach consensus on future strategies. This report must be read in context with broader state health care reform and assisted suicide legislation, as well as important federal legislative and regulatory approaches that affect medical practitioners and the prescription of controlled substances.

## **BIBLIOGRAPHY STRUCTURE**

As discussed above, this bibliography is intended as an informative guide to the legal constraints to effective pain relief. The materials in this bibliography include information on intractable pain statutes in general, with some specific references to articles addressing the clinical, legal, and regulatory barriers to the management of pain. The emphasis is on the legal and regulatory barriers to effective pain management. However, the focus of the project, in line with the Institute of Human Values in Health Care's mission, is on the medical, ethical and legal impact of these barriers on other factors such as professional training, institutional organization, or social constructs. As such, this bibliography is aimed at researchers who are interested in developing new scholarship on legal and regulatory issues as they relate to pain management. Many of the materials, however, are also appropriate for lay persons wishing to discover how state medical boards are organized or how its appeals process works. The intent was to avoid policy or politically oriented materials and focus on consumer and advocate information. Since

much of this literature is relatively new, materials written before 1990 were generally excluded. Entries are alphabetized according to category (i.e., State and Federal Statutes/Regulations; Government Publications, etc.).

Obscure publications are, for the most part, excluded. Most of the materials included in this report are easily obtained from any law library or academic research center. However, the Institute of Human Values at the Medical University of South Carolina can assist those individuals without access to such facilities. Any questions or comments should be submitted to the program office at the address listed below. The resource search for this bibliography was conducted in the Law Library at Brooklyn Law School, the College of Physicians and Surgeons Medical Library at Columbia University, and, finally, at the Medical University of South Carolina. Additionally, some general health care, Medicare, and Medicaid web sites are listed, as well as other sources that were retrieved from online search programs like FirstSearch, Westlaw, and Lexis/ Nexis. Finally, some resources were obtained from the American Association of Retired Persons (AARP) extensive Resource Information Center and Publications Department in Washington, D.C. AARP has many resources of interest to older adults and senior advocates. The Uniform System of Citation was used for reference cites, but was modified to include the author and publication full name, when necessary.

## **I. STATUTES**

### **A. Federal**

Before examining individual state policies regarding the prescribing of controlled substances for the treatment of pain, it is necessary to introduce federal provisions. These are explained below.

#### **Controlled Substances Act 21 U.S.C. § 801 (1996)**

Congress states in the legislative findings section of the CSA that “many of the drugs included within this title have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.”<sup>3</sup> Moreover, the regulation implementing CSA states that “for a controlled substance to be effective [a prescription] must be issued for a *legitimate medical purpose* by a practitioner acting *in the usual course of professional practice*.”<sup>4</sup>

#### **Harrison Narcotic Act. 26 C.F.R. §§ 151.90, 151.67 (1939)**

The Code of Federal Regulations (CFR) requires prescriptions by a physician for a controlled substance to be issued for “a legitimate medical purpose in the usual course of professional practice.” Harrison Narcotic Act 26 C.F.R. §§ 151.90, 151.67 (1939). The Department of Justice<sup>5</sup> uses the Harrison Narcotic Act of 1914 in implementing and interpreting the Controlled Substances Act (CSA).<sup>6</sup>

## B. State<sup>1</sup>

In the past ten years, there has been a new trend for states to adopt policies that address the prescribing of opioid analgesics for chronic pain. These new policies take one of three forms: state laws or statutes; administrative regulations; and medical board guidelines. The reason for this trend and the distinctions between these different policies are discussed below.

As mentioned earlier, there has been increasing recognition on the part of health care professionals and policymakers that the management of pain, including chronic noncancer pain, is woefully inadequate. In response, several states have adopted new policies to better characterize the conditions under which opioids could be prescribed for the management of pain. Texas, for example, was the first state to pass an Intractable Pain Treatment Act (IPTA) in 1989.<sup>7</sup> A number of laws have been adopted by different states concerning pain management. (Law is a broad term that refers to rules of conduct with binding legal force). Since 1989, the following states have passed IPTAs that permit the prescribing of opioid medication for chronic pain patients:

<b><u>California</u></b>	<b>Cal. Bus. &amp; Prof. Code § 2241.5 (Deering 1996)</b>
<b><u>Colorado</u></b>	<b>Colo. Rev. Stat. § 18-18-308 (1996)</b>
<b><u>Florida</u></b>	<b>Fla. Stat. ch. 458.326 (1995)</b>
<b><u>Michigan</u></b>	<b>Mich. Stat. Ann. § 14.15 (16204a) (Law. Co-op. 1996)</b>
<b><u>Minnesota</u></b>	<b>Minn. Stat. § 152.125 (1997)</b>
<b><u>Missouri</u></b>	<b>Mo. Rev. Stat. §§ 334.105, 334.106 (1996)</b>
<b><u>Nevada</u></b>	<b>Nev. Rev. Stat. Ann. §§ 630.135, 630.3066, 633.521, 453.1545, 453.256 (Michie 1995)</b>
<b><u>North Dakota</u></b>	<b>N.D. Cent. Code §§ 19-03.3-01, 19-03.3-02, 19-03.3-03, 19-03.3-04, 19-03.3-05 (1995)</b>
<b><u>Ohio</u></b>	<b>Ohio Rev. Code Ann. § 4731.052, 4731.283 (Anderson 1998)</b>
<b><u>Oregon</u></b>	<b>Or. Rev. Stat. §§ 677.470, 677.475, 677.485 (1995)</b>
<b><u>Rhode Island</u></b>	<b>R.I. Gen. Laws § 5-37.4 (1997)</b>
<b><u>Texas</u></b>	<b>Tex. Rev. Civ. Stat. Ann. art. 4495c (Vernon Pamp. Supp. 1996)</b>

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<sup>1</sup> For a brief description of each of the following statutes, see attached, [Fig. 1 “Intractable Pain and Barriers to Effective Pain Relief: Enacted Legislation.](#)

<b><u>Virginia</u></b>	<b>Va. Code Ann. § 54.1-3408.1</b>
<b><u>Washington</u></b>	<b>Wash. Rev. Code Ann. §§ 18.130.340, 69.50.308 (West 1995)</b>
<b><u>Wisconsin</u></b>	<b>Wis Stat. Ann. § 961.38 (1996)</b>

## **II. REGULATIONS AND GUIDELINES<sup>2</sup>**

### **A. Regulations**

Much like a law or statute, a regulation is an official rule or order issued by agencies of the executive branch of government. Regulations have the force of law, and are intended to implement a specific statute. A number of states have adopted regulations for the prescription of controlled substances in the treatment of pain, including:

<b><u>Alabama</u></b>	<b>Ala. Admin. Code r. 540-X-4-.08</b>
<b><u>Arkansas</u></b>	<b>See Arkansas State Medical Board</b>
<b><u>Iowa</u></b>	<b>Iowa Administrative Code § 13.2 (1) – (4) (1997)</b>
<b><u>Louisiana</u></b>	<b>AL. ADMIN. Code tit. 46, §6915 et seq.</b>
<b><u>Nevada</u></b>	<b>Nevada Administrative Code Ch. 630, § 225 (1996)</b>
<b><u>New Jersey</u></b>	<b>New Jersey Administrative Code § 13:35 – 6.6 (g) (1993)</b>
<b><u>Oregon</u></b>	<b>Oregon Administrative Rules 847 – 015 –0030 (1996)</b>
<b><u>Texas</u></b>	<b>Texas Administrative Code tit. 170, §§ 1-3 (1995)</b>

### **B. Guidelines**

In addition to laws and regulations, another method of policy development used by states is guidelines. A guideline is an official policy statement issued by a professional association or government agency to express that group’s attitude about a particular issue. Guidelines, unlike laws or regulations, do not have the force of law. Guidelines, however, are preferred over statutes and regulations for a number of reasons.<sup>8</sup> First, they are a relatively simple way

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<sup>2</sup> For a brief description of each of the following regulations and guidelines, see attached, Fig. 2 “Intractable Pain and Barriers to Effective Pain Relief: Guidelines and Regulations.

to express the attitude or policy of a state medical board. Second, a guideline issued by a state medical board is a more direct and flexible method than statutes and regulations for communicating policy. Third, medical boards, as compared to legislatures, are better suited to take into consideration the current and changing state of clinical medicine and science. Finally, guidelines define the parameters of conduct for professionals that are consistent with accepted standards of practice. Since 1989, the following states have adopted guidelines or policy statements to clarify the board's position with regard to prescribing controlled substances for the treatment of pain:

**For more information about a specific state policy or guidelines, please visit our Pain Policy Map.**

<b><u>Alabama</u></b>	<b>Alabama State Board of Medical Examiners (1994)</b>
<b><u>Alaska</u></b>	<b>Alaska State Medical Board (1993)</b>
<b><u>Arizona</u></b>	<b>Arizona Board of Medical examiners (1990)</b>
<b><u>California</u></b>	<b>Medical Board of California (1994)</b>
<b><u>Colorado</u></b>	<b>Colorado Board of Medical Examiners (1996)</b>
<b><u>Florida</u></b>	<b>Florida Board of Medicine (1996)</b>
<b><u>Georgia</u></b>	<b>Georgia Composite State Board of Medical Examiners (1991)</b>
<b><u>Idaho</u></b>	<b>Idaho State Board of Medicine (1995)</b>
<b><u>Maryland</u></b>	<b>Maryland Board of Physician Quality (1996)</b>
<b><u>Massachusetts</u></b>	<b>Massachusetts Board of Registration in Medicine (1989)</b>
<b><u>Minnesota</u></b>	<b>Minnesota Board of Medical Examiners (1995)</b>
<b><u>Montana</u></b>	<b>Montana Board of Medical Examiners (1996)</b>
<b><u>New Mexico</u></b>	<b>New Mexico State Board of Medical Examiners(1996)</b>
<b><u>North Carolina</u></b>	<b>Board of Medical Examiners of the State of N. Carolina (1991)</b>
<b><u>Ohio</u></b>	<b>Ohio Board of medical Examiners (1996)</b>
<b><u>Oklahoma</u></b>	<b>Oklahoma State Board of Medical Examiners (1994)</b>
<b><u>Oregon</u></b>	<b>Oregon Board of Medical Examiners (1991)</b>

<b><u>Rhode Island</u></b>	<b>Rhode Island Board of Medical Examiners (1995)</b>
<b><u>South Carolina</u></b>	<b>State Board of Medical Examiners of South Carolina (1999)</b>
<b><u>Texas</u></b>	<b>Texas State Board of Medical Examiners (1993)</b>
<b><u>Utah</u></b>	<b>Utah Medical Association (1993)</b>
<b><u>Vermont</u></b>	<b>Vermont State Board of Medical Examiners (1996)</b>
<b><u>Washington</u></b>	<b>Washington State Medical Disciplinary Board (1996)</b>
<b><u>West Virginia</u></b>	<b>West Virginia (1996)</b>
<b><u>Wyoming</u></b>	<b>Wyoming Board of Medicine (1996)</b>

### III. OVERVIEW MATERIAL/RELEVANT STATUTE LISTS

**The Pain Relief Act**, *Journal of Law Medicine & Ethics*, 24 (1996): 285-86. The primary goal of the Act is to terminate actions against providers engaging in justifiable pain management practices as early as possible in the disciplinary or criminal process. The objective is to prevent unnecessary investigations, protracted proceedings, and inappropriate legal sanction. To this end, the act provides that disciplinary action or state criminal prosecution cannot be brought against a health care provider under certain circumstances. Where such action is brought, the Act sets a procedural and substantive standard for the evaluation of the professional's practices. The Act is the product of the Project on Legal Constraints on Access to Effective Pain Relief, whose principal investigators were Nancy Neveloff Dubler, LL.B., Sandra H. Johnson, J.D., LL.M., Robert J. Levine, M.D., and Benjamin W. Moulton, J.D., M.P.H.

### IV. CASE LAW<sup>9</sup>

Even though criminal prosecutions of physicians are still rare, they have become more common within the past ten years. Detailed examination of these cases, however, illustrates that fear of criminal prosecution or investigation should not deter physicians from aggressively using opioid analgesics to manage terminal pain, provided that pain has been carefully assessed and treated and communication with families and involved professionals is thorough.<sup>10</sup> In fact, as these and other cases demonstrate, patients' fears about dying in pain or suffering from lack of institutional sensitivity to the quality of dying are justified.

*Hoover v. Agency for Health Care Administration*, 676 So.2d 1380 (Fla. App. 1996). Appellate court overturned disciplinary penalties against physician for use of controlled substances in pain

management noting the "paucity of evidence" to support the board's action and the board's reliance on the testimony of doctors who lacked expertise in chronic pain management.

***In the Matter of Dileo, M.D.***, 661 So.2d 162 (La. App. Ct. 1995). Physician appealed from a judgment of the Board imposing disciplinary actions against him for prescribing various substances to eight of his patients which were in excess of legitimate medical amounts. The Court vacated the judgment of the trial court upholding the Board's decision and dismissed all charges against the physician. Seven of the physician's patients had chronic pain. The Court reasoned that "this was not a situation where a physician was prescribing pain medication without an examination or a reasonable belief that the patient was in pain or in need of medication. Rather, the record shows that the patients being treated had suffered serious injury or other medical complications which supported the use of pain medications."

***Smith v. California State Board of Pharmacy***, 37 Cal. App. 4th 229 (Cal. App. 1995). Pharmacist appealed from the Board's suspension of his pharmacy license. The Board accused the pharmacist of falsifying records and dispensing excessive amounts of controlled substances. The facts suggest the pharmacist was the pharmacist-in-charge, and the proper action was in negligence. The Court ruled the pharmacist was deprived of due process because imprecise charges were levied against him. Reversed.

***Konstantin, M.D. v. Drug Enforcement Administration***, 50 F.3d 15 (9th Cir. 1995). Physician petitioned the Court for review of a Drug Enforcement Administrator's order to increase sanctions against him for violation in prescribing drugs. Physician wrote prescriptions for undercover agents, often without physical exams. DEA estimated that up to 30% of his patients were controlled substance abusers. Reportedly, the physician gave them prescriptions to prevent them from getting worse drugs on the street. Petition denied.

***Colorado State Board of Medical Examiners v. Davis***, 893 P.2d 1365 (1995). Physician appealed the Colorado State Board of Medical Examiner's decision to revoke his medical license. The Board found that the physician's care fell below accepted medical standards when he prescribed Demerol for patient's use by home injection and prescribed unnecessary medication to two other patients who were subsequently hospitalized for habitual drug use. Physician was addicted to drugs since the 1960's. Most recently, physician administered Demerol to his patients while diverting some of the drugs for his own use. Following a police investigation, he was arrested. Physician admitted his dependency, but alleged that such dependency qualifies him under the 'American with Disabilities Act.' Decision to revoke physician's license affirmed.

***Hook's-Superx, Inc. v. McLaughlin***, 632 N.E.2d 365 (Ind. Ct. App. 1994). Pharmacy contends that it owed no duty to patient to refuse to fill prescriptions presented by patient. Over ten months, patient presented prescriptions to be filled to help alleviate his back pain. His physician then refused to issue any more suspecting that he was addicted to the drugs. The Court found that since patient did not show that the pharmacy knowingly, and in bad faith, filled the prescriptions, there was no breach of duty. Reversed and remanded. **Note:** The Supreme Court of Indiana (***Hook's-Superx, Inc. v. McLaughlin***, 642 N.E.2d 514 (Ind. S. Ct. 1994)) vacated the

opinion of the Court of Appeals and affirmed the trial court in its denial of Hook's motion for summary judgment.

***Hook's-Superx, Inc. v. McLaughlin***, 642 N.E.2d 514 (Ind. S. Ct. 1994). The Supreme Court of Indiana found that where a pharmacy customer is having a prescription for dangerous drugs refilled at an unreasonably faster rate than the rate prescribed, the pharmacist has a duty to cease refilling the prescription pending direct and explicit directions from the prescribing physician. Considering the pertinent factors -- the relationship between the parties, foreseeability of the harm, and the public policy concerns -- the court concluded that a duty should be recognized. "Clearly, society has an interest in preventing the overuse and misuse of prescription drugs. Recognizing that pharmacists have a duty, the court argued, helps further this goal."

***Fattah, M.D. v. State Medical Board of Ohio***, 1994 WL 73903 (Ohio App. 10 Dist.). Physician appeals from a judgment affirming Board's revocation of physician's license to practice medicine and surgery. The Court ruled that physician's acts and omissions constituted a failure to use reasonable care and discrimination in the administration of drugs or failure to employ acceptable scientific methods in the selection of drugs or other treatment. Physician violated Ohio Administrative Code which prohibits a physician from utilizing a controlled substance without considering the drug's potential for abuse or if the patient will use the drug for non-therapeutic use.

***Brown, M.D. v. Louisiana State Board of Medical Examiners***, 637 So.2d 1113 (La. Ct. App. 1994). Psychiatrist sought review of Board's decision to suspend his license for four months to practice and permanently revoke his ability to prescribe medication. The psychiatrist had charged undercover agents \$80 to write prescriptions for controlled substance, without conducting physical or mental examinations. The Court of Appeals stated the majority of the sanctions were not excessive, considering the psychiatrist behavior. However, the Court required the Board to remove a provision that permanently prohibited the psychiatrist from ever applying for a controlled substance permit again. Amended and affirmed.

***Thompson v. West Virginia Board of Osteopathy***, 442 S.E.2d 712 (W.V. Ct. App. 1994). Petitioners, decedent's family, were entitled to compel Board to fulfill legal duty to consider and adopt formal findings of fact and consideration of law but not to compel the Board to take disciplinary action against physician who doubled patient's pain medication, which may have resulted in patient's heart attack and death.

***People v. Schade***, 30 Cal. App. 4th 1515 (Cal. App. 1994). Physician appealed conviction on 13 counts of prescribing illegal prescriptions for a controlled substance and 1 count of involuntary manslaughter. Physician defended all of his prescriptions as necessary for "pain treatment." However, evidence showed the doctor prescribed high levels of drugs. In addition, the physician routinely failed to give physical exams, conduct background checks, order lab work, and refer patients to other doctors. Despite this evidence, the Court of Appeals dismissed all counts ruling that the trial court erred by failing to instruct the jury on the definition of the technical term 'addict.' Involuntary manslaughter affirmed.

***United States v. Tran Trong Cuong, M.D.***, 18 F.3d 1132 (1994). Physician was convicted of distributing controlled substances by prescription outside the usual course of medical practice. Evidence was presented that patients faked pain symptoms, yet physician wrote prescriptions and suggested they be filled at different pharmacies. Patient records indicated a charge of \$35 for issuing prescriptions; and patients were kept on narcotics for years when complaints were merely for headaches, backaches and other subjective ailments. However, because of improper introduction of reputation evidence by the government, these convictions are being reversed for a new trial.

***Hollabaugh, M.D. v. Arkansas State Medical Board***, 861 S.W.2d 317 (Ark. Ct. App. 1993). Physician appealed the Court's approval of the Board's suspension of her license for prescribing excessive amounts of controlled substances. Physician defended her prescription habits with detailed evaluations and expressed her belief that the pain resulting from most medical conditions is not adequately treated by most physicians. The Board's primary evidence consisted of pharmacists' testimony regarding the types, amounts and frequencies of the prescriptions. The Court of Appeals ruled that the Board failed to present standard of care and sufficient substantive evidence to support its findings. Reversed.

***Eaves v. Board of Medical Examiners***, 467 N.W.2d 234 (Iowa 1991). Physician appeals an order upholding the Board's decision imposing discipline for excessively prescribing controlled drugs. His patients complained of severe and chronic pain. The State's witness testified that narcotic pain medication should not be used for long-term treatment in the absence of a terminal disease. Physician was found violating Iowa law in prescribing excessive dosages of medication in five of the seven patients investigated. The Board imposed a three-year probation, \$1000 fine, additional medical education classes, prohibition against continued prescription of addictive drugs for chronic pain and submission of new treatment plans for his patients. Affirmed.

***Hulse v. Sheriff of Clark County***, 498 P.2d 1317 (Nev. 1972). Physician wrote numerous prescriptions for extremely large number of controlled substances. The Court found that since there was a genuine physician-patient relationship, that physician's prescription of the drugs was in good faith, that there was nothing to suggest the physician was concerned with anything except treatment of a genuine physical ailment and relief of pain, it was improper to hold the physician over for trial on charges of unlawfully prescribing narcotic drugs. Reversed.

## **V. PRACTICE MANUALS/INSTRUCTIONAL MATERIALS/LOOSELEAF SERVICES**

Frolik, LA and M C. Brown, "Advising the Elderly or Disabled Client: Legal, Health Care, Financial, and Estate Planning." (1992).

- Desktop reference book for attorneys and advocates. Supplemented regularly. Available from Rosenfeld Launer Publications, Englewood, New Jersey.

Health Care Law Sourcebook: A Compendium of Federal Laws, Regulations, and Documents Relating to Health Law (Wayne J. Miller, ed., 1991).

- Provides text of federal laws, regulations and other government documents relevant to the delivery of health care services. Intended for attorneys and health care practitioners. Part One includes information on Medicare reimbursement and certification. Part Eight includes other health care laws. Part Nine includes recent legislation. Two volumes, updated periodically. A Matthew Bender publication.

## **VI. GOVERNMENT PUBLICATIONS**

### **A. Manuals**

Agency for Health Care Policy and Research, *Managing Cancer Pain*, AHCPR pub. no. 94-0595 (Rockville, Md.: U.S. Department of Health Research, 1994).

### **B. Consumer Materials**

#### **MEDWEB.**

- Listing of consumer-oriented, medically-related websites.

### **C. Department of Health & Human Services**

Acute Pain Management Guideline Panel, *Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline*, AHCPR pub. no. 92-0032 (Rockville, Md.: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service, Feb. 1992).

Depression Guideline Panel, *Depression in Primary Care, vol. 2, Treatment of Major Depression, Clinical Practice Guideline*, no. 5 AHCPR pub. no. 93-0551, (Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, April 1993).

Jacox et al., *Management of Cancer Pain, Clinical Practice Guideline* no. 9, AHCPR pub. no. 94-0592 (Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, March 1994), 134-38.

## **VII. SERIALS/UPDATED PUBLICATIONS**

United Communications Group, Health Care Reform Week.

- Weekly updates on medical related laws and legislation. Focus on health policy and legislation.

## **VIII. BOOKS/PAMPHLETS**

Foley et al., in *Advances in Pain Research and Therapy*, ed., vol. 16 (New York: Raven Press, 1990).

Health Care Law Institute, *The Fourth Annual Health Care Law Institute*, (1995).

- Summary of seminar held at Creighton School of Law in Omaha, Nebraska on September 22, 1995.

International Association for the Study of Pain; World Health Organization, *Cancer Pain Relief* (Geneva: World Health Organization, 1986).

International Association for the Study of Pain, Task Force on Professional Education, *Core Curriculum for Professional Education in Pain* (Seattle: IASP Publications, 1991).

Jaffe, J.H., "Drug Addition and Drug Abuse," in *The Pharmacological Basis of Therapeutics*, ed. A.G. Gilman et al., 7th ed. (New York: Macmillan, 1985), 532-81.

Kleinman, A., *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).

Scarry, E., *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985).

Schiro, J., "Symptom Management and the Hospice Patient," in Washington State Medical Association, Washington State Physicians Insurance, and Washington State Cancer Pain Initiative, *Pain Management and the Terminal Patient* (Seattle: Washington State Medical Association, 1992), 165-83.

Smith, R.S., "Ethical Issues Surrounding Cancer Pain," in *Current and Emerging Issues in Cancer Pain; Research and Practice*, ed. C.R. Chapman and K.M. Foley (New York: Raven Press, 1993), 385-92.

Washington State Medical Association, *Pain Management and Care of the Terminal Patient* (Seattle: Washington State Medical Association, 1992).

Weissman et al. *Handbook of Cancer Pain Management*, 3d ed. (Madison: Wisconsin Pain Initiative, 1992).

World Health Organization, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee, WHO Technical Report Series 804* (Geneva: World Health Organization, 1990).

## **IX. ACADEMIC ARTICLES/PUBLICATIONS**

Growing attention to end of life care issues has spawned a new wave of studies and research. The American Society of Law, Medicine, and Ethics, for example, has published a special issue of the *Journal of Law, Medicine, & Ethics* as part of a multi-year project to address legal and regulatory barriers to effective pain relief. The results of this project and numerous other studies are listed below.

## **A. Project on Legal Constraints on Access to Effective Pain Relief:**

**Note: The following 10 articles can be found in: The Journal of Law, Medicine & Ethics Winter 1996: Volume 24, Number 4.**

Alpers A. “Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying.”

- Examines criminal investigations and prosecutions of physicians and nurses in connection with their care of dying patients and concludes that the criminal law has failed to protect patients and families and has significant power to deter appropriate pain management for dying patients.

Haddox, JD and GM Aronoff. “Commentary: The Potential for Unintended Consequences from Public Policy Shifts in the Treatment of Pain.”

- Cautions against possible unintended consequences of intractable pain treatment acts, suggesting that health care professionals look to the guidelines prepared by the Federation of State Medical Boards for an approach to this issue.

Hoffmann, DE. “Pain Management and Palliative care in the Era of Managed Care: Issues for Health Insurers.”

- Reports on empirical study of medical directors at Blue Cross Blue Shield Plans regarding their awareness of and response to issues of pain management and palliative care for their insured populations.

Jost, TS. “Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets.”

- Examines the gaps and deficiencies in Medicare and Medicaid funding of pain relief, and explores the effects of Medicare and Medicaid fraud enforcement on pain management.

Martino, AM. “In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?”

- Argues that a complex “ethic of underprescribing” underlies the continued reluctance of physicians to use opioids to treat chronic pain. She contends that state medical boards are uniquely positioned to promote a new ethic for pain management, but stresses the difficulties for boards in attaining this goal. She thinks success may hinge on whether boards can change their approach to pain management and persuade a skeptical medical community that adopting a risk for underprescribing will serve the long-term interests of patients and the profession.

**Note: The following 10 articles can be found in: The Journal of Law, Medicine & Ethics Winter 1996: Volume 24, Number 4.**

Conant, L and A Lowney “The Role of Hospice Philosophy of Care in Nonhospice Settings.”

- Argues that the hospice philosophy of care should be an integral part of the overall palliative goals of medicine.

Hyman, CS “Pain Management and Disciplinary Action: How State Medical Boards Can Remove Barriers to Effective Treatment.”

- Outlines four practical steps through which boards of medicine can improve pain management provided in their jurisdictions.

Lo, B, K H. Rothenberg & M Vasko. “Appropriate Management of Pain: Addressing the Clinical, Legal, and Regulatory Barriers.”

- Discusses the articles and resources developed by the Project and offers a description of its work.

Johnson, SH “Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act.”

- Provides analysis and rationale for Pain Relief Act prepared by the Project on Legal Constraints on Access to Effective Pain Relief.

Joranson, DE and AM. Gilson “Improving Pain Management Through Policy Making and Education for Medical Regulators.”

- Provides a critical review of trends in state medical regulatory policy concerning controlled substances for intractable pain.

Pisano, DJ “Controlled Substances and Pain Management: Regulatory Oversight, Formularies, and Cost Decisions.”

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