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# A CHRONIC PROBLEM: PAIN MANAGEMENT OF NON-CANCER PAIN IN AMERICA

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Pain can have debilitating effects on an individual. It can erode an individual's quality of life<sup>1</sup> as well as his or her ability to earn an income.<sup>2</sup> In cases where chronic pain is inadequately treated, patients can develop difficulties functioning.<sup>3</sup> They become less involved with their friends and family<sup>4</sup> and often suffer from poor attendance records at work.<sup>5</sup> It is estimated that the cost of chronic pain in the U.S. is approximately \$600 billion annually,<sup>6</sup> yet at least 116 million Americans with the condition continue to be under-treated.<sup>7</sup> A study conducted by the World Health Organization found that sufferers of chronic pain are more than four times as likely to suffer from depression and anxiety disorders.<sup>8</sup>

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1. See PATRICIA W. IYER, *MEDICAL-LEGAL ASPECTS OF PAIN AND SUFFERING* 316 (2003).
2. See *AAPM Facts and Figures on Pain: Lost Productive Time and Cost Due to Common Pain Conditions in the United States Workforce*, AM. ACAD. PAIN MED., [http://www.painmed.org/patientcenter/facts\\_on\\_pain.aspx#lost](http://www.painmed.org/patientcenter/facts_on_pain.aspx#lost) (last visited Feb. 27, 2013) (reporting the average number of productive hours lost per week among workers in the United States as a result of common pain conditions).
3. See Michael A. Ashburn & Peter S. Staats, *Management of Chronic Pain*, 353 LANCET 1865, 1865 (1999) (noting that individuals with chronic pain often experience depression, fatigue, and overall decreased bodily functioning).
4. See Jane E. Brody, *Chronic Pain: A Burden Often Shared*, N.Y. TIMES, Nov. 13, 2007, [http://www.nytimes.com/2007/11/13/health/13brod.html?\\_r=0](http://www.nytimes.com/2007/11/13/health/13brod.html?_r=0) (noting that the anxiety and stress that individuals experiencing chronic pain encounter is generally also shared by family members and friends).
5. See Anne-Marie Vidal, *The Politics of Pain: The Controversy Surrounding Chronic Pain and Opioids*, PROHEALTH (Nov. 15, 2002), <http://www.prohealth.com/library/showarticle.cfm?libid=8932>.
6. Salynn Boyles, *100 Million Americans Have Chronic Pain*, CBS NEWS (June 30, 2011, 5:31 PM), <http://www.cbsnews.com/stories/2011/06/30/health/webmd/main20075918.shtml>.
7. Maia Szalavitz, *Report: Chronic, Undertreated Pain Affects 116 Million Americans*, TIME (June 29, 2011), <http://healthland.time.com/2011/06/29/report-chronic-undertreated-pain-affects-116-million-americans/>.
8. Vidal, *supra* note 5.

In order to address the disparity in chronic pain management, the United States Congress declared the years from 2001 through 2010 the “Decade of Pain Control and Research.”<sup>9</sup> Despite such initiatives, our healthcare system is still in need of improved pain management techniques.<sup>10</sup> Social barriers, particularly related to the prescription and usage of opioids, hinder our ability to help millions of Americans suffering from chronic (non-cancer) pain.<sup>11</sup> For example, although opioids are widely accepted as an appropriate treatment of cancer pain, pain at end-of-life, and acute pain,<sup>12</sup> use of opioids for chronic, non-malignant pain remains an issue of considerable debate.<sup>13</sup> Such issues need to be addressed, but not by restricting access to effective pain management.<sup>14</sup> There is no quick fix for the pain management crisis.<sup>15</sup> Promotion of a better understanding among the general public is the primary step that needs to be taken towards better advocacy for those suffering from chronic pain.<sup>16</sup>

This article addresses the advocacy needs in pain management. The three core barriers to effective treatment are: A) misinformation regarding chronic pain and its management, B) fears of addiction, and C) restrictive drug control legislation. Part I explains the barriers to effective treatment, which include misinformation regarding chronic pain and its management, fears of addiction by both patients and physicians, and restrictive drug control legislation. Part II suggests ways to overcome these barriers. These solutions include actions to minimize and transcend these barriers that can be taken by patients, their families, healthcare workers, legislators and policymakers.

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9. Frank Brennan et al., *Pain Management: A Fundamental Human Right*, 105 ANESTHESIA & ANALGESIA 205, 208 (2007).

10. Boyles, *supra* note 6.

11. *Id.*

12. B.-J. Collett, *Chronic Opioid Therapy for Non-Cancer Pain*, 87 BRIT. J. ANAESTHESIA 133, 133–34 (2001) (discussing the widespread use of opioids for treating various levels of pain in several countries).

13. Michael Clark, *Benefits and Risks of Opioids in Arthritis Management*, JOHNS HOPKINS ARTHRITIS CENTER, <http://www.hopkinsarthritis.org/patient-corner/disease-management/benefits-and-risks-of-opioids-for-chronic-pain-management/> (last updated July 31, 2012).

14. See Penney Cowan, *The Myths of Pain Control*, CHRONICLE (Am. Chronic Pain Ass’n, Rocklin, Cal.), Fall 2006, at 1, available at [http://www.theacpa.org/uploads/documents/chronicle\\_fall06\\_82806.pdf](http://www.theacpa.org/uploads/documents/chronicle_fall06_82806.pdf) (acknowledging that while they are not for everyone, opioids can be effective in providing pain relief).

15. See generally David E. Joranson & Karen M. Ryan, *Ensuring Opioid Availability: Methods and Resources*, 33 J. PAIN & SYMPTOM MGMT. 527, 531–32 (2007) (explaining that fear of addiction, strict drug control laws, and lack of education create barriers to the availability of opioids as a treatment method).

16. INST. OF MED., *RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION, AND RESEARCH* 1, 4 (2011) (presenting findings and recommendations as to how to change education and research to better address pain in the United States).

## I. BARRIERS TO EFFECTIVE TREATMENT

A. *Misinformation Regarding Chronic Pain*

The first of these three core barriers seems to be rooted in social misconceptions related specifically to the role of pain in everyday life and opioids that can be used to relieve it. In the United States, there is the widespread misperception that physical dependence is the same as addiction to opioids.<sup>17</sup> The continued lack of distinction can be partly attributed to the inaccurate use of these terms in the realms of professional education and narcotic control laws at both the national and international levels.<sup>18</sup> Social misconceptions about chronic pain result from confused terminology, in that there is a lack of distinction between “physical dependence” and “addiction,”<sup>19</sup> as well as perpetuated fears of addiction<sup>20</sup> and restrictive drug control legislation utilizing the same confused terminology.<sup>21</sup>

While “addiction” is often used interchangeably with “physical dependence,” they should not hold the same negative connotations.<sup>22</sup> Although both terms are used to refer to a patients’ biological and/or psychological need for a substance to feel good, normal, or better, in this article the term “addiction” will exclusively refer to the type of physical and psychological dependence leading to criminal or self-destructive behaviors.<sup>23</sup> Meanwhile, “physical dependence,” commonly referred to as “drug dependence” or “tolerance,” will be used to describe a biological and/or psychological need for a substance (in this case, opioids) to feel normal, good, or better, but not by definition a state of being anti-social or prone towards criminality or violence.<sup>24</sup>

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17. See Robert L. Fine, *Ethical and Practical Issues with Opioids in Life-Limiting Illness*, 20 BAYLOR U. MED. CENTER PROC. 5, 7–8 (2007).

18. See June L. Dahl, *Working with Regulators to Improve the Standard of Care in Pain Management: The U.S. Experience*, 24 J. PAIN & SYMPTOM MGMT. 136, 142 (2002) (discussing the confusion among many health care providers regarding the definitions of addiction and tolerance and the failure of most medical schools to educate students about pain management); cf. Martha A. Maurer et al., *Federal and State Policies at the Interface of Pain and Addiction*, in PAIN AND CHEMICAL DEPENDENCY 377, 377 (Howard S. Smith & Steven D. Passik eds., 2008) (noting the crucial need for health care providers to understand and accurately the terminology surrounding addiction and pain, especially as they relate to the law).

19. See Fine, *supra* note 17, at 7–8.

20. See *Myths and Misconceptions Surrounding Addiction in Chronic Pain Patients Treated with Opioid Analgesics*, PAIN LIVE (Oct. 11, 2011), <http://www.painlive.com/publications/pain-management/2011/september-2011/Myths-and-Misconceptions-Surrounding-Addiction-in-Chronic-Pain-Patients-Treated-with-Opioid-Analgesics>.

21. See Maurer et al., *supra* note 18, at 377.

22. See Fine, *supra* note 17, at 7–8.

23. See NAT’L INST. ON DRUG ABUSE, MEDIA GUIDE 2 (2011), available at [http://www.drugabuse.gov/sites/default/files/mediaguide\\_web\\_1.pdf](http://www.drugabuse.gov/sites/default/files/mediaguide_web_1.pdf) (discussing the difference between the terms *physical dependence* and *addiction*).

24. *Id.* The distinction this article makes between “addiction” as bad and “dependence” and “tolerance” as morally neutral is essential to maintaining clarity in what is being discussed throughout this article, namely that physical dependence does not by necessity imply anti-social behavior, but quite

The lack of distinction between these terms contributes to inadequate treatment of pain relief by perpetuating the second core barrier: the fear that even prescription use of pain medications will lead to the socially unacceptable behaviors usually associated with addiction.<sup>25</sup> The difference between addiction and dependence is related to the after-effects of drug use: patients with chronic pain experiencing improved function with drugs are “opioid-dependent” while those who do not show improved functioning, but instead display anti-social behaviors are considered “opioid-addicted.”<sup>26</sup> According to national pain experts, opioid addiction can be described as a “primary chronic, neurobiological disease, with genetic psychosocial, and environmental factors influence its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.”<sup>27</sup> Using DSM-III-R criteria, Hoffman and colleagues found that of chronic-pain patients, 1.9% misused analgesics and 12.6% were analgesic dependent.<sup>28</sup>

Meanwhile, the third core barrier, restrictive drug control legislation, reinforces these misconceptions (and continues the trends of inadequate pain management) by using the same confused terminology and creating an environment that punishes physicians and other healthcare providers for prescribing opioids that could potentially aid patients relieve their pain.<sup>29</sup>

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the contrary when it comes to pain management. See Srdjan S. Nedeljkovic et al., *Assessment of Efficacy of Long-Term Opioid Therapy in Pain Patients with Substance Abuse Potential*, 18 CLINICAL J. PAIN S39, S43 (2002) (finding that the majority of patients receiving long-term opioid therapy in one study experienced increased activity levels). Yet, since some people associate any drug use with negative social behaviors, this article relegates the term that means dependence and bears the most negative connotations to situations where dependence has in fact lead to negative social behaviors. See e.g., Jerry Shaw, *Negative Effects from Drug Abuse*, LIVESTRONG (Sept. 28, 2010), <http://www.livestrong.com/article/254271-negative-effects-from-drug-abuse/> (discussing the negative effects of drug abuse).

25. See Fine, *supra* note 17, at 7–8.

26. Scott Fishman, *Addiction vs. Dependence on Pain Medications*, DISCOVERY HEALTH, <http://health.howstuffworks.com/diseases-conditions/pain/medication/addiction-v-dependence-on-pain-medications.htm> (last visited Mar. 29, 2013).

27. Jette Højsted & Per Sjøgren, *Addiction to Opioids in Chronic Pain Patients: A Literature Review*, 11 EUR. J. PAIN 490, 492 (2007).

28. Norman G. Hoffman et al., *Prevalence of Abuse and Dependency in Chronic Pain Patients*, 30 INT. J. ADDICTIONS 919, 923 (1995).

29. See Diederik Lohman et al., *Access to Pain Treatment as a Human Right*, BMC MED., 2, 4, 5 (Jan. 2010), <http://www.biomedcentral.com/content/pdf/1741-7015-8-8.pdf> (identifying restrictive drug control legislation and enforcement practices as a barrier to access to pain management).

*B. Fears of Addiction**1. Patients' Fears of Addiction*

Since patients that live with chronic pain often experience comorbidities like depression and anxiety,<sup>30</sup> in addition to possible disturbances in sleep cycles,<sup>31</sup> decreased cognitive and physical functioning,<sup>32</sup> and other disruptions of daily living which decrease the quality of life for patients and those around them, society has much to gain from pain management regimens.<sup>33</sup> Usually this is accomplished through the continuous suppression of pain through use of analgesic therapies such as non-opioid analgesics and opioid analgesics.<sup>34</sup> The latter are generally stronger and used for more severe chronic pain.<sup>35</sup> However, despite their general effectiveness, opioids have not traditionally been patients' primary choice of treatment in combating chronic pain.<sup>36</sup>

Opioids have historically been associated with addiction.<sup>37</sup> Studies have shown that if prescribed and used correctly, opioids can be highly effective in treating a broad range of pain across different populations.<sup>38</sup> However, researchers have also found that certain groups of patients are at risk of addiction and abuse.<sup>39</sup> The exact risk of abuse remains uncertain, however, prevalence estimates of addiction within chronic non-malignant pain patients range from zero to fifty percent.<sup>40</sup> Additionally, recent epidemiological studies have found that patients receiving higher doses of medically prescribed opioids for chronic pain are at

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30. See Bruce Nicholson & Sunil Verma, *Comorbidities in Chronic Neuropathic Pain*, 5 PAIN MED. S9, S10–S11 (2004).

31. See Qian Chen et al., *Characteristics of Chronic Pain Associated with Sleep Difficulty in Older Adults: The Maintenance of Balance, Independent Living, Intellect, and Zest in Elderly (MOBILIZE) Boston Study*, 59 J. AM GERIATRICS SOC'Y 1385, 1385–87 (2011).

32. See Tamara A. Baker et al., *Factors Influencing Chronic Pain Intensity in Older Black Women: Examining Depression, Locus of Control, and Physical Health*, 17 J. WOMEN'S HEALTH 869, 874 (2008) (finding that decreased physical functioning correlated with increased pain in a sample of black women experiencing chronic pain); Shulamith Kreitler & David Niv, *Cognitive Impairment in Chronic Pain*, PAIN: CLINICAL UPDATES (Int'l Ass'n for the Study of Pain, Seattle, Wash.), July 2007, at 2–3 (revealing that patients with chronic pain in one sample also experienced cognitive difficulties such as lower attention span, decreased verbal abilities, and mental flexibility and memory deficits).

33. See generally Warren A. Katz & Robert L. Barkin, *Dilemmas in Chronic/Persistent Pain Management*, 56 DISEASE-A-MONTH 233, 233–34 (2010).

34. See NAT'L PHARMACEUTICAL COUNCIL, PAIN: CURRENT UNDERSTANDING OF ASSESSMENT, MANAGEMENT, AND TREATMENTS 33, 38 (2001).

35. *Id.* at 38.

36. See Katz & Barkin, *supra* note 33, at 240, 244.

37. See Fine, *supra* note 17, at 7.

38. See Collett, *supra* note 12, at 133, 134 (discussing patient surveys and case reports that support the effectiveness of opioids for treating various types of pain).

39. See Joy R. Goebel et al., *Addressing Patients' Concerns About Pain Management and Addiction Risks*, 11 PAIN MGMT. NURSING 92, 92–93 (2010).

40. Højsted & Sjøgren, *supra* note 27, at 507.

increased risk for overdose, when compared to patients receiving lower doses.<sup>41</sup> Other groups at high risk of addiction include individuals diagnosed with non-opioid substance abuse, males (particularly of younger ages), and those with mental health disorders.<sup>42</sup>

Another explanation for the lack of opioid use among chronic pain patients is rooted in the idea that pain is a part of the human condition that people should not rush to relieve. For example, some individuals perceive pain to be necessary, natural, and (at times) beneficial in the sense that its presence is essential in the diagnosis of health ailments.<sup>43</sup> By treating pain, rather than the underlying ailment causing the pain, some patients fear that they are putting their health at risk of worsening in the future.<sup>44</sup>

A third explanation can be found in the idea that pain is a positive means of building character. This remains a common belief among both religious and non-religious people.<sup>45</sup> In one study, it was found that approximately one-third of patients agreed with the belief that pain builds character.<sup>46</sup> However, the same study found that this has an insignificant effect on the under treatment of pain.<sup>47</sup>

A fourth explanation for why opioid use is lacking among chronic pain patients is the idea that opioids should be and/or are only prescribed for cancer patients or patients that are near death.<sup>48</sup> Patients fear that opioid treatments could impair their quality of life more than their current level of pain, primarily through unintended consequences (e.g. substance dependency<sup>49</sup> or effects on mental and physical health).<sup>50</sup>

A fifth explanation can be found in the belief held by some individuals that opioid use is acceptable, but only in cases where doses are correlated to the severity of the disease, rather than the intensity of pain.<sup>51</sup>

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41. E.g., Kate M. Dunn et al., *Opioid Prescriptions for Chronic Pain and Overdose*, 152 ANNALS INTERNAL MED. 85, 90 (2010) (reporting in one study that patients receiving higher doses of opioids for chronic non-cancer pain were at greater risk of overdose than patients receiving lower doses).

42. See Goebel et al., *supra* note 39, at 93.

43. See Brennan et al., *supra* note 9, at 208 (discussing the cultural myth that pain is an inevitable and natural part of the human experience).

44. *Id.* at 209.

45. See Otto F. Weis et al., *Attitudes of Patients, Housestaff, and Nurses Toward Postoperative Analgesic Use*, 62 ANESTHESIA & ANALGESIA 70, 73 (1983).

46. *Id.*

47. *Id.*

48. See Russell K. Portenoy et al., *Opioid Use and Survival at the End of Life: A Survey of a Hospice Population*, J. PAIN & SYMPTOM MGMT. 532, 533 (2006).

49. See Brennan, *supra* note 9, at 209.

50. See Collett, *supra* note 12, at 135–36.

51. See Mark Sullivan & Betty Ferrell, *Ethical Challenges in the Management of Chronic Nonmalignant Pain: Negotiating Through the Cloud of Doubt*, 6 J. PAIN 2, 7 (2005) (arguing that pain relief should be provided regardless of whether pain is proportional to the disease in question).

Finally, a sixth explanation for the lack of opioid use to treat chronic pain is the fear of stigmatization.<sup>52</sup> This issue is a separate one from whether or not the patient and/or his or her family believe that opioid use results in addiction; rather, this explanation focuses on whether or not they believe others believe it does.<sup>53</sup>

## 2. Physicians' Fears of Enabling Criminal Behavior

Physicians and other healthcare providers are accustomed to taking into consideration the risks and benefits of prescribing medications, particularly when weighing the benefits of treatment versus the risks of potential adverse effects.<sup>54</sup> However, in the case of opioids, the boundaries are not always clear.<sup>55</sup> Although the prescription of opioids does provide chronic pain patients with short-term and/or immediate relief of pain symptoms, opioids also provide the opportunity for potential misuse by the patient, possibly leading to addiction.<sup>56</sup>

Physicians' choices regarding the prescription of opioids for chronic pain patients are shaped by a number of factors. Physicians' fears of addiction developing in their chronic pain patients due to opioid usage, particularly within patients with substance misuse/abuse histories, is one such factor.<sup>57</sup> Another is their fear of legal repercussions for the over-prescription of opioids for chronic pain relief.<sup>58</sup> Physicians also consider how persistent and uncontrolled pain might affect a patient in the long-term when opioids treat pain in the short-term.<sup>59</sup> Finally, physicians face fears that under certain social conditions, patients' medication may be distributed illegally either by the patient or another individual with access to the prescribed opioids.<sup>60</sup>

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52. See Brennan, *supra* note 9, at 208.

53. See *id.*

54. See Goebel et al., *supra* note 39, at 92–93 (elaborating on the process that clinicians use to determine pain treatment options for patients).

55. Bhusan Bhamb et al., *Survey of Select Practice Behaviors by Primary Care Physicians on the Use of Opioids For Chronic Pain*, 22 CURRENT MED. RES. & OPINION 1859, 1864 (2006) (noting that physicians have different comfort levels in prescribing narcotics).

56. See Goebel et al., *supra* note 39, at 92–93.

57. Alex Baldacchino et al., *Guilty Until Proven Innocent: A Qualitative Study of the Management of Chronic Non-cancer Pain Among Patients with a History of Substance Abuse*, 35 ADDICTIVE BEHAV. 270, 270–71 (2010) (finding that physicians were more hesitant to prescribe opioids to patients who had a history of substance abuse).

58. See Brennan, *supra* note 9, at 209.

59. See Rollin M. Gallagher & Lisa J. Rosenthal, *Chronic Pain and Opiates: Balancing Pain Control and Risks in Long-Term Opioid Treatment*, 89 ARCHIVES PHYSICAL MED. REHABILITATION S77, S78 (2008) (discussing the limited data regarding long-term opioid use, but noting that the evidence that does exist is generally positive).

60. See Howard L. Fields, *The Doctor's Dilemma: Opiate Analgesics and Chronic Pain*, 69 NEURON 591, 591 (2011) (discussing physician concerns in prescribing opioids including the potential for abuse and illegal distribution).

Like patients, physicians fear their patients may become addicted.<sup>61</sup> This fear has an effect on the way physicians prescribe opioids.<sup>62</sup> For example, physicians have been found to be especially reluctant to prescribe opioids when their patients have a history of substance abuse.<sup>63</sup> The rise of abuse of opioids and other prescription drugs among patients may be fueling these fears.<sup>64</sup> So much, in fact, that legal action has been taken by the government to limit physicians' ability to distribute opioids.<sup>65</sup>

The United States currently has a federal and state regulatory framework that creates a closed distribution system, whereby state-licensed and federally registered practitioners and researchers have the ability to prescribe and dispense opioids.<sup>66</sup> Under the "unlawful diversion statute," it is a federal felony to "knowingly and intentionally acquire, or aid and abet someone else in acquiring a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge."<sup>67</sup> This includes the unlawful distribution of a controlled substance by a medical practitioner outside "the usual course of medical practice"<sup>68</sup> and is punishable by up to four years imprisonment and a \$250,000 fine.<sup>69</sup> According to Title 21, U.S. Code, Section 841(a)(1), if a person, including a medical practitioner "knowingly or intentionally. . . manufacture[s], distribute[s], or dispense[s], or possess[es] with intent to manufacture, distribute, or dispense, a controlled substance"<sup>70</sup> he or she is also guilty of a felony and faces a imprisonment for up to twenty years, a \$1 million fine, and a period of supervised release following imprisonment of up to three years.<sup>71</sup>

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61. See ALFRED V. ANDERSON ET AL., OPIOID PRESCRIBING: CLINICAL TOOLS AND RISK MANAGEMENT STRATEGIES 2 (2009).

62. *Id.* at 14.

63. See, e.g., Baldacchino et al., *supra* note 57, at 271.

64. See generally OFFICE OF NAT'L DRUG POL'Y, OFFICE OF THE PRESIDENT, EPIDEMIC: RESPONDING TO AMERICA'S PRESCRIPTION DRUG ABUSE CRISIS, EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES (2011) (providing an overview of the prescription drug abuse problem and offering strategies to curb its rise).

65. See, e.g., Kevin B. O'Reilly, *States Try More Aggressive Rx Opioid Controls*, AM. MED. NEWS (Oct. 17, 2011), <http://www.ama-assn.org/amednews/2011/10/17/pr121017.htm> (discussing actions taken in several states to curb prescription of opioids).

66. See DAVID JORANSON, CTR. FOR LAWFUL ACCESS & ABUSE DETERRENCE, THE EFFICACY OF FDA OPIOID-SPECIFIC REMS: A COMMENTARY 1 n.2 (2010), available at <http://claad.org/downloads/Product-specific%20REMS%20commentary%20012510.pdf>.

67. 21 U.S.C. § 843(a)(3) (2011).

68. 21 C.F.R. § 1306.04(a) (2012). See also 21 U.S.C. § 822(b) (2011) (authorizing practitioners to dispense controlled substances in compliance with the CSA and "to the extent authorized by their registration").

69. 21 U.S.C. § 843(d)(1) (2011).

70. § 841(a).

71. § 841(b).

However, since the regulatory authority over the practice of medicine is entrusted to state medical licensing boards, actual punishments will vary by state.<sup>72</sup> For example, a lesser charge for unlawful diversion would be a violation of Title 21, U.S. Code, Section 844, a federal misdemeanor statute.<sup>73</sup> However, previous convictions of medical practitioners have resulted in the suspension and/or revocation of Drug Enforcement Administration (DEA) licenses, significant monetary fines, and probationary periods.<sup>74</sup> Such legal action has directly affected the way physicians prescribe pain medication in that they are choosing to be risk adverse, that is, intentionally under-medicate pain patients.<sup>75</sup>

It should also be mentioned that countervailing pressures to prescribe medications also exist. These pressures may be created out of desires to treat pain more “compassionately”<sup>76</sup> and the growing belief that pain is “indicative of pathology and therefore amenable to treatment.”<sup>77</sup> For example, there have been cases where medical boards have made medical malpractice decisions when doctors failed to prescribe opioids for chronic pain.<sup>78</sup> However, while these legal actions against opioid prescribers have occurred, they are the outlying cases.<sup>79</sup>

The choice to under-medicate pain patients also stems from physician and healthcare providers’ fears that they may be unintentionally enabling criminal behavior by prescribing opioids to their patients.<sup>80</sup> According to a 2009 National Survey on Drug Use and Health, among persons aged twelve or older who used pain relievers non-medically, over sixty percent got the drug from a friend, relative, drug dealer, or the Internet.<sup>81</sup> In other words, those abusing pain relievers are not the same individuals who are receiving prescriptions for them. Thus, in order to

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72. See JORANSON, *supra* note 66, at 4.

73. 21 U.S.C. § 844 (2011); see also Ronald J. Friedman, *Increased Scrutiny of Medical Providers: A Cause for Reflection and Diligence*, PAIN PRACTITIONER, Summer 2010, at 26, 27.

74. See Friedman, *supra* note 73, at 27.

75. See *id.* at 33 (concluding that fear of prosecution and fines has had a “chilling effect” on how doctors prescribe medication).

76. Christine S. Moyer, *Physicians Struggle to Treat Pain Amid Opioid Overdose Crisis*, AM. MED. NEWS (Nov. 14, 2011), <http://www.ama-assn.org/amednews/2011/11/14/pr121114.htm>.

77. Anna Lembke, *Why Doctors Prescribe Opioids to Known Opioid Abusers*, 367 NEW ENG. J. MED. 1580, 1580 (2012).

78. See, e.g., *Bergman v. Chin*, No. H2057321, 2001 WL 1517376 (Cal. App. Dep’t Super. Ct. June 13, 2001) (finding that a doctor’s conduct was reckless where he refused to provide appropriate pain medication to an elderly patient experiencing “out of control” pain).

79. See, e.g., *Hoover v. Agency for Health Care Admin.*, 676 So. 2d 1380, 1381 (Fla. Dist. Ct. App. 1996) (discussing actions taking against a physician for inappropriate and excessive prescribing of Schedule II controlled substances to patients).

80. See Fields, *supra* note 60, at 592 (explaining how a doctor’s decision to prescribe pain killers is complicated by the difficulty of determining when a patient is pretending to be in pain).

81. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2009 NATIONAL SURVEY ON DRUG USE AND HEALTH 28 (2010).

restrict the diversion of opioids and other pain relievers, some physicians and healthcare providers may choose to limit the amount prescribed.<sup>82</sup>

The chilling effect on proper treatment is understandable when even one patient who becomes addicted could lead to an expensive, time consuming, and potentially reputation ruining investigation, even if eventually it is concluded that the physician did not “knowingly” cause the illegal “distribution of a controlled substance.”<sup>83</sup> Even worse, just prescribing “outside the usual course of medical practice,” which could mean more than the average dose for a particular patient, or treating more pain patients than other doctors, could trigger an investigation.<sup>84</sup> Thus, physicians and healthcare providers have to make some difficult decisions when treating chronic pain patients, the first of which is whether or not to prescribe opioids at all, even if they are likely to be the best possible treatment for the patient in question.<sup>85</sup>

The legal risks are compounded by the medical complexities of treating someone with opioids.<sup>86</sup> Although prescribing opioids will reduce pain immediately, it is only a “quick fix” in that the amount prescribed will only work for a certain amount of time before the body builds up its own tolerance level, and higher doses are needed to relieve pain.<sup>87</sup> Thus, physicians have to weigh the risks and benefits of persistent and uncontrolled pain in the long-term versus the risks and benefits of prescribing opioids in the short-term within a small amount of time, as a patient’s pain endures.<sup>88</sup> Greater dosages also require more intensive monitoring on the part of the physician or healthcare provider because prolonged use of opioids may affect cognition and psychomotor functioning.<sup>89</sup>

### C. Restrictive Drug Control Legislation

Although a bulk of the debate regarding chronic pain and opioid usage revolves around physician/patient relations, outside agencies also influence the dynamics of the debate. Agencies such as the DEA and state medical boards can affect the way physicians approach pain management through potential or

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82. See Fields, *supra* note 60, at 591 (stating that doctor awareness of opioid abuse has resulted in their hesitancy in prescribing them to patients, particularly for long periods of time or for high dosages).

83. See Friedman, *supra* note 73, at 32–33 (suggesting ways a physician can protect his or her reputation and medical practice from the devastating impact of government investigations).

84. See *id.* at 31–32.

85. See Fields, *supra* note 60, at 591.

86. See Henry McQuay, *Opioids in Pain Management*, 353 LANCET 2229, 2229–30 (1999) (explaining the varying adverse side effects that may occur from opioid use).

87. See *id.* at 2230–31 (discussing tolerance issues surrounding pain medication).

88. George R. Hansen, *Management of Chronic Pain in the Acute Care Setting*, 23 EMERGENCY MED. CLINICS N. AM. 307, 312, 319 (2005).

89. See *id.* at 319–22 (discussing the importance of physician monitoring of patients to prevent adverse side effects from long term and greater dosages of opioids).

perceived regulatory disciplinary measures.<sup>90</sup> These outside agencies influence the way physicians prescribe opioids for chronic pain patients by investigating prescribers of opioids,<sup>91</sup> placing physicians at risk of sanction for over-prescribing opioids,<sup>92</sup> and providing no disincentives or punishments for under-treatment of chronic pain.<sup>93</sup> Studies suggest that fears of regulatory punishment (i.e. criminal prosecution) are the most frequently cited reason that physicians choose not to provide adequate treatment for chronic pain via the prescription of opioids.<sup>94</sup>

The DEA has steadily increased the amount of resources dedicated to investigating the diversion of controlled pharmaceuticals, such as opioids, since the findings of a report by the United States House of Representatives that was published in 2005.<sup>95</sup> In this report, the House discussed the “lack of effort to address this problem [of identifying prescription drug abuse]” made by the DEA.<sup>96</sup> Despite the DEA taking steps to improve its reputation by working to control prescription drug abuse, several shortcomings identified in 2002 still remain, according to a 2006 Justice Department Office of the Inspector General’s report.<sup>97</sup> Consequently, the DEA continues to feel the pressure to perform and has since moved from working to control pharmaceutical diversion over the Internet to investigating the physicians who prescribe controlled pharmaceuticals.<sup>98</sup>

According to Title 21, U.S. Code, Section 827(a)(3), all medical practitioners are required to maintain an accurate and up-to-date record of distribution of controlled substances,<sup>99</sup> which are subject to audit and administrative inspection by the DEA.<sup>100</sup> In the past, physicians have been investigated by the DEA and tried for such criminal offenses as conspiracy to engage in drug trafficking,<sup>101</sup> healthcare

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90. See M.M. Reidenberg & O. Willis, *Prosecution of Physicians for Prescribing Opioids to Patients*, 81 CLINICAL PHARMACOLOGY & THERAPEUTICS 903, 903 (2007).

91. See *id.*

92. See *id.* at 905 (noting that state medical boards have the authority to refer physicians who over-prescribe opioids to the criminal justice system for prosecution).

93. See Ann M. Martino, *In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?*, 26 J.L. MED. & ETHICS 332, 332–33 (1998) (explaining that although physicians are subject to sanctions for over-prescribing, there is no such risk for under-prescribing).

94. See *id.* at 332.

95. See Laxmaiah Manchikanti, *National Drug Control Policy and Prescription Drug Abuse: Facts and Fallacies*, 10 PAIN PHYSICIAN 399, 414 (2007) (“Consequently the DEA increased the amount of resources and manpower dedicate to investigating the diversion of controlled pharmaceuticals.”).

96. H.R. REP. NO. 108-576, at 28 (2004).

97. OFFICE OF THE INSPECTOR GEN., U.S. DEP’T OF JUSTICE, EVALUATION & INSPECTIONS DIV., U.S. DEPT. OF JUSTICE, NO. I-2006-004, FOLLOW-UP REVIEW OF THE DRUG ENFORCEMENT ADMINISTRATION’S EFFORTS TO CONTROL THE DIVERSION OF CONTROLLED PHARMACEUTICALS III (2006).

98. *Id.* at 5.

99. 21 U.S.C. § 827(a)(3) (2011).

100. § 880(b)(1).

101. See e.g., Andrew Welsh-Huggins, *Autopsy: Accused Ohio Pill Mill Doctor Facing Trial Committed Suicide by Drug Overdose*, THE REPUBLIC (Nov. 8, 2012), <http://www.therepublic.com/view/story/314d7bc92ef040ce922f448d54624dbf/OH--Drug-Deaths-Doctors-Suicide> (explaining the

fraud,<sup>102</sup> drug-trafficking resulting in serious bodily injury,<sup>103</sup> and drug-trafficking resulting in death<sup>104</sup>—all related to the choices they made in their prescription practices—and were forced to face the legal consequences of their perceived criminal actions, whether they were in fact guilty or not.

Meanwhile, state medical boards influence physicians' prescription practices by punishing what they see as bad behavior.<sup>105</sup> However, studies have shown that state medical boards are only likely to take away licenses to practice medicine from physicians following prosecution, rather than before.<sup>106</sup> According to a 2007 study, fifty-three doctors were indicted or convicted of criminal activities related to opioids in 2004 and 2005.<sup>107</sup> Of these cases, thirty-two criminal charges were based on allegations of prescribing opioids outside of the bounds of normal medical practice.<sup>108</sup> In only two of these cases were state medical boards willing to make judgment prior to criminal action.<sup>109</sup> Since this study utilized media resources,<sup>110</sup> it is possible that state medical board actions are sensitive to the media, particularly if the media projects any sort of unprofessionalism among pain physicians that will reflect poorly on state medical boards and/or the medical profession.<sup>111</sup> Either way, the fact that any physicians have lost their licenses without first being first

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severity of the charges the doctor faced, including “conspiracy to engage in corrupt activity [and] funding drug trafficking,” after allegedly writing “more than 14,000 prescriptions” during a nine-month period while operating a clinic that was only open thirty-six hours per week).

102. See e.g., Carl Lietz, *Court of Appeals Affirms Life Sentences for Pain Management Physician (and Creates Circuit Split)*, FED. CRIM. LAWYER BLOG (Sept. 20, 2011), [http://www.georgiafederalcriminallawyerblog.com/health\\_care\\_fraud/](http://www.georgiafederalcriminallawyerblog.com/health_care_fraud/) (discussing charges against a Florida doctor for health care fraud and unlawfully dispensing controlled substances).

103. See O'Reilly, *supra* note 65. In September 2003, William E. Hurwitz, M.D. was charged with forty-nine counts, including drug-trafficking conspiracy to distribute oxycodone and other pain medications; and drug trafficking resulting in death and serious bodily injuries, along with health care fraud by a federal grand jury. *Id.* He was convicted on fifty counts of drug trafficking, including one count relating to death and serious bodily injuries in December 2004 and later sentenced to twenty-five years in federal prison and a fine of \$1 million dollars. *Id.*

104. See e.g., Tina Rosenberg, *Doctor or Drug Pusher?*, N.Y. TIMES, June 17, 2007, § 6 (Magazine), at 48 (discussing a North Carolina doctor sentenced to 30 years in prison on several charges, including the charge of drug trafficking resulting in death when his patient died from taking prescribed OxyContin at fatal dosages).

105. See Diane E. Hoffmann & Anita J. Tarzian, *Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards*, 31 J.L. MED. & ETHICS 21, 21 (2003) (indicating that state medical boards have investigated and disciplined physicians for overprescribing, and that as a result physicians will inadequately prescribe opioids).

106. Reidenberg & Willis, *supra* note 90, at 904 (examining forty-seven cases involving criminal prosecution of doctors for opioid offenses, and finding that only two were reviewed by a state medical board prior to indictment).

107. *Id.* at 903. Study researchers reviewed media reports and journal articles to determine this number; thus, it only reflects published cases of doctors charged or convicted with opioid offenses. *Id.*

108. *Id.* at 904.

109. *Id.*

110. *Id.* at 903.

111. See Martino, *supra* note 93, at 332 (indicating that perception of regulatory risks to prescribing opioids far exceeds the reality).

convicted of a crime undoubtedly has a chilling effect on the prescription of opioids.<sup>112</sup>

Consequently, physicians may need to deal with repeated requests for better pain management, but the brunt of under-medication is born by the chronic pain patients themselves, their families, friends, and work associates.<sup>113</sup> Historically, there has been no risk of criminal prosecution, loss of professional privileges, or loss of reputation associated with telling a suffering patient that there is nothing more that can be done to help relieve his or her pain.<sup>114</sup> In other words, incentives have been created for physicians to under-prescribe medications to prevent placing their “livelihood, reputation, and status”<sup>115</sup> at stake through the regulatory action of medical boards and the DEA, but there is no countervailing risk associated with under-treating a patient in pain.<sup>116</sup> As a result, physicians choose not to prescribe opioids as often as patients might need or want for their chronic pain in order to avoid potential legal repercussions.<sup>117</sup> Thus, physicians find themselves in a balancing act that weighs the benefits of prescribing opioids to patients against the potential risk of being investigated by government agencies for trying to provide adequate treatment to their chronic pain patients.<sup>118</sup>

## II. OVERCOMING BARRIERS TO EFFECTIVE TREATMENT OF CHRONIC PAIN

The largest barrier to overcome is the misconceptions people have about the treatment of chronic pain with opioids. Fears of potential addiction continue to limit patients’, family members’, and physicians’ willingness to consider opioids for the treatment of chronic pain.<sup>119</sup> In order to overcome these barriers, advocacy

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112. *Id.* (indicating that doctors second-guess decisions and under-prescribe out of a fear of being sanctioned for overprescribing opioids).

113. *See* Brody, *supra* note 4 (noting that the stress associated with chronic pain is often born by family and friends, as well as the patient themselves).

114. *See* Martino, *supra* note 93, at 332–33. *But see* *Bergman v. Chin*, No. H2057321, 2001 WL 1517376 (Cal. App. Dep’t Super. Ct. June 13, 2001) (finding that a physician’s under-treatment of patient pain constituted elder abuse, despite the fact that there is no recognized cause of action for medical malpractice for under-treatment of pain).

115. Martino, *supra* note 93, at 338.

116. *See supra* note 115 and accompanying text.

117. *See* Martino, *supra* note 93, at 332 (indicating that physicians most often cite the fear of regulatory reprisal as the reason they under-treat chronic pain).

118. *See* Joyce S. Fontana, *The Social and Political Forces Affecting Prescribing Practices for Chronic Pain*, 24 J. PROF. NURSING 30, 30–31 (2008) (examining different factors, including physician fear of regulatory scrutiny, that have led to inadequate prescribing practices for patients with chronic pain).

119. Margo McCaffery & Betty Rolling Ferrell, *Correcting Misconceptions About Pain Assessment and Use of Opioid Analgesics: Educational Strategies Aimed at Public Concerns*, 44 NURSING OUTLOOK 184, 186 (1996) (noting that patients, their family members, and the general public have fears of opioid addiction that pose barriers to effective pain management).

and education regarding chronic pain management is necessary.<sup>120</sup> Misconceptions about opioid usage for chronic pain need to be addressed at the level of patients and their families, healthcare providers (especially physicians), and policymakers (legislators and agencies).<sup>121</sup>

Misconceptions about opioid usage in chronic pain patients can be mitigated by understanding that the amount of medication required to treat pain varies from person to person, and over time in the same person. Thus, it is not possible to pinpoint a specific acceptable dose of opioids for chronic pain patients, but only a range of acceptable levels given the trajectory of each particular patient's pain relief.<sup>122</sup> The actual amount prescribed to patients will vary, depending on: the degree of pain experienced, tolerance level, effectiveness of the treatment, and the amount of time the patient has been treated for chronic pain.<sup>123</sup> It is even possible that tolerance varies over time, affecting the effectiveness of pain control differently at each stage of treatment.<sup>124</sup>

Similarly, it is important to remember that the amount prescribed is not a sign that the physician is over-prescribing for a particular patient, as pain management is very patient specific.<sup>125</sup> Nor is how often a physician prescribes pain medication to his patients a sign of over-prescribing; different physicians serve different patient populations and specialize in different conditions.<sup>126</sup> Thus, the amount prescribed to patients, in and of itself, is not necessarily an indicator of potential addiction among

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120. See AM. ACAD. FAM. PHYSICIANS, AMERICAN ACADEMY OF FAMILY PHYSICIANS PAIN MANAGEMENT AND OPIOID ABUSE: A PUBLIC HEALTH CONCERN 5–6 (2012), available at [http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/clinical/painmanagement/painmanagementopioids.Par.0001.File.tmp/Opioid%20Abuse%20Position%20Paper%20FINAL.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/painmanagement/painmanagementopioids.Par.0001.File.tmp/Opioid%20Abuse%20Position%20Paper%20FINAL.pdf) (noting that the American Academy of Family Physician seeks to find a solution to America's pain management problems through advocacy, collaboration, and education).

121. See McCaffery & Ferrell, *supra* note 119, at 186 (noting that misunderstandings about opiate addiction by patients, their families, and the general public result in the under-treatment of pain; it follows that misconceptions about opiates need to be addressed at these levels); Russell K. Portenoy & Seddon R. Savage, *Clinical Realities and Economic Considerations: Special Therapeutic Issues in Intrathecal Therapy – Tolerance and Addiction*, 14 J. PAIN & SYMPTOM MANAGEMENT S27, S32 (1997) (noting that physician's misconceptions about opioid addiction also result in the under-treatment of pain).

122. See *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain*, AGENCY MED. DIRECTORS GROUP 3 (2010), <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf> (recommending a dosing threshold for pain medication, but noting that effective pain management requires frequent assessments and tracking of pain relief).

123. See *id.* at 6–7; THE BRITISH PAIN SOCIETY, OPIOIDS FOR PERSISTENT PAIN: GOOD PRACTICE 28 (2010), available at [http://www.britishpainsociety.org/book\\_opioid\\_main.pdf](http://www.britishpainsociety.org/book_opioid_main.pdf) (indicating that factors such as a higher tolerance levels, increased pain intensity, or the development of an additional painful condition may require increased doses of opioids).

124. *Id.*

125. See, e.g., Rosenberg, *supra* note 106 (noting that “[d]ose alone says nothing about proper medical practice” and that different patient populations may require significantly higher or lower doses).

126. *Id.*

a patient population.<sup>127</sup> For addiction to exist, patients must also exhibit tendencies towards anti-social behavior.<sup>128</sup>

*A. Advice for Patients and Their Families*

Patients and their families should work with their healthcare providers when deciding on the best treatment plan for their chronic pain. Patients can ensure that they receive adequate chronic pain management by being aware of their own personal and family medical histories, sharing this information with their physicians and other healthcare providers, being able to differentiate between tolerance and addiction when using opioids, and keeping careful record of their dosages and how they affect treatment success.<sup>129</sup>

Patients need to be aware of their own personal medical histories, as well as their family medical history; this helps providers plan for potential risk for addiction or negative outcomes during treatment.<sup>130</sup> Patients also need to disclose any history of substance abuse and/or family history of substance abuse prior to seeking prescriptions, while also being aware of when and if they are demonstrating potential addictive behaviors following use of opioids.<sup>131</sup> Doing so does not mean the patient will not be treated, but will give the physician the opportunity to implement extra precautionary measures to monitor use and watch for possible abuse.<sup>132</sup>

This information should be shared with healthcare providers, as a display of tendencies toward abuse requires close monitoring if and when opioids are prescribed for chronic pain.<sup>133</sup> Although opioid-treated patients have been found to be less likely to develop addiction if they maintain a stable regime,<sup>134</sup> as a cohort they present “high rates of addiction comorbidity,” especially if they have a previous history with substance abuse.<sup>135</sup> Thus, patients and their families should be aware of the common signs of drug abuse, such as increased usage, requests for

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127. *Id.*

128. See Michelle Meadows, *Managing Chronic Pain*, FDA CONSUMER, Mar.–Apr. 2004, at 23, 27 (“Addiction is characterized by craving and compulsive use of drugs.”).

129. See Jeffrey Fudin et al., *Chronic Pain Management with Opioids in Patients with Past or Current Substance Abuse Problems*, 16. J. PHARMACY PRAC. 291, 294–95, 303 (2003).

130. *See id.*

131. *See id.* at 292, 293–94; see also Andrew Kolodny et al., *Cautious, Responsible Opioid Prescribing*, ADDICTION MED. UNIT, N.Y. ST. OFF. ALCOHOLISM & SUBSTANCE ABUSE SERVICES, <http://www.oasas.ny.gov/admed/rx/documents/OpioidPrescribing.pdf> (last visited Mar. 29, 2013) (indicating the importance of disclosing past and current drug before initiating opioid therapy).

132. See Kolodny et al., *supra* note 131.

133. See Jane C. Ballantyne, *Opioid Analgesia: Perspectives on Right Use and Utility*, 10 PAIN PHYSICIAN 479, 484, 486–87 (2007) (stating that patients with a personal or family history of drug abuse require increased monitoring).

134. *Id.* at 485.

135. *Id.*

early refills, simultaneous abuse of alcohol, doctor shopping, and prescription forgery.<sup>136</sup>

Again, these outcomes do not affect all chronic pain patients. Rather, some opioid-treated patients develop tolerance without addiction,<sup>137</sup> so patients need to make sure they keep an accurate and detailed record of their drug usage and its effects.<sup>138</sup>

Being forthcoming and cooperative is especially useful if patients fear that their physician or other healthcare provider may suspect addiction when that is not necessarily the case.<sup>139</sup> A drug diary allows physicians and other healthcare providers to track trends and adjust dosage according to effectiveness, particularly if a patient has moved or changed physicians.<sup>140</sup> However, if the physician shows signs of fearing potential addiction, patients can also bring along a friend or family member as their supportive advocate to reassure the medical provider that drug-seeking behaviors have not developed.<sup>141</sup>

### *B. Advice for Physicians and Other Healthcare Providers*

Since patients and their families might not always be able to recognize the difference between tolerance (which is acceptable in chronic pain patients) and addiction (which is not), it is important that physicians and other healthcare providers are themselves clear on the difference.<sup>142</sup> Since the misconception that tolerance and addiction are the same is the source of unwarranted fears among

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136. See generally CIGNA BEHAVIORAL HEALTH, TIPS FOR ADDRESSING POTENTIAL MEDICATION ABUSE IN PAIN PATIENTS (2006), available at <http://www.cignabehavioral.com/web/basic/site/provider/treatingBehavioralConditions/narcoticArticlePCPNewsletter.pdf> (noting that patient behaviors such as increased use of opiates, doctor shopping, concurrent use of alcohol, early refills, and “scamming” are indicative of drug abuse).

137. See Jette Højsted et al., *Classification and Identification of Opioid Addiction in Chronic Pain Patients*, 14 EUR. J. PAIN 1014, 1014 (2010) (noting that according to one health organization, addiction diagnosis requires three out of six factors, of which increased tolerance is only one, to be present).

138. See Andrea M. Trescot et al., *Opioid Guidelines in the Management of Chronic Non-Cancer Pain*, 9 PAIN PHYSICIAN 1, 18, 28 (2006); Fudin et al., *supra* note 129, at 294–95 (emphasizing the importance of patients keeping detailed information on drug usage).

139. See AM. ACAD. OF PAIN MGMT., *Advocating for a Loved One in Pain*, NAT’L FAM. CAREGIVERS ASS’N, [http://65.36.182.14/caregiving\\_resources/aapm.cfm](http://65.36.182.14/caregiving_resources/aapm.cfm) (last visited Mar. 29, 2013) (suggesting ways that patients and patient advocates can more effectively insist on treatment to manage pain).

140. *Chronic Pain Management: An Appropriate Use of Opioid Analgesics*, ACP INTERNIST EXTRA, Jan. 2008, at 6 (noting that a physician may require a patient using opioid therapy to keep a pain diary as a method to monitor pain treatment).

141. See AM. ACAD. OF PAIN MGMT., *supra* note 139.

142. See McCaffery & Ferrell, *supra* note 119, at 186 (noting that patients, their families, and the general public have serious misconceptions about opioid addiction); Portenoy & Savage, *supra* note 121 (noting that physicians’ misconceptions about opioid addiction result in the under-treatment of pain; it follows that physicians must be instructed properly in the difference between opioid addiction and tolerance).

patients and physicians alike, it is essential that this issue is addressed if chronic pain patients are to receive adequate care.<sup>143</sup>

Physicians and other healthcare providers can use the following criteria to assess chronic pain patients prior to implementing opioid therapy, also known as the “4 A’s: analgesia, activities of daily living, adverse events, and aberrant drug-taking behaviors.”<sup>144</sup> Other factors that healthcare providers should consider include:

- Using a multidisciplinary approach to pain management in both pharmacological and non-pharmacological interventions (physical therapy, psychological interventions, alternative approaches, etc.) prior to actual prescription of opioids if patients fear potential addiction;<sup>145</sup>
- Prescribing opioid medication for acute and/or chronic pain after determining the futility of alternative therapies and allowing the lowest effective dose of opioids but also watching not to under-medicate;<sup>146</sup>
- Referencing guidelines regarding opioid use for chronic pain, such as the one published by the American Academy of Family Physicians<sup>147</sup> or the Substance Abuse and Mental Health Services Administration;<sup>148</sup>
- Assessing the patient’s individual needs: the site, duration, intensity and quality, as well as the impact of pain; the individual’s previous experiences with pain, disability, and emotional distress; possible history with substance abuse, comorbidities, and other behavioral factors;<sup>149</sup> and

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143. See *id.* (noting that unwarranted patient and physician fears about opioid addiction result in the under-treatment of chronic pain).

144. See Steven D. Passik, *Issues in Long-term Opioid Therapy: Unmet Needs, Risks, and Solutions*, 84 *MAYO CLINIC PROC.* 593, 597 (2009).

145. See Ken Berkowitz & Robert D. Kerns, Remarks at the National Ethics Teleconference on Ethical Considerations in Opioid Therapy for Chronic Pain Management 1, 3 (Nov. 30, 2005), available at

[http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CEsQFjAA&url=http%3A%2F%2Fwww.ethics.va.gov%2Fdocs%2Fnet%2FNET\\_Topic\\_20051130\\_Opioid\\_Therapy\\_Chronic\\_Pain.doc&ei=enskUJyNB4WN6QHx7oHADQ&usg=AFQjCNFLgQxLl2bjDbzR1BaX0-9b9R8-hg](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CEsQFjAA&url=http%3A%2F%2Fwww.ethics.va.gov%2Fdocs%2Fnet%2FNET_Topic_20051130_Opioid_Therapy_Chronic_Pain.doc&ei=enskUJyNB4WN6QHx7oHADQ&usg=AFQjCNFLgQxLl2bjDbzR1BaX0-9b9R8-hg).

146. See *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain*, *supra* note 122, at 1 (describing the conditions under which opioid therapy should be prescribed).

147. See BARBARA L. BITTNER ET AL., AM. ACAD. OF FAMILY PHYSICIANS, USING OPIOIDS IN THE MANAGEMENT OF CHRONIC PAIN PATIENTS: CHALLENGES AND FUTURE OPTIONS 2 (2010), available at <http://www.mc.uky.edu/equip-4-pcps/documents/CRx%20Literature/Opioids%20for%20chronic%20pain.pdf>.

148. *Pain Management Without Psychological Dependence: A Guide for Healthcare Providers*, IN BRIEF (Ctr. for Substance Abuse Treatment, U.S. Dep’t of Health & Human Servs., Rockville, Md.), Summer 2006, at 1–3, available at [http://www.kap.samhsa.gov/products/brochures/pdfs/saib\\_0401.pdf](http://www.kap.samhsa.gov/products/brochures/pdfs/saib_0401.pdf).

149. See Passik, *supra* note 144, at 594–95 (discussing factors that should guide physicians in choosing pain therapy for patients).

- Using a comprehensive assessment inclusive of patient history, related to medical, family, psychosocial, medication, and past interventions; physical examinations; diagnostic studies; and note of any underlying conditions.<sup>150</sup>

Similarly, physicians and other healthcare providers should pay close attention to their patients' personal and family medical histories prior to prescribing opioids.<sup>151</sup> However, this should not deter them from considering opioid therapy as an option for pain relief even among patients with substance abuse histories (personal or familial) for the reasons discussed earlier.<sup>152</sup> Instead, following the introduction of opioid therapy, physicians and other healthcare providers should continue to keep careful record of their patients' dosages and the effects of treatment and be able to differentiate between tolerance and addiction.<sup>153</sup>

To ensure that a patient's chronic pain is well controlled, without temptations for supplementation with alcohol or illegal drugs, physicians and other healthcare providers should question their chronic pain patient's on the following points:

- Use of other substances, including prescription drugs from other physicians, alcohol or illicit drugs, and at what dosages, and how often<sup>154</sup>
- Whether these substances are used by the individual to ease pain: physical, emotional, or in a social context<sup>155</sup>
- What other effects the pain medications are having on the individual (e.g. feelings of euphoria, withdrawal symptoms when discontinued, unwanted side-effects)<sup>156</sup>

Opioid therapy should be stopped or an alternative treatment plan developed if the pain resolves itself or if the opioid therapy no longer achieves its initial goals of easing pain, improving function, and/or enhanced quality of life, or if the patient exhibits symptoms of addiction.<sup>157</sup> In order to avoid symptoms of withdrawal and rebound increases in pain, the use of opioids should be tapered off.<sup>158</sup>

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150. *Id.* at 594.

151. See Ken Solis, *Ethical, Legal, and Professional Challenges Posed By "Controlled Medication Seekers" to Healthcare Providers, Part 2*, 7 AM. J. CLINICAL MED. 86, 87–88 (2010) (discussing the importance of recognizing warning signs for opioid dependence before prescribing).

152. See Passik, *supra* note 144, at 594–95 (recommending that individuals with a history of substance abuse consult a pain specialist or psychologist before beginning opioid therapy).

153. *Id.* at 597.

154. See Seddon R. Savage et al., *Challenges in Using Opioids to Treat Pain in Persons with Substance Use Disorders*, ADDICTION SCI. & CLINICAL PRAC., June 2008, at 4, 9 (discussing the importance of assessing other drug use prior to proscripting opioid treatment).

155. *Id.* at 16–17.

156. *Id.* at 9.

157. Several scholarly articles discuss situations that would warrant the curtailment of opioid treatment. See, e.g., Clark, *supra* note 13; Savage et al., *supra* note 154, at 22–23.

158. See Clark, *supra* note 13.

*C. Advice to Legislators and Other Regulatory Agencies*

In the past, the American healthcare system has “failed to recognize chronic pain as a legitimate condition,” particularly among chronic pain patients.<sup>159</sup> This is in part due to its association with other health disparities such as race, ethnicity, age, gender, and socioeconomic status.<sup>160</sup> Thus, legislators and other agency members can help promote the adequate management of chronic pain by advocating for increased access to comprehensive assessments, greater coordinated care, and the research funding needed to identify new therapies and areas of clinical guidance.<sup>161</sup>

Legislators, advocates, and policymakers have many options in terms of what they can do to help promote the adequate management of chronic pain patients. One option is working to amend privacy requirements to help limit disclosure of the fact that a particular patient is being treated with opioids to only the most necessary situations.<sup>162</sup> These efforts can help patients be less hesitant to try opioids for pain management, but these privacy concerns need to be balanced against the need to share information that will help healthcare professionals more effectively exclude potential drug abusers, addicts, or dealers from obtaining drugs under the pretense of seeking treatment.<sup>163</sup> Advanced information sharing could also help patients locate the best healthcare providers for chronic pain through the development and application of quality indicators and performance measures,<sup>164</sup> but again, it is essential that any means implemented to achieve these goals avoid creating a chilling effect on chronic pain patients’ willingness to seek treatment.<sup>165</sup>

Another potential area for advocacy would be the reform of reimbursement practices for chronic pain. Currently, Medicare and Medicaid maintain fee-for-service systems for reimbursement that inadequately compensate healthcare professionals for the time it requires “to assess, counsel, and educate” which are

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159. See MAY DAY FUND, A CALL TO REVOLUTIONIZE CHRONIC PAIN CARE IN AMERICA: AN OPPORTUNITY IN HEALTH CARE REFORM 4 (2010), available at <http://www.maydaypainreport.org/docs/A%20Call%20to%20Revolutionize%20Chronic%20Pain%20Care%20in%20America%2003.04.10.pdf>.

160. *Id.*

161. *Id.* at 10–11.

162. See Lianne Lian Hu et al., *Privacy Protection for Patients with Substance Use Problems*, 2 SUBSTANCE ABUSE & REHABILITATION 227, 228 (2011) (discussing issues such as stigma and discrimination caused by inadequate privacy policies in the context of patients who have substance abuse problems).

163. See *id.*; MAY DAY FUND, *supra* note 159, at 10–11 (advocating for a “balanced approach” to regulating opioids used for pain management).

164. See MAY DAY FUND, *supra* note 159, at 9 (recommending the development of advanced information sharing systems to monitor pain disorders, treatments and outcomes).

165. Although advanced information sharing could help patients locate the best healthcare provider, prescription monitoring can have a negative and possibly chilling effect on opioid prescription and use, as there are some concerns over patient privacy. See generally Hu et al., *supra* note 162 (discussing privacy concerns surrounding health information for patients who have substance abuse problems).

essential to the adequate treatment of chronic pain.<sup>166</sup> The Department of Health and Human Services (HHS) should explore outcome-based payments and the use of team approaches to treatment to help assure proper assessment and follow-up for chronic pain patients.<sup>167</sup> Such monetary incentives would also encourage healthcare professionals to take the time necessary to adequately assess and manage chronic pain.<sup>168</sup>

Finally, advocates need to find a better approach to the regulation of controlled prescription drugs, particularly opioids. Legislation needs to clearly distinguish between dependency or tolerance in the medical context and addiction and the problems it causes.<sup>169</sup> Furthermore, there needs to be an education campaign to teach healthcare professionals, regulators, law enforcement, and the general public that opioid use per se is not wrong or a social evil, that such drugs can help normalize the lives of chronic pain patients, and that the amount of drug prescribed alone is not an indicator of abuse, but an indicator of individual patient needs and tolerances for the medication.<sup>170</sup>

Quasi-government organizations, such as state medical boards (and accreditation organizations indirectly), can also exercise influence over pain management policies.<sup>171</sup> In particular, they can work to encourage the training of healthcare professionals in pain assessment and treatment.<sup>172</sup> Since states have the ability to set the standards and/or appoint those who set standards for medical licensing and discipline, they can look towards incorporating more pain management content on licensing exams.<sup>173</sup>

### III. CONCLUSION

Now is the time to remove both social and legal barriers to adequate chronic pain management. According to a report from the Institute of Medicine, more than 100 million Americans suffer from chronic pain and many more family members, friends, and colleagues suffer with them because of the irritability, depression, and loss of productivity caused by uncontrolled pain.<sup>174</sup> It is estimated that the under-

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166. See MAY DAY FUND, *supra* note 159, at 10.

167. *Id.*

168. *Id.*

169. See interview by Jennifer Lobb with Jennifer Schneider (Apr. 2005) (transcript available at <http://www.jenniferschneider.com/articles/addiction-tolerance-dependence.html>) (commenting on the “widespread misunderstanding” of the differences between dependency or tolerance and addiction).

170. See *id.*; Hoffmann & Tarzian, *supra* note 105, at 22–23 (discussing the evolution of opioid pain treatment and concluding that state medical boards are still looking for the “right balance” in promoting and regulating opioid therapies).

171. See MAY DAY FUND, *supra* note 159, at 9 (proposing pain care training changes through state medical boards, professional schools, and residency training programs).

172. *Id.*

173. *Id.* at 9–11.

174. INST. OF MED., *supra* note 16, at 1.

treatment of chronic pain costs our country \$600 billion a year in other medical treatments and lost productivity.<sup>175</sup> We can no longer afford to ignore such a wasteful expenditure of healthcare dollars and such a needless loss of quality of life. We need to start by helping the public, medical professionals, and governmental actors understand that the proper medical management of opioid use for the treatment of chronic pain has none of the negative social side effects associated with addiction or illegal drug use. Second, laws, regulations, and enforcement practices need to accurately reflect this distinction and even actively encourage the effective management of chronic pain without stigmatizing the healthcare professionals involved in providing such care, the family members who seek help for their loved ones, or the patients who take opioids or other controlled substances to manage their pain. Finally we can all do our part by educating ourselves and advocating for those suffering from chronic pain.

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175. Boyles, *supra* note 6.