

2000

A Prescription for the Pain: The Emerging Standard of Care for Pain Management

Ben A. Rich

Follow this and additional works at: <http://open.mitchellhamline.edu/wmlr>

Recommended Citation

Rich, Ben A. (2000) "A Prescription for the Pain: The Emerging Standard of Care for Pain Management," *William Mitchell Law Review*: Vol. 26: Iss. 1, Article 3.

Available at: <http://open.mitchellhamline.edu/wmlr/vol26/iss1/3>

This Article is brought to you for free and open access by the Law Reviews and Journals at Mitchell Hamline Open Access. It has been accepted for inclusion in William Mitchell Law Review by an authorized administrator of Mitchell Hamline Open Access. For more information, please contact sean.felhofer@mitchellhamline.edu.

© Mitchell Hamline School of Law

A PRESCRIPTION FOR THE PAIN: THE EMERGING STANDARD OF CARE FOR PAIN MANAGEMENT

Ben A. Rich†

I. INTRODUCTION	2
II. MODERN MEDICINE'S LEGACY OF PAIN	6
III. THE CULTIVATION OF IGNORANCE	14
IV. THE METAPHYSICS OF PAIN	17
V. CURATIVE VS. PALLIATIVE MEDICINE: THE CLASH OF ABSOLUTES.....	21
VI. WESTERN CULTURE'S AMBIVALENCE TOWARDS PAIN	26
VII. THE DUTY TO RELIEVE SUFFERING.....	31
A. <i>The Scope of the Duty</i>	31
B. <i>Potential Sources of the Duty</i>	32
VIII. REASONS WHY THE DUTY TO RELIEVE PAIN IS BREACHED	39
A. <i>Barriers to Effective Pain Management</i>	39
B. <i>Lack of Knowledge Regarding Pain Assessment and Pain Management</i>	40
C. <i>Concerns About Narcotics—The Phenomenon of Opiophobia</i>	42
1. <i>The Regulatory Milieu</i>	44
2. <i>Must a War on Drugs Preclude a War on Pain?</i>	55
D. <i>The Low Priority of Pain Relief in the Health Care Setting</i>	61

† Ben A. Rich, J.D. Washington University-Saint Louis, Mo. (1973), Ph.D. (philosophy) University of Colorado, Boulder (1995). Private law practice—Hollowell, Silverstein, Rich and Brady, Raleigh, N.C., 1976-1980; Deputy Commissioner, North Carolina Industrial Commission, 1980-81; Legal Counsel, University of North Carolina Hospitals, Chapel Hill, 1981-84; Senior Resident Counsel, University of Colorado Health Sciences Center, Denver, 1984-1986; General Counsel, University of Colorado System, Boulder, 1986-1990; Visiting Associate Professor, University of Colorado School of Law, Boulder, 1990-1991; Associate Clinical Professor, University of Colorado School of Medicine, Denver, 1992-1995. Since 1995, Assistant Professor and Assistant Director, Program in Health Care Ethics, Humanities and Law, University of Colorado Health Sciences Center, Denver. Effective February, 2000, Dr. Rich will assume the position of Associate Professor, Bioethics Program, University of California, Davis Medical Center, Sacramento.

	<i>E. Reasons Do Not Equal Excuses—Moral Courage and the Duties of Caregivers</i>	63
IX.	ENFORCING THE DUTY TO PROVIDE PAIN RELIEF	70
	<i>A. The Standard of Care</i>	70
	<i>B. The Judicially Imposed Standard of Care</i>	72
	<i>C. Informed Consent: The Paradigm Case of Judicially-Imposed Standard of Care</i>	75
	<i>D. Clinical Practice Guidelines and the Standard of Care</i>	81
	<i>E. A Case in Point—James v. Hillhaven Corp.</i>	84
X.	THEORIES OF RECOVERY.....	89
XI.	CONCLUSION.....	90

*The Fellowship of those who bear the Mark of Pain. . . .
Those who have learnt by experience what physical
pain and bodily anguish mean . . . they are united in a
secret bond . . . one and all they know the longing to be
free from pain.*

*Albert Schweitzer*¹

I. INTRODUCTION

During the last twenty-five years, the literature of the health care profession has documented a serious and persistent problem—the undertreatment of pain and the failure to effectively address suffering in the clinical setting.² Generally speaking, clinicians have escaped both professional sanctions and malpractice liability for what would seem to be a serious dereliction of duty.³ There is a marked and curious disparity between the way in which patients and the lay public view the responsibility of caregivers to deal with pain and suffering, and the way in which the providers themselves view their responsibility.⁴ The argument of this article is

1. ALBERT SCHWEITZER, ON THE EDGE OF THE PRIMEVAL FOREST AND MORE FROM THE PRIMEVAL FOREST 116 (1948).

2. See generally *infra* notes 30-34. Even a representative sampling of this literature will not adequately convey its magnitude. What is as revealing as the literature itself is what does not appear, which is any study, survey, or even article or opinion piece suggesting either that the data and the conclusions drawn from it—that pain is widely, persistently, and systematically undertreated by health care professionals—are flawed, exaggerated, or inconsistent with the real world experience of other health care professionals.

3. See *infra* Section IX.E.

4. See Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine*, 306 NEW

that health care providers in general, and physicians in particular because of their control over prescription medications, have both an ethical and a legal duty to relieve the pain and suffering of their patients whenever possible.⁵ Health care providers also should not inflict unnecessary pain and suffering.⁶ Moreover, because of changing public and professional attitudes toward this duty, clinicians will not in the future, as they have in the past, be able to escape liability for failure to meet this duty to their patients.⁷

There are three basic categories of pain: acute, cancer, and chronic nonmalignant (sometimes referred to as "intractable").⁸ Cancer pain, and pain associated with other terminal or progressive and incurable conditions, is sometimes considered to be within the special domain of palliative medicine or hospice care.⁹ Such patients, as a general rule, tend to fare better with regard to pain control because it is a recognized tenet of clinical practice that if a patient is terminally ill, then it is appropriate to cease and desist from aggressive curative measures and to concentrate instead on palliation, which is characterized by a singular focus on maximizing the patient's quality of life.¹⁰ This sharp distinction between curative and palliative medicine is problematic, for it suggests that so long as curative measures are underway, the physician's responsibility to

ENG. J. MED. 639, 640 (1982). Cassell notes this disparity when he observes that "[t]he relief of suffering, it would appear, is considered one of the primary ends of medicine by patients and lay persons, but not by the medical profession." *Id.*

5. See *infra* Section VIII.D-E.

6. See *infra* Section VIII.D-E.

7. See generally Shannon Brownlee et al., *The Quality of Mercy*, U.S. NEWS & WORLD REP., Mar. 17, 1997, at 54 (describing the increasing empathy in the medical community toward chronic pain).

8. See RONALD MELZACK & PATRICK D. WALL, *THE CHALLENGE OF PAIN* 52-56 (1982). While some of the basic textbooks on pain continue to identify only two broad categories of pain (acute and chronic), a further distinction between chronic nonmalignant pain and cancer pain acknowledges the different trajectories that pain will take in the course of the patient's illness. See *id.* That is, the latter will likely increase with the progression of the illness until death, while the former will likely be a lifelong affliction with which the patient must cope.

9. Palliative medicine is defined as "the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life." OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 3 (Derek Doyle et al. eds., 2d ed. 1998). For purposes of this article, hospice care will be considered comprehensive palliative care that is provided under the auspices of a hospice, whether it is an in-patient unit or home hospice. For a more extensive discussion of the nature of hospice, see MARCIA LATTANZILIGHT ET AL., *THE HOSPICE CHOICE: IN PURSUIT OF A PEACEFUL DEATH* 44-57 (1998).

10. See OXFORD TEXTBOOK OF PALLIATIVE MEDICINE, *supra* note 9, at 3.

the patient does not include, in any significant way, making the patient comfortable and being concerned about quality of life.¹¹ A fundamental thesis of this article is that allowing a patient to experience unnecessary pain and suffering of any form is substandard and unethical medical practice regardless of the nature of the patient's condition or the goals of medical intervention.¹²

Section II will survey the literature documenting the extent to which caregivers fail to address issues of pain and suffering in their patients.¹³ As noted at the outset, this failure has been consistently documented in the professional literature for over two decades, a period in which, ironically, major advances have been achieved in pain management strategies and techniques. Section III will defend the proposition that the medical profession has, in a very real sense, cultivated its ignorance of the major advancements in pain management strategies and modalities.¹⁴ In the process the medical profession has sent forth generation after generation of young physicians armed only with the myths, misinformation, and anachronistic views about pain relief that were formed by teachers and mentors many decades ago.

Section IV will consider the most salient and singular aspect of pain and suffering in the clinical setting, its subjectivity.¹⁵ Perhaps more than any other factor, the objective nonverifiability of a patient's complaints of pain contributes to the willingness of health care professionals to dismiss or discount the extent of suffering the patient reports. Section V discusses the prevailing curative model of medical practice and considers how it has rigidly dictated the profession's values, priorities, and goals with regard to patient care.¹⁶ Curative measures have been viewed as at the opposite end of the clinical continuum from palliative measures, such that prioritizing efforts to make a patient comfortable and to relieve suffering are seen as tantamount to "giving up" on the patient and declaring that there is no hope and nothing more that medicine has

11. See *infra* Section V.

12. For purposes of this article, "unnecessary pain and suffering" will refer to pain, and the suffering which its persistence engenders, that could be safely and effectively relieved by the application of currently available knowledge, skills, and interventions, both pharmacological and non-pharmacological.

13. See *infra* Section II.

14. See *infra* Section III.

15. See *infra* Section IV.

16. See *infra* Section V.

to offer.

Section VI explores the role of social and cultural perspectives and attitudes on the undertreatment of pain.¹⁷ Western culture has a profound ambivalence toward the pain and suffering we encounter in life, and the extent to which it is reasonable and appropriate to expect or demand that health care professionals offer relief. Section VII poses the question whether, current approaches to the contrary notwithstanding, there is, in fact, a duty on the part of health care professionals in general, and physicians in particular, to seek to relieve the pain and suffering of their patients.¹⁸ This section argues that such a duty does exist; potential sources as well as the scope of such a duty are considered.¹⁹

Section VIII reviews in some detail the most often-cited barriers to effective pain management.²⁰ One of the most significant, noted initially in section III,²¹ is that far too many clinicians lack knowledge and skill in pain relief.²² The roots of this ignorance can be traced to the medical schools that train health care professionals. These schools have continued to resist incorporating pain management and palliative care into their curricula despite the uncontroverted evidence that their graduates lack the knowledge, skills, and attitudes necessary to appropriately relieve many types of pain. While the culpability of these educational institutions may not be legal in nature, it is, at the very least, moral. Perhaps the most significant barrier, in the sense that all others may flow from it, is the psychosocial phenomenon aptly referred to as "opiophobia."²³ While this unreasoning fear of and distaste for the use of opioid analgesics is not confined to the United States, the decades-old "war on drugs" has clearly exacerbated the problem here because state medical licensing boards and the physicians whom they regulate have been "conscripted" into that war, much to the detri-

17. See *infra* Section VI.

18. See *infra* Section VII.A–B.

19. See *infra* Section VII.A–B.

20. See *infra* Section VIII.A–D.

21. See *infra* Section III.

22. See *infra* Section III.

23. The term "opiophobia" refers to the unscientific and irrational fears that many people, including many health care professionals, have about the dangers and evils of narcotics, even when prescribed to relieve pain. 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, 336 (1998).

ment of their patients with severe and persistent pain.²⁴

Curiously, another significant barrier is that hospitals have only recently begun to make effective pain management an institutional priority such that medical and nursing staff might expect to incur adverse consequences for failure to provide this essential aspect of patient care.²⁵ While hospital protocols routinely provide for the monitoring of vital signs, patients are less regularly asked about the level of their pain, or promptly and effectively cared for if they report it.²⁶ The nursing staff's customary response is that the schedule specified by the attending physician for the administration of pain relief does not permit them to do anything more for the patient.²⁷

Section IX suggests that there are legal means available to confirm and enforce a professional duty to provide effective pain relief.²⁸ The need for and appropriateness of strong ethical and legal standards for the care of pain patients is reasonable. It is arguably the only effective way to raise the unconscionably low standard of care that now prevails in health care outside of the hospice and pain clinic settings. Clinical practice guidelines, promulgated by a national agency, provide an excellent example of an *appropriate* standard to *which* physicians *should be held* for pain management.²⁹

II. MODERN MEDICINE'S LEGACY OF PAIN

The failure to address, in action rather than merely in rhetoric, the medical community's failure to address pain management is both a perplexing and disturbing phenomenon. For the last twenty-five years, by far the most frequently discussed issue in law journal articles on health care has been the crisis in medical malpractice litigation.³⁰ Similarly, in bioethics journals the two issues

24. Another way of articulating the same phenomenon and its problematic consequences is offered by physician and bioethicist Steven Miles: "cancer patients have been the victims of friendly fire in the war against drugs." See Phebe Saunders Haugen, *Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law*, 23 WM. MITCHELL L. REV. 325, 337 n.76 (1997).

25. See *infra* Section VIII.A-B.

26. See *infra* Section VIII.A-B.

27. See *infra* Section VIII.A-B.

28. See *infra* Section IX.A-E.

29. See *infra* Section IX.D.

30. The term "crisis" frequently appears in the title of articles on the subject of medical practice. See, e.g., David J. Nye et al., *The Causes of the Medical Malpractice*

which competed for the title of “most discussed” are abortion³¹ and the right to die.³² Thus medical ethics and medical jurisprudence have been singularly inattentive to the epidemic of undertreated pain.³³ However, in medical and nursing literature, as well as a number of important books, the scope and magnitude of the problem has been starkly revealed. For example, in a 1978 book Steven Brena wrote:

The epidemic of chronic disabling pain in our society has magnified a strictly medical problem into a major social issue. Just as pain in the individual is a warning that something is wrong either physically or emotionally—quite often both—the pain epidemic can be viewed as an alarm signaling to us that something is wrong with our social philosophy and laws.³⁴

Brena correctly indicates that the epidemic of untreated or undertreated pain is an extremely complex, multi-dimensional problem.³⁵ The source of this complexity, as will be discussed at

Crisis: An Analysis of Claims Data and Insurance Company Finances, 76 GEO. L.J. 1495 (1988); Michael J. Saks, *In Search of the “Lawsuit Crisis,”* 14 LAW, MED. & HEALTH CARE 77 (1986).

31. See BARRY R. FURROW ET AL., HEALTH LAW 935 (2d ed. 1991). As the editors of this health law casebook observe: “[T]he amount, nature and diversity of the academic writing on abortion is truly remarkable. The writings range from the polemic to the theological, and sometimes both are contained in the same books and articles (on both sides of the issue).” *Id.*

32. The “right to die” is admittedly a problematic term, since in academic discourse as well as the popular press it has come to include a broad range of questions from the right to refuse life-sustaining medical interventions to physician-assisted suicide and euthanasia. See, e.g., WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., SUBSTANTIVE CRIMINAL LAW § 7.8, at 246 (1986); Kate E. Bloch, Note, *The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats*, 39 STAN. L. REV. 929, 933-34 (1987); Catherine D. Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 350 (1986). The issue vividly demonstrates the way in which medical jurisprudence and medical ethics have become virtual Siamese twins in that many of the same “authorities” discuss the fine points of legal, ethical, and metaphysical issues surrounding human dying and death in a wide range of academic publications.

33. See, e.g., Ben A. Rich, *A Legacy of Silence: Bioethics and the Culture of Pain*, 18 J. MED. HUMAN. 233 (1997).

34. CHRONIC PAIN: AMERICA’S HIDDEN EPIDEMIC 4-5 (Stephen F. Brena ed., 1978).

35. See *id.*

length in section VI,³⁶ is the remarkable ambivalence with which Western culture regards pain.³⁷ However, this section focuses on the medical aspect of the problem.

One proposition, which at this time is virtually beyond scientific dispute, is: most pain that patients experience can be safely and effectively controlled.³⁸ There is a strong consensus that while ninety percent of all pain experienced by patients can be relieved, in excess of fifty percent (perhaps as much as seventy to eighty percent) of the pain experienced by patients is not relieved.³⁹ The nature and extent of the problem of undertreated pain began to be documented and discussed in the early 1970s, most notably in a study appearing in a highly regarded medical journal.⁴⁰ This study of inpatients at two major New York City teaching hospitals revealed that a substantial number of patients who were being treated for pain continued to have significant levels of pain despite the treatment.⁴¹ When questioned as a part of the study, the physicians responsible for the care of these patients demonstrated knowledge deficits about the therapeutic dose range for the narcotic analgesics they were prescribing.⁴² The physicians also had significant misunderstanding of the nature of addiction and the risks it posed to patients being treated for pain.⁴³ The study reached a number of important conclusions.⁴⁴ It found that "excessive and unrealistic concern about the danger of addiction in the hospitalized medical patient is a significant and potent force for undertreatment with narcotics."⁴⁵ Toward the end of the article, the authors issued an

36. See *infra* Section VI.

37. See *infra* Section VI.

38. See MELZACK & WALL, *supra* note 8, at 52-56 (supporting this basic proposition and discussing the causal and therapeutic mechanism of pain in a highly regarded text).

39. See generally WORLD HEALTH ORGANIZATION, *CANCER PAIN RELIEF AND PALLIATIVE CARE* (1990).

40. See Richard M. Marks & Edward J. Sachar, *Undertreatment of Medical Inpatients with Narcotic Analgesics*, 78 *ANNALS INTERNAL MED.* 173, 173-81 (1973).

41. See *id.* at 174-76.

42. See *id.*

43. See *id.* at 177-80.

44. See *id.*

45. *Id.* at 180. It is important to note that most of the physicians surveyed were not senior physicians with outdated information about narcotics and their effects, but internal medicine residents who should be privy to the most current information. See *id.* at 177. Because of this situation, the authors were sufficiently moved by the consistent reports of inadequate pain relief by the patients to call for

admonition that was singularly prophetic when viewed from the perspective of the current movement for physician-assisted suicide (PAS): “no patient should ever wish for death because of his physician’s reluctance to use adequate amounts of potent narcotics.”⁴⁶ The relationship between the undertreatment of pain and the PAS movement is the subject of considerable debate.⁴⁷

A review of the medical and nursing literature in the more than two decades since these findings and recommendations were published reveals a desultory chronicle of clinical ignorance and indifference to patient suffering.⁴⁸ An important work appearing in 1977 documented another of the widely recognized barriers to effective pain management, the failure of health care institutions generally, and hospitals in particular, to make pain relief a priority.⁴⁹ The authors of this study make the following remarkable assessment:

Chief among the difficulties facing anyone who would reform current practices of pain management in our hospitals is the far from obvious fact that most aspects of pain work are peripheral to the attention and the responsibilities of the staff. By responsibilities we mean not merely the staff’s perceived responsibilities, but also its actual legal and organizational ones. We are asserting, in other words, that *the staff is not genuinely accountable for much of its interaction with or behavior toward patients in pain.*⁵⁰

a major initiative to reeducate physicians about the proper and adequate use of narcotic analgesics. *See id.* at 181.

46. *Id.* (quoting JAFFE J., *The Pharmacologic Basis of Therapeutics* 247 (3d ed. 1966)).

47. *See, e.g.*, Howard Brody, *Assisted Death—A Compassionate Response to Medical Failure*, 327 *NEW ENG. J. MED.*, 1384, 1384-87 (1992); Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 *J. PAIN & SYMPT. MGMT.* 289, 289-97 (1991).

48. A representative sampling, in chronological order, of this literature follows. *See infra* notes 49-86.

49. *See generally* SHIZUKO Y. FAGERHAUGH & ANSELM STRAUSS, *POLITICS OF PAIN MANAGEMENT: STAFF-PATIENT INTERACTION* (1977).

50. *Id.* at 26 (emphasis added). It has only been quite recently the Joint Commission for the Accreditation of Health Care Organizations [hereinafter JCAHO] has included a standard in the chapter of its *Accreditation Manual* on “Patient Rights and Organizational Ethics” on decisions relative to care at the end of life that calls upon accredited institutions to demonstrate the existence and utilization of mechanism designed to address, among other things, “effectively

Among the problems created by this lack of accountability for effective pain relief on the part of either the medical or the nursing staff of most hospitals is that the quality of pain relief any particular patient receives will vary widely depending upon the physicians and nurses who are caring for that patient. Given the woefully inadequate medical and nursing education and training in pain management, about which more will be said in sections to follow,⁵¹ it should not surprise us that the authors conclude that "more often than not they manage it [pain] badly."⁵²

If we move ahead twelve years in the medical literature, we might reasonably hope to find studies and reports that indicate that improvements in the quality of care of patients with pain have become evident. After all, over ten years have passed since the problem was definitively documented and realistic solutions outlined.⁵³ Given the intrinsic beneficence of the medical and nursing professions, surely the clinical and academic leaders will have responded to the call for better education designed to foster more humane treatment of patients.⁵⁴ Some of the best evidence for the changes that may have been wrought appeared in the 1989 edition of *Advances in Pain Research and Therapy*.⁵⁵ One article in particular

managing pain." See *Rights and Ethics Chapter of the Accreditation Manual*, R.I.1.2.8. The new standards read:

Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient's rights to pain management is respected and supported. The health organization plans, supports, and coordinates activities and resources to assure the pain of all patients is recognized and addressed appropriately.

A legitimate concern, however, has been that the context of this standard suggests that according to the JCAHO, only the dying patient has a right to effective pain management, when, as this section of the article is intended to make abundantly clear, all hospitalized patients are at significant risk of having their pain undertreated. In June of 1999 JCAHO adopted new standards for pain assessment and management for all patients, thereby eliminating the concern that the standard only applied to dying patients. Given the date of the Fagerhaugh and Strauss study, one can only speculate as to what might account for the delay of over 20 years in establishing some form of institutional accountability in this important aspect of patient care.

51. See *infra* Sections III, VI.

52. See FAGERHAUGH & STRAUSS, *supra* note 49, at 273.

53. See *supra* notes 48-52.

54. See *infra* notes 55-86.

55. See John P. Morgan, *American Opiophobia: Customary Underutilization of*

sought to discern improvements in physicians' knowledge and attitudes about prescribing practices for narcotic analgesics since Marks and Sachar's 1973 study.⁵⁶ The answer to the question directly posed in the article—"has the practice changed?"—is a resounding "no."⁵⁷ The reasons for the lack of change are clear and consistent with the findings of Marks and Sachar: "Prescribers fear drug dependence and addiction as a result of their prescribing of opioids, so they prescribe less than is necessary to treat pain. This improper use is accompanied by evidence of faulty pharmacological and clinical information about opioids in general"⁵⁸

Another article appearing in the same volume, written by one of the pre-eminent pain specialist in the United States, also refers to "rampant opiophobia" among health care professionals.⁵⁹ The article concludes that "most physicians lack sufficient knowledge of the clinical pharmacologic approaches" that would be necessary for them to assume responsibility "to manage acute and chronic pain in medical illness effectively."⁶⁰

The chronicle of undertreated pain continued the following year with an article by Ronald Melzack, author of one of the most celebrated treatises on pain, titled *The Tragedy of Needless Pain*.⁶¹ As with the other authors cited above, Melzack decries the astounding amount of medical mythology and misinformation that influences physicians' prescribing practices for the treatment of pain.⁶²

Finally, late in 1995 came the publication of the remarkable "Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments" (SUPPORT).⁶³ This massive study, involving more than 9000 patients in five teaching hospitals across the United States, was conducted in two phases.⁶⁴ Phase I documented shortcomings in communication, frequency of aggressive treat-

Opioid Analgesics, 11 ADV. PAIN RES. & THERAPY 181, 181-82 (1989).

56. See *supra* note 40 and accompany text.

57. *Id.*

58. See Morgan, *supra* note 55, at 183.

59. Kathleen M. Foley, *The "Decriminalization" of Cancer Pain*, 11 ADV. PAIN RES. & THERAPY 5, 15 (1989).

60. *Id.*

61. Ronald Melzack, *The Tragedy of Needless Pain*, SCI. AM., Feb. 1990, at 27.

62. See *id.*

63. See The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patient: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments*, 274 JAMA 1591 (1995) [hereinafter "SUPPORT"].

64. See *id.*

ment, and the general characteristics of death in a large, tertiary care hospital.⁶⁵ The results of Phase I indicated extremely poor communication between caregivers and patients or between caregivers and patient's families.⁶⁶ The poor communication resulted in numerous, unwanted, aggressive clinical interventions of dubious benefit, disregard of advance directives, and moderate to severe pain in one-half of the patients during the days immediately prior to death.⁶⁷ Phase II sought to improve the care of seriously ill or dying patients by utilizing a highly skilled nurse to facilitate discussions between caregivers and patients and/or between caregivers and patients' families.⁶⁸ The goal was to increase the extent to which patient wishes and values informed clinical decision making.⁶⁹ Remarkably, the Phase II intervention had no impact whatsoever on any of the areas targeted for improvement, including pain control.⁷⁰ The SUPPORT investigators' conclusion contained substantially more pathos than the typical biomedical research report:

The picture we describe of the care of the seriously ill or dying persons is not attractive. One would certainly prefer to envision that, when confronted with life-threatening illness, the patient and family would be included in discussions, realistic estimates of outcome would be valued, pain would be treated, and dying would not be prolonged. That is still a worthy vision. However . . . [s]uccess will require reexamination of our individual and collective commitment to these goals, and more creative efforts at shaping the treatment process, and, perhaps, more proactive and forceful attempts at change.⁷¹

This same language could be fittingly applied to the plight of patients with pain, i.e., the clinical chronicle of the last quarter century with regard to pain management is not attractive. Realization

65. *See id.*

66. *See id.* at 1592.

67. *See id.* at 1593-94.

68. *See id.* at 1592.

69. *See id.*

70. *See id.* at 1594-95.

71. *Id.* at 1597.

of a vision of the health care system cleansed of ignorance, indifference, fear, and a lack of accountability, while worthy, will clearly require “more creative efforts at shaping the treatment processes” and “more proactive and forceful attempts at change.” Publication of the results of SUPPORT prompted commentary in the clinical and bioethical literature.⁷² One of the more plausible explanations for why the remedial measures implemented in the second phase of the study proved to be such a dismal failure is a systemic one.⁷³ The five study sites have systems in place that are designed to deliver the latest innovations in life-saving (or at least life-extending) high technology medicine to critically ill patients.⁷⁴ Considered from this perspective they are highly effective. These systems are not designed to prioritize or even to take into account any of SUPPORT’s special considerations: maximizing physician-patient (or physician-family) communication and agreement about do not resuscitate (DNR) orders, minimizing the provision of unwanted or marginally beneficial interventions, or assuring the prompt and effective relief of pain and suffering.⁷⁵ Consequently, if these objectives are to be realized in the critical care setting, the existing systems must be modified or entirely redesigned.⁷⁶

SUPPORT provides solid evidence that curative medicine fails to meet the dying patients’ needs, and indeed fails to even recognize such a category of patients.⁷⁷ Other studies,⁷⁸ and the sustained work of those such as medical anthropologist and physician Arthur Kleinman,⁷⁹ demonstrate that the curative model also victimizes those with chronic illness.⁸⁰ Both types of patients require the approach of palliative medicine, in which care is tailored to the individual patient, according to that patient’s actual and perceived

72. See generally *Dying Well in the Hospital: The Lessons of Support*, HASTINGS CTR. REP. (Special Supp.) Nov.-Dec. 1995, at S1.

73. See *id.*

74. See *id.*

75. See *id.*

76. See Bernard Lo, *End-of-Life Care After Termination of Support*, HASTINGS CTR. REP. (Special Supp.) Nov.-Dec. 1995, at S7.

77. See *supra* notes 64-76.

78. See, e.g., Bruce A. Ferrell et al., *Pain in the Nursing Home*, 38 J. AM. GERIATRICS SOC’Y 409 (1990); Paula R. Mobily et al., *An Epidemiological Analysis of Pain in the Elderly: The Iowa 65+ Rural Health Study*, 6 J. AGING & HEALTH 139 (1994).

79. See *infra* note 126.

80. See *infra* Section V.

needs, as well as to their personal values and preferences.⁸¹ Humanistic qualities and interpersonal skills are at least as important as clinical or scientific acumen when it comes to palliative medicine.⁸² It appears that only under this model are the amelioration of pain and other symptoms recognized as a legitimate and an important goal of medicine.⁸³ Section IX will consider a role for the law in changing medicine's culture of pain.⁸⁴

III. THE CULTIVATION OF IGNORANCE

The medical component of the answer to the obvious question of why caregivers fail to provide adequate pain relief to patients in so many instances when it is their power to do so is perhaps most succinctly stated by the late John Bonica, a past President of the International Association for the Study of Pain: "Physicians are poorly trained to manage pain properly. They rely on drugs, which are often ineffective, prescribe too small doses, and often wait for pain before they do something."⁸⁵ Dr. Bonica's remarkable assertion was true when he made it and, as we have seen, it continues to be true today. One significant root of the problem is that the typical medical school curriculum is essentially devoid of courses on pain management.⁸⁶ In 1989, Dr. Bonica could state unequivocally: "No medical school has a pain curriculum."⁸⁷ Several years later the situation remained unchanged.⁸⁸ Despite the increased attention

81. See *infra* Section V.

82. See *infra* Section V.

83. See Ellen Fox, *Predominance of the Curative Model of Medical Care: A Residual Problem*, 278 JAMA 761, 762 (1997).

84. See *infra* Section IX.A-E.

85. 2 NEWSLETTER OF THE NATIONAL COMMITTEE ON THE TREATMENT OF INTRACTABLE PAIN 3 (1979) (interviewing Dr. John Bonica).

86. See *infra* Section VIII.D.

87. See Richard S. Weiner, *An Interview with John J. Bonica, M.D.*, 1 PAIN PRACTITIONER 2 (1989).

88. See Foley, *supra* note 47, at 291; Interview with Deborah Drew, Clinical Nurse Specialist for Palliative Care, Fairview Pain Management Center, in Minneapolis, Minn. (Aug. 14, 1999). Drew received her Masters Degree in Nursing from the University of Minnesota. See *id.* She began her career in cancer care and hospice treatment. See *id.* For the past decade she has focused her clinical expertise in pain management consultations. See *id.* In 1996, Drew opened the University of Minnesota Hospice Center. See *id.* In 1998, she helped create the Fairview Pain Management Center. See *id.* Drew states that efforts in Minnesota by the Minnesota Cancer Pain Initiative and American Cancer Society include free mailings to every professional school materials on pain management.

given to the need to improve the quality of care provided to dying patients,⁸⁹ according to two prominent medical educators: "its role in clinical practice and medical education in the United States remains ill defined."⁹⁰ While palliative care encompasses much more than simply pain management, one of the essential clinical competencies for providing appropriate care to dying patients is pain and symptom assessment and management.⁹¹ In a 1991 poll of class presidents of all American Medical schools, more than twenty-five percent of the respondents indicated that one hour or less of class time in their institution had been devoted to any aspect of terminal care.⁹²

Common sense and common experience shows that medical school and nursing school curriculum committees have precluded pain from entering their curricula in any significant way. This is not because only a small subset of the patients cared for by the typical physician or nurse experiences a problem with pain, or that terminal illness rarely produces pain. Brega's use of the term "epidemic" with regard to the prevalence of chronic pain in America has been confirmed by subsequent studies.⁹³ For example, five million Americans suffer from back pain alone, of which two million are so disabled that they cannot work.⁹⁴ It has been estimated that one family in three includes a victim of persistent pain, and that for sixty million Americans the level of pain severity was sufficiently high to produce partial or total disability.⁹⁵

The message of medical education comes through loud and clear: pain may be a widespread psychosocial problem, but it is neither perceived nor acknowledged to be a medical problem.⁹⁶ If it

See id.

89. This kind of care is referred to as palliative care. See Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127, 130 (1990).

90. See J. Andrew Billings & Susan Block, *Palliative Care in Undergraduate Medical Education: Status Report and Future Directions*, 278 JAMA 733, 733 (1997).

91. See AMERICAN BOARD OF INTERNAL MEDICINE, *CARING FOR THE DYING: IDENTIFICATION AND PROMOTION OF PHYSICIAN COMPETENCY* 41 (1996).

92. See Billings & Block, *supra* note 90, at 734.

93. See *infra* notes 94-95 and accompanying text.

94. See NATIONAL INSTITUTES OF HEALTH, *CHRONIC PAIN: HOPE THROUGH RESEARCH*, Pub. No. 90-2406, 2-3 (1989).

95. See John J. Bonica & C. Richard Chapman, *Biology, Pathophysiology, and Therapy of Chronic Pain*, AMERICAN HANDBOOK OF PSYCHIATRY 721-22 (2d ed. 1986).

96. See *supra* notes 92-95 and accompanying text.

were, given its prevalence in our society, surely medical schools would be training physicians to deal effectively with it.⁹⁷ Further, medical licensing boards would be disciplining physicians who fail to develop and maintain competence in pain management for their patients. Neither do anything of the sort.⁹⁸ However, during the last fifteen to twenty years, some quite prominent academic physicians have become significantly more strident in their condemnation of their own profession's indifference to, or at least incompetence in ameliorating, the suffering of their patients.⁹⁹

97. One argument often voiced by medical school administrators is that exponential growth in medical science and technology has made it impossible to incorporate into the medical school curriculum, including residency training programs, everything that a competent physician needs to know. While this may well be the case, it simply indicates that medical educators have a responsibility to establish priorities when determining what must be included in the medical school curriculum and what may be reasonably left for the young physician to acquire elsewhere. The case that has yet to be made is that minimal competence in pain management and palliative care would fail to make the list of essential topics to be included in the basic medical school curriculum.

98. Quite recently, signs of possible changes in licensing board attitudes have begun to appear. See Sheryl Gay Stolberg, *Amid New Calls for Pain Relief, New Calls for Caution*, N.Y. TIMES, Oct. 13, 1998, at F1. The Medical Board of California expressed the traditional view when it responded to a complaint by the daughter of a terminal cancer patient against the physician whom she alleged had failed to adequately manage his pain. See *id.* The Board declared that while "pain management for your father was indeed inadequate," no disciplinary action against the physician would be taken. See *id.* In 1999, however, the Oregon Board of Medical Examiners announced that it would be taking disciplinary action against a pulmonary specialist for unprofessional or dishonorable conduct and gross or repeated acts of negligence. See AP Newswires, *Roseburg Doctor Faces Penalty on Pain Control*, Mar. 27, 1999, available in 1999 WESTLAW database APWIRESPPLUS. The accusations were based on six cases between 1993 and 1998 in which the physician had failed to administer appropriate pain relief to gravely or terminally ill patients. See *id.* Similarly, the Nevada State Board of Medical Examiners notified physicians in April of 1999 that failure to control pain by using controlled substances in accordance with recently issued guidelines would result in potential license revocation. See NEVADA STATE BOARD OF MEDICAL EXAMINERS, NEW REGULATIONS OF THE BOARD ADOPTED MARCH 15, 1999 (visited Oct. 10, 1999) <<http://www.state.nv.us./medical/newsletters/vol21.html>>.

99. Two articles in particular, separated by nearly 10 years, are particularly significant with regard to this point. The first, written by 12 distinguished physician educators, states unequivocally: "To allow a patient to experience unbearable pain or suffering is unethical medical practice." Sidney H. Wanzer et al., *The Physician's Responsibility Towards Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED., 844, 847 (1989). The second article, by one of the founding fathers of American bioethics, declares, "[N]ot to relieve pain optimally is tantamount to moral and legal malpractice." See Edmund D. Pellegrino, *Emerging Ethical Issues in Palliative Care*, 279 JAMA 1521, 1521 (1998). While Dr. Pellegrino's

When we consider the particular forms of pain and suffering that are associated with the dying process, medical education fares no better.¹⁰⁰ As will be discussed in more detail in section V, the curative model of medical practice has dominated the medical school curriculum.¹⁰¹ The palliative model is at best tolerated in elective courses taken by a very small percentage of any graduating medical school class.¹⁰² A recent study revealed that “graduating medical students and house staff lack important training in the care of the dying, feel ill-prepared for this work, and are eager for more training.”¹⁰³

Efforts to address concerns about the curative model of medical education and practice have resulted in an initiative to access not only medical students’ knowledge and skills, but also physicians’ other essential attributes.¹⁰⁴ Attributes essential to a physician include personal qualities, values and attitudes such as compassion, empathy, and altruism.¹⁰⁵ Furthermore, in the area of skills, the American Association of Medical Colleges’ most recent set of learning objectives for medical students includes “[k]nowledge about relieving pain and ameliorating the suffering of patients.”¹⁰⁶

IV. THE METAPHYSICS OF PAIN

Perhaps the most persistent and eloquent critique of the way in which physicians fail to effectively deal with their patient’s pain and suffering is by Eric Cassell.¹⁰⁷ He criticizes medicine’s failure to address the pain and suffering engendered by illness and offers the beginning of an explanation for the absence of pain management

use of the phrase “moral and legal malpractice” may be somewhat confusing, it does seem clear from the context that his message is that allowing patients to experience unnecessary pain and suffering is both a violation of medical ethics and a departure from an acceptable standard of care, the *sine qua non* of professional negligence.

100. See *infra* Section VIII.D.

101. See *infra* Section V.

102. See *infra* Section VIII.

103. Billings & Block, *supra* note 90, at 734.

104. See *generally* AMERICAN ASSOCIATION OF MEDICAL COLLEGES, TAKING CHARGE OF THE FUTURE: THE STRATEGIC PLAN FOR THE ASSOCIATION OF MEDICAL COLLEGES (1995).

105. See *id.* at 4.

106. See *id.* at 7.

107. See ERIC J. CASSELL, THE NATURE OF SUFFERING (1991).

in the medical curriculum.¹⁰⁸ In his book *The Nature of Suffering*, Cassell begins with these words: "The test of a system of medicine should be its adequacy in the face of suffering; this book starts from the premise that modern medicine fails that test. In fact, the central assumptions on which twentieth-century medicine is founded provide no basis for an understanding of suffering."¹⁰⁹ Dr. Cassell's explanation suggests that this moral failing has a metaphysical foundation.¹¹⁰ Modern medicine has been shaped by the Cartesian dualism of mind and body.¹¹¹ If physical and mental substance exist in separate and incommensurate realms, and medicine's role has been to treat the diseases of the physical body, then to characterize pain as a phenomenon of consciousness and suffering as an experience of persons, not bodies,¹¹² then the responsibility for dealing with pain and suffering has necessarily been removed from the physician's job description. There is an exception, however, and that is pain, which can be directly traced to, and is entirely commensurate with, some objectively discernable tissue injury. Even in such instances, however, the response of the medical profession has generally been too little and too late.¹¹³

For purposes of this article, philosophical and psychosocial distinctions between pain and suffering must be recognized but not belabored. Pain is often characterized as a sensation, to be distinguished from suffering, which is considered an emotion.¹¹⁴ While pain is generally understood as an unpleasant sensation, not all pain results in the experience of suffering, and not all suffering is attended by pain.¹¹⁵ Cassell's thesis is twofold: (1) unrelieved pain

108. *See id.*

109. *Id.* at vii.

110. *See id.*

111. For a general overview of the philosophical problem of mind-body dualism and the influence of Descartes, see 5-6 THE ENCYCLOPEDIA OF PHILOSOPHY 336-45 (Paul Edwards ed., 1967).

112. *See* CASSELL, *supra* note 107, at viii.

113. *See* Bonica & Chapman, *supra* note 95, at 721-22.

114. *See, e.g.*, C. S. LEWIS, THE PROBLEM OF PAIN 78 (1943).

115. The pain of the professional athlete or a pregnant woman during labor and delivery are examples of pain in the absence of suffering. One need only consider the patient with no painful symptomatology who has just been diagnosed with Alzheimer's dementia to understand the idea of suffering in the absence of painful stimuli. To some extent, however, the transition from a biomedical to a biocultural model of pain, which take into account the nonphysiological aspects of the pain experience, blurs earlier distinctions between pain and suffering. *See, e.g.*, DAVID B. MORRIS, ILLNESS AND CULTURE IN THE POSTMODERN AGE 118-28 (1998).

is one of the most common sources of suffering in the clinical context, and (2) a clinician cannot appropriately and effectively respond to a patient's suffering without engaging the patient as a person.¹¹⁶ As he succinctly states: "[b]odies do not suffer; persons suffer."¹¹⁷ While Cassell eloquently makes the case for the physician's responsibility to relieve the suffering engendered by illness, the thesis of this article is more limited. Physicians, as will become evident in progression of this analysis, have an ethical and a legal duty to competently provide pain relief to patients so that untreated pain and the abandonment of the patient in distress inherent in such an omission do not engender unnecessary suffering.¹¹⁸

The legitimacy of Bonica's critique, and that of Cassell's as well, is bolstered by the Executive Summaries of the detailed clinical practice guidelines recently promulgated by expert panels of clinicians brought together under the aegis of the Agency for Health Care Policy and Research (AHCPR) of the U.S. Department of Health and Human Services.¹¹⁹ The first set of guidelines, concerning the management of acute pain arising out of medical or surgical procedures or trauma, begins with this justificatory statement: "Clinical surveys continue to indicate that routine orders for intramuscular injections of opioids 'as needed' fail to relieve pain in about half of postoperative patients. Recognition of the widespread inadequacy of pain management has prompted recent corrective efforts"¹²⁰

Two years later, a very similar statement introduces the guide-

116. See CASSELL, *supra* note 107, at 32.

117. *Id.*

118. See *infra* Section VII. This assertion is hardly a new or a novel contention. Nearly 20 years ago a deputy editor of the *New England Journal of Medicine* wrote:

Few things a doctor does are more important than relieving pain. Yet the treatment of severe pain in hospitalized patients is regularly and systematically inadequate. . . . Pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained.

Marcia Angell, *The Quality of Mercy*, 306 NEW ENG. J. MED. 98, 99 (1982).

119. See AGENCY FOR HEALTH CARE POLICY AND RESEARCH, ACUTE PAIN MANAGEMENT: OPERATIVE OR MEDICAL PROCEDURES AND TRAUMA 1 (1992) [hereinafter AHCPR].

120. See *id.*

lines promulgated by the AHCPR for cancer pain.¹²¹ Since the tissue damage resulting from surgery, trauma, and cancer are almost always objectively demonstrable, medicine's persistent failure to adequately attend to them requires more of an explanation than simply that of residual Cartesian dualism. A patient's complaints of severe pain following open-heart surgery or in the final stages of bone cancer are not merely subjective reports unsupported by objective findings.

If we are to take the explanations offered in medical literature at face value, particularly under the rubric of "barriers to effective pain management," a majority of physicians steadfastly maintain the belief that the risks of pain relief connected with using opioid analgesics often outweigh the benefits. Physicians generally perceive the risks to be, in order of their clinical significance: premature death, drug addiction, respiratory depression, and compromised mental status. On this view, in undertreating pain by underprescribing opioid analgesics, the physician is acting beneficently by sparing the patient the greater of the two evils.¹²² Of course, this is beneficent care on the paternalistic model of the physician-patient relationship, since the patient is not afforded an opportunity to consider the true risks and benefits of pain relief versus continued suffering.¹²³

The victims of chronic, nonmalignant pain, sometimes referred to as "intractable" pain,¹²⁴ are the patients who are most often abandoned by medical practitioners.¹²⁵ Kleinman explains this

121. See AHCPR, MANAGEMENT OF CANCER PAIN 1 (1994).

122. See Melzack, *supra* note 61, at 27.

123. See *id.*

124. The term "intractable" is used to describe any condition or situation that is unmanageable or untreatable. See WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1185 (1993). While there are examples of pain and other symptoms that produce suffering that cannot be relieved, these are exceptions. States which have recently passed legislation related to the care of patients with intractable pain are addressing a much larger population of patients with chronic, nonmalignant pain. Most of these patients have pain which can be alleviated, but only if they are provided with opioid analgesics on a long-term basis. While this approach remains controversial, a consensus supporting it when other treatment modalities have proven inadequate has emerged. See Consensus Statement from the American Academy of Pain Medicine and the American Pain Society, *The Use of Opioids in the Treatment of Chronic Pain*, 13 CLINICAL J. PAIN 6 (1997).

125. "Abandonment" in this context is used broadly, so as to include not only the refusal to provide care and treatment, but also includes the failure or refusal to provide therapies that are available and acceptable, such as the prescribing of

phenomenon this way:

If there is a single experience shared by virtually all chronic pain patients it is that at some point those around them—chiefly practitioners, but also at times family members—come to question the authenticity of the patient’s experience of pain. . . . Chronic pain discloses that the training and methods of health professionals appear to prevent them from effectively caring for the chronically ill. Reciprocally, chronic pain patients are the *bête noire* of many health professionals, who find them excessively demanding, hostile, and undermining of care. A duet of escalating antagonism ensues, much to the detriment of the protagonists.¹²⁶

Chronic pain syndromes are almost by definition conditions in which the degree of objectively verifiable pathology does not explain (or justify) the patient’s complaints of pain and/or claims of functional disability.¹²⁷ In order for a clinician to discharge the professional responsibility to compassionately address such patient’s pain and suffering, there must be a willingness to transcend the limitations of objective findings and engage with the lived experience of illness as related by the patient. This is appropriate, Kleinman maintains, “[b]ecause in the end it *is* the lived experience of different individuals.”¹²⁸

V. CURATIVE VS. PALLIATIVE MEDICINE: THE CLASH OF ABSOLUTES

Kleinman’s eloquent critique of medicine’s failure to embrace pain and suffering in the clinical setting as a professional and ethical responsibility of physicians, for which they must be properly

opioid analgesics for severe chronic nonmalignant pain. Pseudoaddiction is one phenomenon that occurs throughout the population of pain patients, but is especially common among the victims of chronic nonmalignant pain. See Marco Pappagallo & Leslie J. Heinberg, *Ethical Issues in the Management of Chronic Nonmalignant Pain*, in 17 SEMINARS IN NEUROLOGY 203, 205 (1997). Pseudoaddiction is a range or cluster of behaviors that are suggestive of addiction, but are the iatrogenic effect of ineffective pain management. See *id.*

126. ARTHUR KLEINMAN, *THE ILLNESS NARRATIVES: SUFFERING, HEALING AND THE HUMAN CONDITION* 57 (1988).

127. See MORRIS, *supra* note 115, at 119.

128. KLEINMAN, *supra* note 126, at 60 (emphasis added).

trained, actually applies to all forms of chronic illness.¹²⁹ The problem with medical education, he maintains, is primarily one of focus:

For the care of the chronically ill, medical education as it is currently organized can be disastrous. Physicians are encouraged to believe that *disease* is more important than *illness*, and that all they need is knowledge about biology, not knowledge about the psychosocial and cultural aspects of illness. . . . The social science and humanities components of medical education . . . are poor relations with whom few medical students feel at all comfortable associating.¹³⁰

Dr. Kleinman extends his critique beyond the four years of undergraduate medical education to the graduate medical education programs that provide the clinical training of young physicians.¹³¹ He laments that “at present many training programs tacitly inculcate values and behaviors that are antithetical to the humane care of patients.”¹³² When the professional products of these programs encounter the patients whose pain experience is even slightly inconsistent with physiological findings or clinical expectations, the physician’s most common reaction is to question the authenticity of the patient’s complaints.¹³³ The all-too-common response of caregivers to the patients is to label such patient’s requests for more effective medications as “drug-seeking” or addictive behaviors, and their protestations of physically disabling pain as “malingering.”¹³⁴ The haste with which some caregivers dismiss or

129. See *id.* Chronic pain is sometimes further complicated by concurrent illnesses of psychiatric origin, chemical dependency and personality disorders. See Drew, *supra* note 88.

130. Kleinman, *supra* note 126.

131. See Kleinman, *supra* note 126.

132. Kleinman, *supra* note 126, at 257.

133. See Kleinman, *supra* note 126, at 59. Kleinman notes that chronic pain syndromes are conditions in which the extent of demonstrable pathology is insufficient to explain the severity of pain reported by the patient or the physical disability that it is claimed has been produced. See *id.*

134. The extent to which physicians demonstrate a proclivity for discrediting or discounting a patient’s reporting of symptoms is virtually without parallel in the practice of medicine. Generally, medical students are taught to listen carefully to the way in which a patient describes how they feel, and to resist the temptation to rely too heavily on lab tests or other diagnostic procedures. The negative impact

diminish patient complaints pain suggests not only an ambivalence toward the pain experiences of others, but a more fundamental quandary about the place of pain in human experience.¹³⁵

The prevailing curative model of medicine is not only hostile to effective care of chronic pain patients, but to patients with terminal illness as well.¹³⁶ This is because of a widespread notion that curative medicine is at the other end of a continuum from the model of end-of-life care—palliative medicine.¹³⁷ Indeed, the curative and palliative models of medicine appear to instantiate diametrically opposite mind-sets and world views.¹³⁸ The curative model is focused on diagnosing and curing disease.¹³⁹ While the body of the patient is the locus of the disease, idiosyncratic aspects of the individual patient as person are credited with little or no significance insofar as making the diagnosis and effecting the cure are considered.¹⁴⁰ As one commentator characterized the *modus operandi* of the curative model:

Clinical concerns are approached as puzzles to be solved; clinical encounters are treated as occasions for scientific inquiry. Because the object of analysis is the disease process and not the patient, symptoms are treated as clues to diagnosis, instead of as phenomena that are themselves worthy of treatment.¹⁴¹

The curative model devalues or discounts anything that is subjective and, hence, not objectively verifiable and quantifiable.¹⁴²

of physician skepticism about patient reports of pain on the essential element of mutual trust in the patient-physician relationship cannot be underestimated. For an excellent discussion of the importance of trust, see JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT*, 85-104 (1984).

135. *See id.*

136. In a recent report on care at the end of life, the Institute of Medicine concluded that: "Deficiencies in undergraduate, graduate, and continuing education for end-of-life care reflect a medical culture that defines death as failure and ignores care for dying people as a source of professional accomplishment and personal meaning." INSTITUTE OF MEDICINE, *APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE* 207 (Marilyn J. Field & Christine K. Cassel eds., 1997).

137. *See* Fox, *supra* note 83, at 762-63.

138. *See id.*

139. *See id.* at 761.

140. *See id.* at 762.

141. *Id.* at 761.

142. *See id.*

Since pain and suffering, understood as sensation and emotion, are quintessentially subjective human experiences, they lie outside of the acceptable parameters of the curative model.¹⁴³

The *sanctum sanctorum* of the high priests and acolytes of curative medicine is the Intensive Care Unit (ICU). In this domain, the patient's personal identity and subjective experience of illness lose all relevance.¹⁴⁴ Patients are perceived by medical subspecialists in terms of their component parts.¹⁴⁵ Clinical rounds in such units exemplify the narrow focus on the objective and the impersonal.¹⁴⁶ The discussion of each patient concerns blood gas levels, hematocrit, mechanical ventilator settings, and similar products of the diagnostic process.¹⁴⁷ Concerns about prognosis too often are reduced to proposed interventions by the subspecialists to attempt to improve the condition or performance of a particular organ.¹⁴⁸

Critics of such a slavish adherence to the curative model have pointed out that such practices are antithetical to the achievement of a humane and dignified death.¹⁴⁹ One reason for this is that the

143. *See id.*

144. One need only participate as an observer in clinical rounds in an ICU to appreciate the extent of the depersonalization of the patient that is brought about by the curative model. As the team gathers around the bedside of each successive patient, the physician (usually a resident) presenting the case will begin in a stylized fashion: "This is Mrs. Jones, a 54-year-old white female who was brought by ambulance to the hospital on the evening of May 4 with symptoms of acute, severe chest pain . . ." The remainder of the presentation of Mrs. Jones' case will be a litany of procedures performed, test results, current medical telemetry and monitor readings, and immediate plans for further tests or procedures. Often the patient is intubated and on a ventilator, which to many clinicians obviates the need to interact with the patient during rounds. But even when that is not the case, for the most part the attention of the participants remains focused on the chart and the monitors rather than the patient. For further discussion of this phenomenon, see William Frank Monroe et al., *Is There a Person in This Case?*, 11 LITERATURE & MED. 45 (1992).

145. *See id.*

146. *See id.*

147. *See id.*

148. Physician and ethnographer Barry Saunders has observed: "The hospital . . . can be a profoundly anti-narrative institution." DAVID B. MORRIS, *THE CULTURE OF PAIN* 251 (1991). While this tends to be the norm in hospitals, some have broken stride to recognize pain. At Fairview University Medical Center in Minnesota, classes for ICU nurses include physical outcomes of uncontrolled pain. *See Drew, supra* note 88.

149. *See, e.g.*, HOSPICE AND PALLIATIVE CARE 12 (Denice C. Sheehan & Walter B. Forman eds., 1996). One of the fundamental tenets of the hospice movement is that the patient must accept the discontinuation of all curative or life-sustaining measures unless they also have a palliative effect which cannot be achieved by any

devotees of the curative model, by identifying death as the enemy and the ultimate failure, have virtually expunged the term “dying” from the lexicon of the intensive care unit, replacing it with “multi-organ system failure.”¹⁵⁰ One extremely unfortunate result of this linguistic legerdemain is that gravely ill patients and their families cannot be empowered and encouraged to begin to consider end-of-life decisions and options because “multi-organ system failure” does not necessarily translate, in lay terms, to “dying.”¹⁵¹ Rather, multi-organ system failure suggests a need for further clinical innovation by one or more sub-specialists.¹⁵² Physicians seem to have reached the point at which the determination that a patient is dying can only be made *ex post facto*. That is, after all of the efforts of the ICU team and its clinical consultants to reverse the patient’s deterioration fail and the patient goes into irreversible cardiac or pulmonary arrest, and death is declared following an indefinite period of cardio-pulmonary resuscitation, then one can perhaps say, retrospectively, that for some indeterminate period before the declaration of death the patient must have been dying.¹⁵³ The results of this approach to the care of gravely ill patients were vividly confirmed by SUPPORT.¹⁵⁴

other (purely) palliative means, such as palliative chemotherapy for some types of cancer. *See id.*

150. This author has reached this conclusion after many years of participating in regular ethics rounds and clinical ethics consultations involving the care of gravely ill patients, many of whom were actively dying.

151. *See id.*

152. *See id.*

153. A growing number of clinical specialists in end-of-life care have come to the conclusion that the presumption that being at the end of life is discernable may be erroneous. The appropriate response to serious illness requiring intensive or critical care, they suggest, would be to develop parallel streams of plans: one which facilitates discussions about death and optimal support of the patient through death and bereavement; and a second which provides maximal efforts to restore physiologic balance. *See* Joanne Lynn et al., *Prognoses of Seriously Ill Hospitalized Patients on the Days Before Death: Implications for Patient Care and Public Policy*, 5 NEW HORIZONS 56, 60 (1997).

154. *See* SUPPORT, *supra* note 63, at 1591. This study was conducted in two phases. *See id.* The first phase developed baseline data on the care of seriously ill patients in five medical centers across the United States. *See id.* at 1592. The data revealed little or no attention was paid by clinicians to patient directives, the communication between the treatment team and patients and/or family members was poor, and at least half of the patients had moderate to severe pain in the days prior to their death. *See id.* The second phase sought to improve care in these three areas through the use of specially trained and experienced nurses. *See id.* The data analysis after the second phase indicated that there was essentially no

VI. WESTERN CULTURE'S CURIOUS AMBIVALENCE TOWARD PAIN

Pain and suffering in many cultures, including our own, have long been regarded as punishment for sin or disobedience of divine ordinances.¹⁵⁵ Pain of natural origins is viewed as a measure of divine justice.¹⁵⁶ However, the actual infliction of pain became a means to "religious" ends, such as the liberal use of torture during the Inquisition to extract confessions from heretics.¹⁵⁷ A clear sign of the divine origin of disease, pain or suffering was the inability of medicine to deal effectively with it.¹⁵⁸ The bubonic plague, for example, was considered to have been "a manifestation of 'God's just anger with our wicked deeds sent . . . as a punishment to mortal men . . . [which] no doctor's advice, no medicine could overcome or alleviate.'"¹⁵⁹

If human misery in general, and the pain and suffering of illness in particular, are considered part of a divine, cosmic plan, related in some important way to the disposition of divine justice, then efforts to escape from these torments and afflictions through the use of narcotics might appear to be unseemly, if not sacrilegious. Even in the well-known Book of Job, the long-suffering servant of Yahweh, his dignity was to be found, according to many Biblical scholars, in the way in which he as a righteous man bore his many afflictions.¹⁶⁰

The idea of suffering as the *sine qua non* of the human situa-

improvement in the outcomes for patients with regard to these three areas of concern. *See id.*

155. The *Holy Bible* is replete with evidence of this association of pain and punishment for wickedness. Consider the following two examples from the Book of Job. "The wicked man travaileth with pain all his days . . ." *Job* 5:17 (King James). "He is chastened also with pain upon his bed and the multitude of his bones with strong pain . . ." *Job* 33:19 (King James).

156. *See generally* Jonathan Boyarin, *Another Abraham: Jewishness and the Law of the Father*, 9 *YALE J.L. & HUMAN.* 345, 388 (1997).

157. *See* Donald Caton, *The Secularization of Pain*, 62 *ANESTHESIOLOGY* 493, 494 (1985).

158. *See id.* at 493-94.

159. *Id.* at 494 (quoting BOCCACCIO G., *THE DECAMERON* 30-31 (R. Allison, ed., 1980)).

160. *See* BERNHARD W. ANDERSON, *UNDERSTANDING THE OLD TESTAMENT* 514-19 (2d ed. 1966). It is interesting to note, however, that much of the Book of Job attests to his outrage at God for visiting undeserved suffering upon him. *See id.* at 514. Only much later, after God reminds him that his finitude precludes him from judging the Creator, does he repent of his defiance and acquiesce in the mystery of suffering. *See id.* at 517-18.

tion has not remained exclusively within the province of religion. In delivering the 1935-1937 Gifford Lectures at the University of Glasgow on the subject "Why are we here?," the humanist W. Macneile Dixon, suggested the following alternative view:

No philosophers, or men of science, have so far had the hardihood, as far as I know, to deny us our pains. They relieve us of all else. They have taken from us our personality, our freedom, our souls, our very selves. They have, however, left us our sorrows. Let us take, then, as our foundation the proposition "I suffer, therefore I am." And let us add to it the converse and equally true statement, "I am, therefore I suffer."¹⁶¹

Dixon, who was not a philosopher by training, but rather a distinguished professor of English language and literature, is correct when he suggests that philosophers have been, throughout the history of Western civilization, singularly inattentive to pain and suffering.¹⁶² But in elevating pain and suffering to the ultimate ontological fact of humanity, Dixon makes a secular argument for enduring, rather than seeking to alleviate, the travails of body and soul.¹⁶³

Ivan Illich, the great critic of medicine and culture, expressed a similar attitude decades later.¹⁶⁴ He finds the contemporary pursuit of pain relief through the medical arts to signal a radical departure from our European heritage.¹⁶⁵ It would have been unthinkable "that pain ought not to be suffered, alleviated, and interpreted by the person affected, but that it should be . . . destroyed through the intervention of a . . . physician."¹⁶⁶ The reasons

161. See W. MACNEILE DIXON, *THE HUMAN SITUATION* 90 (1937).

162. See *id.*; see also Henry John McCloskey, *Pain and Suffering*, in *ENCYCLOPEDIA OF ETHICS* 927 (Lawrence C. Becker & Charlotte B. Becker eds., 1992). The following observation in this regard appears in the *ENCYCLOPEDIA OF ETHICS*: "Knowledge concerning the nature, causes, and extent of human and animal suffering is of the greatest importance in consequentialist ethics, and most of the major deontological ethics as well. Yet there is a poverty of writings concerning pain and suffering both in ethics and philosophical psychology." *Id.*

163. See DIXON, *supra* note 161, at 90.

164. See IVAN ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* (1976).

165. See *id.*

166. *Id.* at 149.

offered by Illich as to why the idea of professional and technical pain-killing was “alien to all European civilizations” are quite consistent with Dixon’s perspective—that pain was the human experience of a flawed or corrupted universe of which human beings are very much a part.¹⁶⁷ Furthermore, the very word “patient” has its classical roots in the Latin *patior*, which means “to endure pain or suffering.”¹⁶⁸ To note this, however, is merely to highlight the persistent ambivalence of the medical profession toward pain and suffering as an aspect of the experience of illness. On the one hand the medical literature is replete with nostrums acknowledging the primary duty of the physician to relieve pain and suffering.¹⁶⁹ On the other hand extended discussions of how the physician is to discharge this responsibility rarely appear in medical textbooks¹⁷⁰ or medical school curricula.¹⁷¹

There is another perspective on the evolution of the medical profession’s attitude toward pain and suffering that is at variance from Dixon and Illich.¹⁷² According to this view, as the Age of Faith gave way to the Age of Reason in Western Europe, the secularization of society brought with it in turn a more secularized view of disease and pain.¹⁷³ The philosophical perspective which was promoted by John Locke in the seventeenth century, Jeremy Bentham in the eighteenth century, and John Stuart Mill in the nineteenth

167. *See id.*

168. *See* XI OXFORD ENGLISH DICTIONARY 342-43 (2d ed., 1989).

169. *See* Ad Hoc Committee on Medical Ethics, *American College of Physicians Ethics Manual*, 101 ANNALS INTERNAL MED. 129, 131 (1984). The *Ethics Manual* of one of the leading national medical organizations states, “[t]he primary goals of the physician are to relieve suffering, prevent untimely death, and to improve the health of the patient while maintaining the dignity of the person.” *Id.* at 131.

170. *See* William J. Donnelly, *Taking Suffering Seriously: A New Role for the Medical Case History*, 71 ACADEMIC MED. 730 (1996). Donnelly suggests that there needs to be more physician discussion regarding patient’s pain and suffering. *See id.* at 731.

171. Suffering, to the extent that it is recognized as a necessary element of medical education, is usually associated as an aspect of the care of dying patients. *See generally* Annual Medical School Questionnaire from the Liaison Committee on Medical Education (Part II) (Feb. 14, 1993). A 1992-93 survey by the AMA revealed that only 5 out of 126 medical schools had a separate required course on death and dying. *See id.*

172. *See infra* notes 173-177 and accompanying text.

173. A contemporary exception, however, is the AIDS epidemic, which some religious conservatives insist upon viewing as a plague visited by God upon those who practice homosexual sex or engage in intravenous drug use. For an excellent discussion of the concept of plague in the context of AIDS, see SUSAN SONTAG, AIDS AND ITS METAPHORS 44-60 (1988).

century considered pain in conjunction with its antithesis—pleasure—to be the ultimate basis for all human motivation.¹⁷⁴ Actual or anticipated pain generates avoidance behaviors, while actual or anticipated pleasure generates approach behaviors. In the rationalism that pervaded Enlightenment thinking, pain was no longer considered to be, at least in most instances, something that was visited upon a person. Pain was not an individual's burden to suffer in dignified silence, but rather something that one could avoid or curtail by taking appropriate remedial measures. The life of reason involved an evaluation of the benefits and burdens posed by any course of action on the basis of the pain and pleasure that it promised.

On this view, the desire to minimize or alleviate suffering should not be equated with a flight from reality or a denial of a fundamental aspect of the self. While soul-making of a sort may take place in the crucible of genuinely intractable pain *or* unrelievable suffering, allowing someone to suffer when relief is available, at least without their informed consent, might reasonably be viewed as latently, if not patently sadistic. In the words of William James, written in 1901:

A strange moral transformation has within the past century swept over our Western world. We no longer think that we are called on to face physical pain with equanimity The way in which our ancestors looked upon pain as an eternal ingredient of the world's order, and both caused and suffered it as a matter-of-course portion of their day's work, fills us with amazement.¹⁷⁵

Our attitudes toward pain and the need to endure rather than to seek relief from it are shaped by non-intellectual forces as well. We need only look at various aspects of contemporary American culture to discern that the lives of many persons, particularly young

174. John Locke observed: "Things then are good or evil only in reference to pleasure or pain;" "Pleasure and pain, and that which causes them, good and evil, are the hinges on which our passions turn;" "[P]assions are moved by things only as they appear to be the causes of leasure and pain." 1 JOHN LOCKE, AN ESSAY CONCERNING HUMAN UNDERSTANDING, Book II, Ch. XX, §§ 2, 3, & 14 (John W. Yolton ed., 1961).

175. WILLIAM JAMES, THE VARIETIES OF RELIGIOUS EXPERIENCE 297-98 (Martin E. Marty ed., 1982).

adult males, are not governed by a rational hedonism that pursues happiness by maximizing pleasure while minimizing pain. As one scholarly study on the subject of pain phrases it: "the American definition of manhood requires an impassive immersion in pain. . . . From boot camp to football practice, we use pain today, in whatever diminished and misguided ethical sense, to know whether someone is a man—or to know what kind of man he is."¹⁷⁶ Even males who have not allowed themselves to be fully conscripted into the "Cult of Machismo" nevertheless are encouraged by parents and other role models to minimize any expression of pain.¹⁷⁷ For children of both genders, the parental admonition is to "behave like a big girl (or boy) and don't cry," particularly when the pain they experience is the product of medical ministrations. The not-so-subtle message conveyed is that good children either do not experience or at least do not express pain, particularly in the context of illness and its medical treatment.¹⁷⁸ To highlight the persistent ambivalence, however, Americans have, at the same time, been consuming a phenomenal amount of over-the-counter and prescription medications for the relief of a wide variety of physical pain and mental distress.¹⁷⁹

Such pervasive ambivalent attitudes toward the relief of pain and suffering go a long way to explaining society's failure to hold health care professionals responsible for violation of a professional responsibility to relieve the pain and suffering of patients. There are clear signs that we now stand on the threshold of a new era of accountability in this regard.¹⁸⁰ Imposing accountability where it

176. MORRIS, *supra* note 148, at 181 (1991).

177. For a general discussion of the cultural influences on pain perception and pain expression, see MARK ZBOROWSKI, *PEOPLE IN PAIN* 14-48 (1969).

178. See Gary A. Walco et al., *Pain, Hurt, and Harm: The Ethics of Pain Control in Infants and Children*, 331 *NEW ENG. J. MED.* 541, 544 (1994). The bitter irony in this regard is that until quite recently the medical profession labored under the quite remarkable myth that children, especially infants, did not have the capacity to experience pain. See *id.* As a result, very young children were, and to some extent still are, the most "at risk" group of patients for undertreated pain.

179. See, e.g., RICHARD HUGHES & ROBERT BREWIN, *THE TRANQUILIZING OF AMERICA: PILL POPPING AND THE AMERICAN WAY OF LIFE* (1979); PETER D. KRAMER, *LISTENING TO PROZAC* (1993).

180. One among the many indicators is a bill introduced in the Senate under the name "Conquering Pain Act of 1999." See *Conquering Pain Act of 1999*, Pub. L. No. 106, § 941 (1999). Among the features of this proposed legislation is the recognition that widespread undertreated pain constitutes a major public health problem, the call for a Surgeon General's report concerning the state of pain and

has not existed before requires clearly articulated and widely disseminated standards of professional conduct, as well as the underlying principles that support those standards. The following section examines that important project.¹⁸¹

VII. THE DUTY TO RELIEVE SUFFERING

A. *The Scope of the Duty*

It is important to carefully circumscribe the caregiver's responsibility so that deficiencies in performance can be readily identified and generally free of the critique that the evaluative standard has been seen too high. First, the suffering at issue is that of the patient with whom he or she has entered into a professional relationship.¹⁸² Second, the term suffering as used in this analysis does not encompass the larger philosophical questions and concerns which illness and dying engender that are clearly beyond the clinical competency of the average physician, and which more appropriately fall within the ambit of pastoral care or clinical psychology.¹⁸³ The focus of this analysis will be on the pain and other forms of discomfort produced by serious injury and illness, and the suffering that results from the caregiver's failure to competently and sensitively respond to the patient's plight either directly or through the mobilization and coordination of other health care professionals.

symptom management in the United States, the confrontation of reimbursement barriers for effective pain management, public education initiatives, and the development of provider performance standards in pain and symptom management. *See id.*

181. *See infra* Section VII.A–B.

182. For a philosophical discussion of the duty to relieve suffering in situations in which there is no special duty-engendering relationship between the sufferer and those in a position to offer relief, see Susan James, *The Duty to Relieve Suffering*, 93 ETHICS 4 (1982).

183. State-of-the-art palliative care, which in its broadest sense is care directed toward the relief of pain and suffering engendered by the experience of serious illness, is generally considered to be a multidisciplinary undertaking. *See* AMERICAN BOARD OF INTERNAL MEDICINE, *supra* note 91, at 41. For example, the American Board of Internal Medicine has identified seven components of clinical competence that are important in providing quality end-of-life care. *See id.* One of these components is denominated "Team Approach," and includes an understanding on the part of the physician that the care of such patients usually involves not only physicians and nurses, but social services professionals, palliative care or hospice professionals, pharmacists, chaplains, patient advocates, as well as the patient's family. *See id.*

Third, this duty is restricted to the types of pain and suffering that can be relieved or at least ameliorated without causing still greater problems for the patient.¹⁸⁴ In other words, considered objectively, the benefits of applying the means available to relieve a patient's pain must exceed the risks or burdens.¹⁸⁵ As previously noted, when we explore the reasons offered by caregivers for their failure to relieve suffering, we encounter many arguments which are based upon and reflective of an incredible mythology concerning the perils and evils believed to be inherent in the aggressive treatment of pain.¹⁸⁶ An important question which we must seek to answer is whether physicians and nurses, as highly skilled and educated professionals, can avoid accountability for their failure to relieve pain and suffering (that as a matter of scientific fact can be safely and effectively relieved) on the grounds that they are simply the victims of prevailing myths from which they have failed to disabuse themselves.

B. Potential Sources of the Duty

When conducting an inquiry into the duties of a physician, the first step (and sometimes last resort) is to consult the Hippocratic Oath.¹⁸⁷ However, for reasons that have been discussed at length

184. *See id.*

185. *See id.*

186. An aggressive approach to the relief of severe and persistent pain often, though not invariably, involves the sustained use of opioid analgesics. A number of powerful myths about the use of opioids continue to be passed from one generation of physicians to another, including that sustained use of opioids invariably leads to addiction (as opposed to physiological dependence), that there are maximum doses (ceilings) for opioid analgesics which under no circumstances can be exceeded, and that large doses of opioids invariably lead to respiratory depression. Each of these beliefs deserves the label of "myth" because there is no reliable scientific data to support any of them, while solid data to the contrary is readily available in the medical literature. For a discussion of the process by which these myths are perpetuated, see C. Stratton Hill, Jr., *When Will Adequate Pain Treatment Be the Norm?*, 274 JAMA 1881 (1995).

187. The Hippocratic Oath calls physicians to a higher ethical standard than that of society in general. *See* C. Everett Koop, *Introduction to Dusquene Law Review*, 35 DUQ. L. REV. 1, 1 (1996). Koop paraphrases the oath as follows:

I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, nor will I suggest such a plan. . . . In purity and in holiness I will guard my life and my art.
Into whatsoever house I enter, I will do so to help the sick, keeping

elsewhere, the fact that the Oath makes no specific reference to the relief of suffering should not be dispositive of the issue of the physician's duty in that regard.¹⁸⁸ In his seminal article on the relationship between suffering and the goals of medicine, Eric Cassell begins with the assertion that "[t]he obligation of physicians to relieve human suffering stretches back into antiquity."¹⁸⁹ Pain and suffering often attend injury and illness, and if the physician's charge is to cure or ameliorate the latter, then doing battle against the former might reasonably be considered inherent in the process.¹⁹⁰ But the issue is clouded by the fact that both diagnostic and therapeutic interventions often cause pain—everything from the mild discomfort of a vaccination, to the moderate but brief pain when a dislocated limb is reset, to the significant nausea and malaise of chemotherapy.¹⁹¹

In an attempt to articulate an ethics of pain management for healthcare professionals, philosopher Rem Edwards argues that "there is a broadly based humanistic ethics which applies to the domain of medical care which gives patients a strong *prima facie* right to freedom from unnecessary pain"¹⁹² The existence of this right gives rise to three concomitant moral obligations of the medical practitioner to the patient.¹⁹³ The first is a duty to minimize (physician induced) iatrogenic pain. This means not inflicting additional pain and suffering upon a patient beyond what is an

myself free from all intentional wrong-doing and harm. . . .

Whatever in the course of practice I see or hear . . . what ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

Id.

188. See, e.g., Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 91-93 (1993).

189. See Cassell, *supra* note 4, at 639. Cassell cites no authority for this proposition, perhaps because to him its validity is self-evident or otherwise unassailable.

190. See *id.*

191. The AHCPR clinical practice guidelines for cancer pain contain a separate section addressing the need to anticipate and effectively manage procedure-related pain. See AHCPR, *supra* note 121, at 107-14.

192. Rem B. Edwards, *Pain and the Ethics of Pain Management*, 18 SOC. SCIENCE & MED. 515, 517 (1984).

193. See *id.* Edwards does not discuss the theoretical foundations of these rights and duties, although he maintains that "they can be derived . . . from almost every major philosophical theory of ethics. . . . In that sense they are broadly justifiable." *Id.*

unavoidable consequence of a reasonable effort to effect a cure.¹⁹⁴ The second duty is to be a competent pain management practitioner. This duty requires applying state-of-the-art techniques effectively in order to relieve as much pain and suffering as is possible without, in so doing, imposing burdens on the patient which exceed the benefits.¹⁹⁵ Third, the patient must be adequately informed of the risks and benefits of alternative pain management strategies, including the "strategy" of not pursuing pain relief.¹⁹⁶ Given the well-documented knowledge deficits about pain relief of many health care professionals, there exists a legitimate question whether many currently possess the ability to fully and accurately inform patients about available techniques and therapies and their respective risks and benefits.¹⁹⁷ For example, even in what would seem to be the most straightforward of clinical situations, pain relief for a patient with terminal cancer, one commentator concludes:

American doctors regularly refuse to prescribe effective doses of narcotic painkillers to dying patients on the grounds that the patients might become addicted. The

194. *See id.*

195. This is a duty that can reasonably be placed on all physicians who care for patients with pain, and not one that is reserved for specialists in pain management and/or palliative care. For example, it is the position of the World Health Organization that pain control and palliative care should not belong strictly to pain control specialists. *See* Jan Stjernswärd et al., *The World Health Organization Cancer Pain and Palliative Care Program: Past, Present, and Future*, 12 J. PAIN & SYMPT. MGMT. 65, 68 (1996).

It is time for pain control/palliative care to be incorporated into existing systems of care and for physicians most likely to see chronically ill patients in the first line of duty (general practitioners, oncologists) to make pain control and palliative care a part of their routine clinical practices.

Id.

196. *See* Ezekiel J. Emanuel, *Pain and Symptom Control: Patient Rights and Physician Responsibilities*, 10 HEMATOL/ONCOL CLINICS OF N. AM. 41, 47 (1996). The commentator states, "[a]s a part of the process of informed consent, physicians also have an obligation to ensure that patient's refusal of pain management or palliative care is not based on incoherent, inconsistent, and irrational beliefs." *Id.*

197. For a discussion of the risk/benefit analysis for opioid analgesics, see Seddon R. Savage, *Long-term Opioid Therapy: Assessment of Consequences and Risks*, 11 J. PAIN & SYMPT. MGMT. 274 (1996).

treatment of cancer pain, clearly, is still not based solely on scientific fact but draws on ignorance, fear, prejudice, and on an invisible, unacknowledged moral code expressing half-baked notions about the evil of drugs and the duty to bear affliction.¹⁹⁸

Further,

If significant numbers of clinicians are unable to make the most basic and fundamental distinction between addiction and physiological dependence on opioid analgesics for the relief of severe pain, then they are unlikely to be able to competently perform an appropriate risk/benefit analysis among alternative modalities of treatment and the default position of admonishing the patient to endure the unrelieved pain.¹⁹⁹

The current statements of the ethical principles governing clinical practice clearly states the duty to relieve suffering. For example, the American Medical Association Code of Medical Ethics states in pertinent part, “[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.”²⁰⁰ While this provision specifically mentions dying patients,²⁰¹ it is difficult to imagine a legitimate basis for limiting the physician’s duty to relieve pain and suffering to terminal patients. Furthermore, the American Nursing Association’s Position Statement on relief of

198. MORRIS, *supra* note 148, at 192.

199. *Id.* A new debate has just recently developed over the extent to which it is fair and reasonable to hold physicians accountable for their lack of up-to-date knowledge and skills in the assessment and management of pain. One school of thought, which is more consistent with the arguments made in this article, is that professionals (including physicians) have a duty to continue their education throughout their professional life, in order to practice consistent with advances in science and technology. The other school of thought, which seems to have arisen solely in the context of challenging the pain management practices of physicians, maintains that it is unduly harsh to take physicians to task when they were never educated properly (about pain assessment and management strategies) in medical school and residency training. See Dick Merrit et al., *Last Acts Coalition, State Initiatives in End-of-Life Care: Policy Guide for State Legislatures*, April 1999, at 6-7.

200. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS 40 (1996).

201. *See id.*

pain in dying patients provides:

Nurses should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying patient. The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified.²⁰²

The AMA Code also addresses another issue that has arisen in the debate over the nature and extent of the physician's professional responsibility to relieve pain and suffering. The issue is whether physicians should be insulated from ethical or legal responsibility for undertreating pain because their medical education in this area was demonstrably inadequate.²⁰³ The AMA's Principles of Medical Ethics states, "[a] physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated."²⁰⁴ The suggestion that a professional cannot be charged with possessing any knowledge or skill that was not covered as part of their basic education and training directly contradicts fundamental principles of professionalism.²⁰⁵

In justifying their opposition to physician-assisted suicide legislation, the AMA and the ANA have relied heavily on the argument that dying patients who receive appropriate pain management and

202. AMERICAN NURSES ASSOCIATION, COMPENDIUM OF POSITION STATEMENTS ON THE NURSE'S ROLE IN END-OF-LIFE DECISIONS 7 (1992) (including the position Statement on Promotion of Comfort and Relief of Pain in Dying Patients).

203. See AMERICAN MEDICAL ASSOCIATION, *supra* note 200, at 40.

204. AMERICAN MEDICAL ASSOCIATION, *supra* note 200, at xiv.

205. Among the current opinions of the AMA on Professional Rights and Responsibilities is the following:

CONTINUING MEDICAL EDUCATION. Physicians should strive to further their medical education throughout their careers, for only by participating in continuing medical education (CME) can they continue to serve patients to the best of their abilities and live up to the professional standards of excellence. Fulfillment of mandatory state CME requirements does not necessarily fulfill the physician's ethical obligation to maintain his or her medical expertise.

Id. at 136.

palliative care rarely request medical assistance in ending their lives.²⁰⁶ This argument illegitimately presumes that most, if not all requests for medical assistance in dying come from patients with uncontrolled pain.²⁰⁷ However, a more important point is that there is a developing consensus among health care professionals that the failure to either effectively manage pain that can be managed, or to refer the patient to a professional who can bring state-of-the-art techniques to bear on the problem, constitutes both a breach of professional ethics and a departure from an emerging standard of care.²⁰⁸

The concept of a legal right of patients to effective management of their pain and the correlative duty on the part of caregivers, particularly physicians because of their virtual monopoly on the authority to prescribe narcotics, to provide effective pain management to their patients, has barely begun to emerge in the last decade.²⁰⁹ In a much earlier work on the legal rights of the critically ill, John Robertson answers the question “[d]oes a patient have the right to receive effective medication for pain?” with “probably not.”²¹⁰ The basis for this reply is that physicians need only comply

206. See, e.g., Paul Wilkes, *The Next Pro-Lifers*, N.Y. TIMES MAGAZINE, July 21, 1996.

207. A report on the first year of experience under Oregon’s physician-assisted suicide law questioned whether “patients request lethal prescriptions because of inadequate care at the end of life?” and concluded:

We found that . . . patients were significantly more likely . . . to have expressed concern to their physicians about loss of autonomy and loss of control of bodily functions. . . . Thus, the decision to request and use a prescription for lethal medications during the first year of legalized physician-assisted suicide in Oregon was associated with views on autonomy and control, not with fear of intractable pain or concern about financial loss.

Arthur E. Chin, et al., *Legalized Physician-Assisted Suicide in Oregon: The First Year’s Experience*, 340 NEW ENG. J. MED. 577, 582 (1999).

208. See, e.g., Nathan I. Cherney & Raphael Catane, *Professional Negligence in the Management of Cancer Pain*, 76 CANCER 2181 (1995).

209. One of the first commentators to seriously discuss poor pain management as an example of medical malpractice was Canadian legal scholar and bioethicist Margaret Sommerville. See, e.g., Margaret A. Sommerville, *Death of Pain: Pain, Suffering, and Ethics*, in PROGRESS IN PAIN RESEARCH AND MANAGEMENT 41 (G.F. Gebhart, et al. eds., 1994); Margaret A. Sommerville, *Pain and Suffering at the Interfaces of Medicine and Law*, 36 U. TORONTO L.J. 286 (1986).

210. See JOHN A. ROBERTSON, THE RIGHTS OF THE CRITICALLY ILL 15 (Norman Dorsen ed., 1983). Robertson notes that doctors have an obligation to provide

with the prevailing standard of care, and since it is abundantly clear that “doctors have traditionally failed to alleviate pain,” it would be very difficult for the patient/plaintiff to establish that her undertreated pain constituted a departure from the applicable standard of care.²¹¹ What Robertson fails to consider is the implications of the fact that the medical profession’s failure to adopt and consistently apply readily available therapeutic modalities which would improve patient care presents precisely the type of situation that is ripe for judicial standard-setting. Particularly when deficiencies in the prevailing custom and practice are so clearly inconsistent with a traditionally recognized goal of the profession, courts are likely to feel an irresistible impulse to do as they have done in the past, and find the entire profession to be negligent. In the words of Judge Learned Hand:

There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence. . . . Indeed, in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.²¹²

In the next section, reasons and explanations that are usually offered for the failure of physicians to adequately manage pain are discussed.²¹³ Judge Hand’s language, and more recent case precedent, cast a long and ominous shadow over the legal defensibility of current medical practice in the area of pain management.²¹⁴

Professor Robertson presciently notes that “[a]s more attention is paid to the effective management of chronic pain . . . a

patients with the treatment that other doctors would customarily provide to manage pain, even though the doctors have often failed to alleviate pain. *See id.*

211. *See id.*

212. *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932) (citation omitted). The device in question in this case was a functioning radio for receiving current weather reports, the absence of which contributed to the loss of a barge being towed by the tug in question. *See id.* at 739.

213. *See infra* Section VIII.A–E.

214. *See infra* Section IX.E.

medical standard of care assuring critically ill patients effective pain relief may be established.”²¹⁵ The final section will discuss the clinical practice guidelines promulgated by the Agency for Health Care Policy and Research (AHCPR) and their appropriateness as a national standard of care for the treatment of pain.²¹⁶ For purposes of this section, what is significant about the guidelines is that among other things they purport to recognize, or to reaffirm, a professional responsibility to provide effective pain relief.²¹⁷

The material in Section II²¹⁸ establishes at least a *prima facie* case that if there is a duty to provide effective pain relief whenever it is indicated and feasible, then in most clinical settings that duty is breached more often than it is fulfilled.²¹⁹ If we assume, as we should, that most persons enter the health care professions with genuinely beneficent motivation, then we must seriously explore the most plausible explanations for this breach, and the extent to which they should be considered genuine mitigating factors.

VIII. REASONS WHY THE DUTY TO RELIEVE PAIN IS BREACHED

A. *Barriers to Effective Pain Management*

The Agency for Health Care Policy and Research discusses barriers to effective pain management in its cancer pain guidelines.²²⁰ The barriers are divided into three categories: problems related to health care professionals, problems related to patients, and problems related to the health care system.²²¹ The first cate-

215. ROBERTSON, *supra* note 210, at 15.

216. *See generally* AHCPR, *supra* note 121.

217. The acute pain management guidelines state, “[h]ealth care is both a technical and an ethical enterprise. The ethical obligation to manage pain and relieve the patient’s suffering is at the core of a health care professional’s commitment.” AHCPR, *supra* note 121, at 4. Similarly, the cancer pain guidelines include the following statement: “The obligation to alleviate suffering is an essential component of the clinician’s broader ethical duties to benefit and not harm; it dictates that health professionals maintain clinical expertise and knowledge in the management of pain, even when present educational programs do not provide this.” *Id.* at 10.

218. *See supra* Section II.

219. While it is estimated that pain can be safely and effectively relieved in 90% of all patients, the evidence indicates that pain is not relieved in 80% of patients. *See* Betty R. Ferrell & Michelle Rhiner, *High-Tech Comfort: Ethical Issues in Cancer Pain Management for the 1990s*, 2 J. CLIN. ETHICS 108, 108 (1991).

220. *See* AHCPR, *supra* note 121, at 17.

221. *See id.*

gory includes the following sub-categories: inadequate knowledge of pain management, poor assessment of pain, concern about regulation of controlled substances, fear of patient addiction, concern about side effects of analgesics, and concern about patients becoming tolerant to analgesics.²²² These sub-categories can be organized around two basic themes—lack of knowledge and clinical and regulatory concerns about narcotics.²²³

B. Lack of Knowledge Regarding Pain Assessment and Pain Management

We must carefully distinguish between the non-existence of knowledge regarding a particular subject matter and the failure to acquire and apply available knowledge. Perhaps the primary impetus for the promulgation of clinical practice guidelines for pain assessment and management is that the recent studies discussed earlier in this article so clearly demonstrate that many health care professionals lack, or fail to apply, basic knowledge and skills in this area.²²⁴ The neuro-physiological, biochemical, and pharmacological facts upon which the guidelines are based are readily available to all health care professionals.²²⁵ Consequently, the epidemic of undertreated pain is not the product of the limitations of medical science per se; rather, it stems from widespread ignorance and fear among health care professionals. This ignorance of pain assessment and pain management techniques and strategies has been, to some extent, cultivated.²²⁶ This becomes an important point when

222. *See id.*

223. *See id.*

224. The AHCPR is not the only organization which has promulgated clinical practice guidelines for pain assessment and management in response to the widespread problem of undertreated pain. For other such guidelines, see AMERICAN PAIN SOCIETY, *QUALITY ASSURANCE STANDARDS FOR RELIEF OF ACUTE PAIN AND CANCER PAIN*, PROCEEDINGS OF THE 6TH WORLD CONGRESS ON PAIN (1991); AMERICAN PAIN SOCIETY, *PRINCIPLES OF ANALGESIC USE IN THE TREATMENT OF ACUTE PAIN AND CHRONIC CANCER PAIN: A CONCISE GUIDE TO MEDICAL PRACTICE* (1989); American Academy of Pediatrics, *Guidelines for the Elective Use of Conscious Sedation, Deep Sedation, and General Anesthesia in Pediatric Patients*, 76 *PEDIATRICS* 317, 317-21 (1985); National Institutes of Health, *The Integrated Approach to the Management of Pain*, 2 *J. PAIN & SYMPT. MGMT.* 35 (1987).

225. *See supra* note 224 and accompanying text.

226. For this charge to be sustainable, one must make the case that professionals have some minimal responsibility to stay current in the literature of their profession that pertains to their type of practice. Therefore, one must be able to persuasively maintain that if a health professional cares for patients in pain, then she is implicitly charged with a responsibility to be conversant with the

we consider potential legal liability for the failure to relieve pain, since ignorance of what is required to adequately care for a patient has never been a recognized defense to a medical malpractice claim.²²⁷

If pain were a rare phenomenon in the clinical setting, which only a few physicians encountered in a small number of patients, there would be no legitimate basis for concern. Of course, the reality is quite to the contrary.²²⁸ It is the rare health care professional who does not encounter patients with pain on a regular basis. This basic fact of clinical practice makes the failure to educate health care professionals in state-of-the-art pain assessment and pain management even more indefensible.²²⁹

current clinical literature on assessing and managing pain, and dealing appropriately with the side-effects or other problems associated with the preferred modalities of treatment. If the relevant (and current) clinical literature is replete with authoritative studies and guidelines which state, for example, that it is exceedingly rare for a patient to become addicted to the opioid analgesics that have been prescribed to manage their pain, then a practitioner who continues to deny opioid analgesics to their patients with pain on the grounds that they are concerned about the risk of addiction can justly be accused of having cultivated their ignorance of both the risk of addiction and/or the prevailing distinction between physiological dependence and addiction. A similar line of argument can be made with regard to those clinicians who steadfastly undermedicate their pain patients on the grounds that they have reached the ceiling on that particular analgesic. See Jane Porter & Hershel Jick, *Addiction Rare in Patients Treated with Narcotics*, 302 NEW ENG. J. MED., 123, 123 (1999); Wanzer et al., *supra* note 99, at 847.

227. A typical general articulation of the knowledge required of a physician is that “[e]ach physician may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States” *Hall v. Hilbun*, 466 So. 2d 856, 871 (Miss. 1985) (emphasis added). As will be discussed in another section of this article, while it may be the case that the level of knowledge and the standard of practice for pain management among physicians is remarkably low, that lack of knowledge and low standard of practice is not likely to offer a legitimate defense to a patient’s malpractice claim grounded upon failure to manage pain given the wealth of information “reasonably available” to all physicians. See *infra* Part X.

228. Based upon the most reliable data, it was estimated that in 1988 one-quarter of the population of the United States experienced moderate to severe pain that required significant therapeutic interventions such as opioid analgesics. See John J. Bonica, *Pain Research and Therapy: History, Current Status and Future Goals*, in ANIMAL PAIN 2 (Charles E. Short & Alan Van Poznak eds., 1992).

229. The absence of any formal pain curriculum in the schools that train health care professionals is not for lack of positive suggestions by skilled professionals. See, e.g., Issy Pilowsky, *An Outline Curriculum on Pain for Medical*

C. Concerns About Narcotics—The Phenomenon of Opiophobia

Any discussion of the care of patients with serious pain and the concerns that it engenders with physicians should include certain caveats. First, the use of narcotics to manage pain or treat any other medical condition, as with medical and surgical procedures generally, involves inherent risks.²³⁰ Consequently, the responsibility of the clinician is to be able to knowledgeably assess the potential risks and benefits of any given intervention and to communicate those to the patient so that he or she may then provide an informed consent or refusal. With regard to the relief of pain, perhaps more than other medical interventions, the patient is in the best position to determine how much pain she is willing or able to endure in order to avoid the real (as opposed to the mythical) risks of any particular pain relief modality.

Second, as the clinical practice guidelines make clear, state-of-the-art pain management is multifaceted, and rarely should be based exclusively on opioid analgesics.²³¹ Therefore, pharmacological approaches include opioid and non-opioid (adjuvant) drugs.²³² Nonpharmacological pain management techniques include physical and psychosocial interventions.²³³ While the most severe and persistent types of pain, such as that involving terminal cancer, usually require large and sustained doses of opioid analgesics as a part of the therapeutic regimen, there may be exceptions.²³⁴

Schools, 33 PAIN 1 (1988); *Pain Curriculum for Basic Nursing Education*, ASP NEWSLETTER, Sept.-Oct. 1993, at 4-6; International Association for the Study of Pain ad hoc Committee on University Courses and Curricula, *Curriculum Outline on Pain for Pharmacy Students*, 1 J. PHARM. CARE IN PAIN & SYMPT. CONTROL 45 (1993).

230. A "risk of the procedure" is one which has some statistical possibility of arising as a result of a medical intervention that is performed within the standard of care. See AHCP, *supra* note 121, at 50-51, 61-65. In the case of pain management, the risk of any intervention should be assessed on the reasonable assumption that it will be provided in a nonnegligent manner. See *id.* The risk so assessed and so disclosed, should then be balanced by the patient, in consultation with the health professional, against the risks or burdens of alternative strategies as well as doing nothing. See *id.* Part of the mythology surrounding pain management is that there are no risks to the patient in the undertreatment or nontreatment of pain. See *id.*

231. See AHCP, *supra* note 121.

232. See *supra* notes 235-40.

233. See *supra* notes 235-40.

234. A compelling example is described by novelist, Reynolds Price, a victim of cancer of the spinal cord. See REYNOLDS PRICE, A WHOLE NEW LIFE 149-60

With this background, let us consider the phenomenon that has come to be characterized as “opiophobia.”²³⁵ As the term has come to be used, opiophobia denotes an unreasonable fear of and resultant reluctance to prescribe, administer, or receive opioid analgesics,²³⁶ even for the relief of severe pain which is unresponsive to other available pain management strategies.²³⁷ While the phenomenon of opiophobia is not unique to American culture, the openly declared war on drugs by American politicians and bureaucrats has produced a particularly virulent form of it in this country.²³⁸ A detailed examination of the psycho-social, cultural, and political forces underlying American opiophobia is beyond the scope of this article, and is readily available in other sources.²³⁹ However, the intricacies and interrelationships between federal and state laws regulating the prescribing of opioid analgesics have been repeatedly identified as one of the more significant barriers to the provision of effective pain management and palliative care.²⁴⁰

(1994). Price ultimately found relief from excruciating pain only when he abandoned the pharmacopeia of powerful drugs that had been prescribed and underwent hypnosis and biofeedback. *See id.*

235. Although it is unclear who first used the term “opiophobia,” a number of highly regarded specialists in the field of pain management and palliative care have utilized it without hesitation as an apt description of attitudes and behaviors of both patients and physicians. Indeed, the term has even been applied to similar populations of laypersons and professionals in Europe. *See, e.g.,* John P. Morgan, *American Opiophobia: Customary Underutilization of Opioid Analgesics*, 11 *ADV. PAIN RES. & THERAPY* 181; M. Zenz & A. Willweber-Strumpf, *Opiophobia and Cancer Pain in Europe*, 341 *THE LANCET* 1075 (1993) (describing incident of physician refusing to issue more due to the drug’s addictive qualities).

236. The major group of drugs used in cancer pain management are called opioid analgesics. *See* Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 *J.L. Med. & Ethics* 308, 310 (1992). The term “opioid” is a general term that describes naturally occurring and semisynthetic drugs derived from the juice of the opium poppy and completely synthetic drugs. *See id.*

237. *See id.*

238. For an account of opiophobic behaviors on the part of Canadian physicians, see Sommerville, *Death of Pain: Pain, Suffering, and Ethics*, *supra* note 209, at 43-44.

239. *See, e.g.,* MORRIS, *supra* note 115.

240. The Policy Studies Division of the Pain Research Group at the University of Wisconsin Medical School is at the forefront of initiatives devoted to understanding the impact of narcotics law and regulation on physician prescribing practices and the formulation of reform measures to enhance the quality of care of patients with pain. For an example of their work in this area, see David E. Joranson, *Federal and State Regulation of Opioids*, 5 *J. PAIN & SYMPT. MGMT.* S12-S23 (1990).

1. *The Regulatory Milieu*

The oversight of the prescribing practices of physicians takes place at both the federal and state levels. The authority which provides the primary regulatory basis for the narcotics used in pain relief are the Uniformed Controlled Substances Act²⁴¹ and the Federal Food, Drug, and Cosmetic Act.²⁴² The former is administered by the federal Food and Drug Administration (FDA).²⁴³ The FDA evaluates and approves drugs before they can be available for medical use.²⁴⁴ It also provides information to consumers regarding drugs.²⁴⁵

The Uniform Controlled Substances Act divides such drugs into five different schedules.²⁴⁶ Schedule I substances are described as "those that have no accepted medical use in the United States and have a high abuse potential."²⁴⁷ Among the examples of Schedule I substances listed by the Drug Enforcement Agency (DEA) are heroin, marijuana, LSD, peyote, and mescaline.²⁴⁸ Schedule II substances are considered to have a high abuse potential plus "severe psychic or physical dependence liability."²⁴⁹ Among the examples of Schedule II substances are some of those most fre-

241. See UNIFORM CONTROLLED SUBSTANCES ACT § 101 (1994).

242. See 21 U.S.C. § 301 (1994).

243. See U.S. Food and Drug Administration, *Frequently Asked Questions* (visited Dec. 4, 1999) <<http://www.fda.gov/opacom/faqs/genfaqs.html>>.

244. See U.S. Food and Drug Administration, *Drug Information* (visited Dec. 4, 1999) <<http://www.fda.gov/cder/drug.htm>>.

245. See *id.*

246. See UNIFORM CONTROLLED SUBSTANCES ACT § 201-212 (1994).

247. DRUG ENFORCEMENT ADMINISTRATION, *PHYSICIAN'S MANUAL* 3 (1990).

248. See *id.* The characterization of some of these substances as having "no accepted medical use" is controversial. For example, recently Arizona passed referenda allowing physicians to prescribe "medicinal" marijuana to patients suffering from severe pain. See Jeffrey Allan Kilmark, *Government Knows Best? An Analysis of the Governor's Power to Veto and the Legislature's Power to Repeal or Amend Voter Enacted Initiative and Referendum Petitions in Arizona*, 30 ARIZ. ST. L.J. 829, 829 (1998).

249. See *id.* The precise connotation of the term "liability" is unclear. Perhaps it is intended to be synonymous with "risk" or "potential." Of course, when crafting a *PHYSICIAN'S MANUAL* in an era of escalating malpractice litigation, it is difficult to imagine a more negatively charged word than "liability." While technically speaking the "liability" to which the *PHYSICIAN'S MANUAL* refers may be that of the patient rather than the prescribing physician, even this suggestion is misleading. When the alternative is severe and persistent pain, being physiologically dependent upon opioid analgesics that are effective in relieving that pain may not constitute a "liability" to the patient.

quently used for pain management: morphine, meperidine (Demerol), oxycodone (Percodan), and fentanyl (Sublimaze).²⁵⁰ The failure of the DEA Physician's Manual to more carefully distinguish among "psychic dependence," "physical dependence," and "addiction" is unfortunate and potentially quite misleading. Experts in pain management sometimes refer to addiction as "psychological dependence" in order that it not be confused with the physical dependence, which can be expected to accompany significant, sustained doses of narcotic analgesics administered to control severe pain.²⁵¹ As one noted pain specialist has observed, "[t]here is a deeply held fear that the long-term exposure to an opioid can create an addiction disorder that could become a problem more significant than the chronic pain that originally justified the therapy."²⁵² This "deeply held fear" is part of the mythology underlying opiophobia, and it survives despite overwhelming scientific evidence that the incidence of addiction among patients who receive opioid analgesics for purposes of pain management is no more than ten percent.²⁵³ Schedule III-V substances are characterized by decreasing potential for abuse.²⁵⁴ Unlike Schedule II substances, physicians may issue prescriptions for them orally or in writing, and may authorize refills.²⁵⁵ Schedule II substances, by contrast, can only be prescribed in writing, and may not be refilled.²⁵⁶

The impact of the DEA's policies and procedures, as well as those of state medical licensing boards, upon the prescribing practices of physicians in caring for patients with pain are noteworthy. The DEA disclaims any intent to discourage the appropriate use of controlled substances by physicians to deal with the genuine medi-

250. See DRUG ENFORCEMENT ADMINISTRATION, *supra* note 247, at 3.

251. The AHCPR's MANAGEMENT OF CANCER PAIN defines addiction as a "[p]attern of compulsive drug use characterized by a continued craving for an opioid and the need to use the opioid for effects other than pain relief." See AHCPR, *supra* note 121, at 185.

252. Russell K. Portenoy, *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, 1 PROC. PAIN RES. & MGMT. 247, 263 (1994).

253. See *id.* See, e.g., Porter & Jick, *supra* note 226.

254. See UNIFORM CONTROLLED SUBSTANCES ACT § 410 (1994).

255. See *id.*

256. There is a provision for an emergency telephone prescription order for a Schedule II substance, but it must be limited to the amount needed to treat the patient during a bona fide emergency period, and within 72 hours the physician must provide the pharmacy with a written and signed prescription order. See DRUG ENFORCEMENT ADMINISTRATION, *supra* note 247, at 13.

cal needs of their patients.²⁵⁷ In the DEA's words: "[c]ontrolled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well-being of patients."²⁵⁸ Nevertheless, it also "strongly endorses" the Multiple Copy Prescription Program (MCCP) administered by a number of states.²⁵⁹ Sometimes referred to as "triplicate forms," and designed to deter the illegal diversion of controlled substances, the MCCP has been identified as one of the most significant barriers to effective pain management in states where it is used.²⁶⁰ The DEA's mission is to strongly discourage drug diversion to illicit uses.²⁶¹ There is no other federal agency with the charge of insuring that drug control laws and regulations do not, in the words of one prominent pain management expert, Kathleen Foley, "[make] people with pain the victims of the war on drugs."²⁶²

The states exercise a parallel authority to prohibit the non-medical use of controlled substances. Most state statutes are based upon the 1970 model Uniform Controlled Substances Act.²⁶³ The definitional language in some of these statutes, however, reflects the prevalent inability (or unwillingness) to appropriately distinguish psychological and physiological dependence, and between addiction and tolerance. For example, the New York State Controlled Substances Act defines an addict as "a person who habitually

257. DRUG ENFORCEMENT ADMINISTRATION, *supra* note 247, at 3.

258. *See id.* at 24.

259. *See id.*

260. In the Report of the Summit on Effective Pain Management convened by the Governor of California in 1994, the state's triplicate prescription system was decried as "outdated, impractical for many modern health care settings, and generally ineffective for monitoring and controlling diversion of medications for nontherapeutic purposes." *See Report, Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing* 8 (1994). Indeed, the administrative complexities and "implied intimidation" of the system had caused nearly fifty percent of California physicians to decline to apply for privileges to prescribe Schedule II medications. *See id.*

261. *See* U.S. Department of Justice Drug Enforcement Administration, DEA *Mission Statement* (visited Dec. 4, 1999) <<http://www.usdoj.gov/dea/agency/mis-sion.htm>>.

262. *See* Dick Merrit et. al., *supra* note 199, at 3. The statement is attributed to Kathleen Foley, M.D., former director of Pain and Palliative Care Services at Memorial-Sloan Kettering Cancer Center and director of the Project on Death in America. *See id.*

263. *See* NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS: UNIFORM CONTROLLED SUBSTANCES ACT (1970).

uses a narcotic drug and who by reason of such use is dependent thereon.”²⁶⁴ That statute prohibits physicians from prescribing controlled substances to an “addict” unless that person is a patient of the physician and is suffering from an incurable and fatal disease.²⁶⁵ Manifestly, current thinking among pain management specialists is that patients with severe chronic pain can only be effectively managed through the long-term administration of opioid analgesics are *not* addicts.²⁶⁶ This is regardless of whether their pain is of malignant or nonmalignant origin, and regardless of the fact that they might be described as “habitual users” and may well be physically dependent upon certain narcotics for control of their pain.²⁶⁷ Nonetheless, a narrow and rigid interpretation of such statutory language would likely preclude a physician from effectively controlling the chronic pain of patients whose condition could not be labeled terminal.

In recent years a number of states have begun to address the problems posed by statutory language such as that in New York. The remedy of choice thus far has been the enactment of so-called “Intractable Pain” statutes. One such statute defines intractable pain as “pain for which, in the generally accepted course of medical practice, the cause cannot be removed and otherwise treated.”²⁶⁸ The statute goes on to provide that in undertaking to treat a patient for intractable pain, “a physician may prescribe or administer

264. N.Y. PUBLIC HEALTH LAW § 3302(1) (McKinney 1993).

265. *See id.*

266. *See e.g.*, Foley, *supra* note 59, at 7-10.

267. In a 1989 article, the Executive Director of the National Institute on Drug Abuse, the nation’s leading agency for drug abuse research, noted that “the confusion between the use of narcotics by legitimate patients and the use of narcotics by street addicts influences the attitudes and behavior of dispensing practitioners, patients and their families, as well as government policymakers who regulate the availability of these drugs.” Charles. R. Schuster, *Does Treatment of Cancer Pain with Narcotics Produce Junkies?*, 11 ADV. IN PAIN RES. & THERAPY 1, 1 (1989). He concluded the article, the title of which he chose to highlight the absurdity of the question, with the reassurance that those in his agency:

recognize our special responsibility to make sure that, in our attempt to reduce drug abuse, we articulate clearly the differences between those for whom narcotics are appropriately prescribed to treat unnecessary suffering and the drug addicts whose narcotics use is the central and destructive focus of their lives.

Id. at 3.

268. FLA. STAT. ANN. § 458.326(1) (West 1995).

any controlled substance under Schedules II-V . . . provided the physician does so in accordance with that level of care, skill, and treatment recognized by a reasonably prudent physician under similar conditions and circumstances.²⁶⁹ These statutes have had very limited impact on the prescribing practices of physicians. For example, four years after enacting its version of an intractable pain statute, California recognized the need for a Pain Summit to address the persistent undertreatment of pain by physicians in the state.²⁷⁰ Florida, with its intractable pain statute in place, attempted unsuccessfully to discipline a physician who treated patients with severe chronic pain by prescribing opioid analgesics.²⁷¹

The monitoring of physicians' prescribing practices that are ostensibly within the scope of their clinical practice (as opposed to the diversion or illicit use that the DEA pursues) at the state level is usually conducted by medical licensing boards. These boards are charged with the responsibility for investigating complaints against physicians for unprofessional practice. These investigations may involve anything from physician drug addiction and alcoholism that impair the ability to practice, to sexual involvement with patients, to practicing other than allopathic medicine.²⁷² When the DEA's investigation of a physician's prescribing practices for controlled substances reveals no diversion or illicit use, it is customary to refer such cases to the appropriate state medical licensing board to determine whether those practices nevertheless constitute unprofessional practice.²⁷³ Recent studies like the one discussed below indicate that such oversight by state licensing boards has a pervasive and profoundly negative impact upon the treatment of severe chronic pain by physicians.

The publication *American Medical News* conducted a survey and received responses from its physician readers from thirty-two

269. *Id.* at § 458.326(3).

270. *See infra* notes 334-36 and accompanying text.

271. *See infra* notes 292-309 and accompanying text.

272. *See, e.g., In re Guess*, 393 S.E.2d 833, 835 (N.C. 1990), in which the North Carolina Supreme Court upheld the disciplinary action taken by the state board. *See id.* Dr. Guess, in a few cases in which allopathic approaches had failed, offered trials of homeopathic remedies to patients. *See id.* The board found that such practices did not "conform to the standards of acceptable and prevailing medical practice in the State of North Carolina." *Id.*

273. *See* Testimony of Michael Mapes, Diversion Program Manager, DEA Denver Division, before Interdisciplinary Task Force on Intractable Pain of the Colorado General Assembly (September 10, 1996).

states.²⁷⁴ A majority of the respondents acknowledged that the potential for disciplinary action by their state medical board caused them to be so conservative in their prescribing practices for patients with chronic, intractable pain that their patients might not be receiving adequate pain relief.²⁷⁵ Such behaviors raise profound moral questions, or so it seems to an objective observer from outside the medical profession. David Morris with such an objective, non-clinician perspective, is one of the very few commentators to seriously question and express concern about the ethical myopia that appears to afflict the medical profession and those who regulate it, at least on the issue of providing effective and readily available pain relief. In one of the strongest statements in print, he declares that “not relieving pain brushes dangerously close to the act of willfully inflicting it.”²⁷⁶ The willful infliction of pain is torture, which is foreclosed to the government by the Eighth Amendment to the U.S. Constitution, even in the punishment of convicted criminals as “cruel and unusual.”²⁷⁷ Why then, do such practices fail to raise so much as an ethical ripple when documented in the medical literature?²⁷⁸ Could it be, as David Morris recently intimated, that the voices of those in pain, and perhaps also those who would decry the failure of physicians to properly attend to it, have been silenced by “the neglect of a biomedical culture in which complaints of pain (subjective and unverifiable) simply do not matter.”²⁷⁹

One ethicist suggests that in their enculturation into medicine, physicians are induced to indulge in two types of “forgetting” with regard to pain.²⁸⁰ One type is “psychological” forgetting, which occurs when the physician distances him or herself from the pain of illness and of the diagnostic and therapeutic procedures which patients must be induced to undergo.²⁸¹ Inherent in this process of discounting the level and the experiential quality of such pain is

274. See Flora J. Skelly, *Fear of Sanctions Limits Prescribing of Pain Drugs*, 37 AM. MED. NEWS 19 (1994).

275. See *id.*

276. MORRIS, *supra* note 148, at 191.

277. See U.S. CONST. amend. VIII.

278. See, e.g., Rich, *supra* note 33.

279. See MORRIS, *supra* note 148, at 134.

280. See William Ruddick, *Do Doctors Undertreat Pain?*, 11 BIOETHICS 246, 247-49 (1997) (dealing with both psychological and conceptual forgetting about pain).

281. See *id.*

the idea that pain in the clinical setting is often unavoidable and that it certainly cannot and should not become the obsessive focus of either the physician or the patient.²⁸² The second type of forgetting is “conceptual.”²⁸³ Traditionally, pain is a symptom of some underlying condition that the physician is charged with diagnosing and curing.²⁸⁴ Thus pain, and more specifically how it is experienced and described, provides important information to the physician, information that would be lost (or so the argument runs) if the pain were promptly and effectively alleviated.²⁸⁵ Such palliative measures would also divert the physician from the primary task of effecting the diagnosis and undertaking curative measures.²⁸⁶ There is also the antiquated but curiously persistent notion that the Hippocratic admonition *primum non nocere* (first do no harm) translates into an admonition not to prescribe strong narcotics just to make a patient more comfortable. According to this view, the adverse side effects, or the mythical perils of addiction and its resulting stigmatization, are presumed to outweigh the patient’s continued suffering, even for those who are near death.²⁸⁷ An often-

282. See *id.* at 247.

283. See *id.*

284. See *id.*

285. See *id.* at 248-49.

286. This traditional approach to patient care has at long last been critiqued. Pellegrino, for example, argues that “[p]alliative care is fundamentally good comprehensive care, and it should be part of the care of *all* patients” Pellegrino, *supra* note 99, at 1522.

287. The AHCPR clinical practice guidelines for the management of cancer pain directly confront such antiquated notions in the following terms:

Clinicians are often concerned that high doses of opioids used for palliation may harm or kill a patient, particularly when doses are further increased to alleviate pain. . . . When the patient’s death is imminent because of the progression of primary disease, an increased risk of earlier death counts little against the benefit of pain relief and a painless death. The ethical duty to benefit the patient through relieving pain is itself adequate to support increasing doses to alleviate pain, even if there might be life-shortening and expected side-effects. . . . The person dying from cancer should not be allowed to live out life with unrelieved pain because of fear of side effects; rather, appropriate, aggressive palliative support should be given.

AHCPR, *supra* note 121, at 64. In order to understand just how much against the traditional grain of medical education and practice such admonitions run, one need only note the remarkable similarity between the above-quoted language and that found in an article on the undertreatment of pain published over 20 years

repeated medical nostrum is that “nobody ever died of pain.”²⁸⁸

These “explanations,” along with the previously discussed “barriers” to effective pain relief, fail to take into account the fundamental ethical principle that ultimately it is for the victim, not the perpetrator, to determine what constitutes harm. The suggestion implicit in the psychological and conceptual “forgetting” thesis, that it is too much to ask physicians to empathize with and minister to their patients in pain, is bogus.²⁸⁹ Physicians who cannot relate to their patient’s pain and suffering by listening and compassionately responding lack essential clinical competencies required to practice their chosen profession.²⁹⁰

The performance of one state medical licensing board demonstrates the legal, ethical, and clinical implications of its scrutiny of the prescribing physicians’ practices. Physicians’ fears of discipli-

before:

Some degree of physical dependence and tolerance develops whenever a narcotic is given in therapeutic dosage over a prolonged period, but in patients with painful terminal illnesses such considerations should not in any way prevent the physician from fulfilling his primary obligation to ease the patient’s discomfort. The physician should not wait until the pain becomes agonizing: *no patient should ever wish for death because of his physician’s reluctance to use adequate amounts of potent narcotics.*

Marks & Sachar, *supra* note 40, at 181. Over 20 years separate these two powerful expressions of the same ethical admonition to physicians. One may reasonably ask why the medical profession is so resistant to calls for beneficence.

288. The implication is that patients have died, or had their lives shortened, by drug overdoses, but not by severe, persistent pain. However, the current view among palliative care specialists is that the risks posed by aggressive pain management strategies have been greatly exaggerated and are not based on objective, verifiable, and scientifically sound data. Furthermore, severe, uncontrolled pain not only destroys a patient’s quality of life, but can produce its own set of adverse sequelae, some of which might be sufficiently serious to contribute to a patient’s earlier demise. See AHCPR, *supra* note 121, at 8.

289. The American Board of Internal Medicine Special Report on physician competency in end-of-life care includes as an essential element of effective pain assessment: “Believe the patient’s complaint of pain.” AMERICAN BOARD OF INTERNAL MEDICINE, *supra* note 91, at 15. Elsewhere in the same report, among the core competencies for physicians who care for patients with pain are “listening, comforting, compassion, courtesy, and sensitivity to patient’s needs for comfort and dignity.” See *id.* at 41.

290. See MORRIS, *supra* note 148, at 264. David Morris articulates this view in the following terms: “Doctors who neglect to gain the skills and knowledge required for clinically effective listening—although this idea is absolutely foreign to Western medicine—are engaged in unethical medical practice.” *Id.*

nary action for less than ultra conservative practices in prescribing opioid analgesics for patients in pain are not without foundation in fact.²⁹¹ In a recent Florida case, the Florida Agency for Health Care Administration (AHCA) filed an administrative complaint against Dr. Hoover, a physician board-certified in internal medicine.²⁹² The complaint alleged inappropriate and excessive prescribing practices of Schedule II controlled substances to seven patients.²⁹³ A hearing officer held that the agency had failed to meet its burden of proof on all charges.²⁹⁴ The AHCA's Board of Medicine rejected the hearing officer's recommended findings as to five of the seven patients whose care was under review and imposed a reprimand, fine, mandatory continuing medical education, and two years of probation upon the physician.²⁹⁵

Dr. Hoover, who represented herself in these proceedings, appealed the Board's action, which was reversed on appeal.²⁹⁶ The appellate court, in a sternly written opinion, criticized the Board's "draconian policy of policing pain prescription practice[s]."²⁹⁷ The basis of the court's reversal was that the Board had "once again engaged in the uniformly rejected practice of overzealously supplanting a hearing officer's valid findings of fact regarding a doctor's prescription practices with its own opinion in a case founded on a woefully inadequate quantum of evidence."²⁹⁸

Given the numerous references in this article to the clinical practice guidelines of the AHCPR, one aspect of the appellate court's reversal is particularly pertinent to this analysis.²⁹⁹ The appellate court ruled that the hearing officer had properly considered the AHCPR guidelines for the management of cancer pain introduced into evidence at the hearing through an expert witness

291. Several other recent cases against physicians that have been prosecuted either under civil or criminal law for pain management practices; however, in these cases prosecutions were later overturned. *See* Hollabaugh v. Arkansas State Med. Bd., 861 S.W.2d 317 (Ark. Ct. App. 1993); *People v. Schade*, 30 Cal. App. 4th 1575 (1994); *In re DiLeo, M.D.*, 661 So. 2d 162 (La. Ct. App. 1995).

292. *See Hoover v. Agency for Health Care Admin.*, 676 So. 2d 1380, 1381 (Fla. Dist. Ct. App. 1996).

293. *See id.*

294. *See id.* at 1382.

295. *See id.*

296. *See id.*

297. *See id.* at 1385.

298. *Id.* at 1381.

299. *See id.* at 1383.

for Dr. Hoover.³⁰⁰ The hearing officer found that the clinical practice guidelines were probative on the issue of Dr. Hoover's treatment of severe, chronic non-cancer pain.³⁰¹ The hearing officer further found the guidelines corroborated the expert testimony that Dr. Hoover's prescribing practices were within the standard of care.³⁰² The Board of Medicine had accepted the AHCA's exception to this finding of fact by the hearing officer on the grounds that the AHCPR guidelines pertained to cancer pain, whereas Dr. Hoover's patients suffered from chronic nonmalignant pain.³⁰³ One possible justification for the hearing officer's reliance on those particular guidelines (in the absence of guidelines on chronic nonmalignant pain) is that in addressing pain in AIDS patients, the authors of the guidelines (an interdisciplinary panel of experts in pain management and palliative care) state:

Pain is a symptom commonly experienced by patients with HIV infection, even in the absence of an opportunistic cancer. . . . The principles of pain assessment and treatment in the patient with HIV positive/AIDS are not fundamentally different from those in the patient with cancer and should be followed for patients with HIV positive/AIDS.³⁰⁴

The clear implication is that some types of chronic noncancer pain can and should be treated in the same way as cancer pain.

The second revealing and disturbing aspect of the treatment of Dr. Hoover by the Florida medical board, which also may have prompted some of the vitriol that appears in the appellate court's opinion, is the selection of the two expert witnesses called by the AHCA in presenting its case.³⁰⁵ Neither had examined any of the patients or patient records in formulating their opinion that Dr. Hoover's care was unprofessional.³⁰⁶ They relied solely on computer printouts from pharmacies that listed the medications that

300. *See id.*

301. *See id.*

302. *See id.*

303. *See id.* at 1382-83.

304. AHCPR, *supra* note 121, at 139.

305. *See Hoover*, 676 So. 2d at 1381.

306. *See id.*

Dr. Hoover had prescribed.³⁰⁷ Still more disconcerting, both of these “experts” acknowledged that they did not treat chronic pain patients, but always referred those patients to other physicians.³⁰⁸ Nevertheless, both deemed themselves, and were deemed by the AHCA and the Board, qualified to opine that Dr. Hoover had prescribed excessive, if not lethal doses of narcotics to these patients, and thereby had practiced below an acceptable standard of care.³⁰⁹

This case illustrates an important point about the professional struggle to raise the standard of care for pain management, i.e., the educational process must begin with the administrative agencies that regulate physicians. The record thus far suggests that many boards are themselves afflicted with the same prejudices, fears, myths, and misinformation about the use of narcotics for pain relief as those whom they regulate. This suggestion was confirmed by a recent survey of state medical licensing board members, which revealed significant knowledge deficits regarding the principles and practices of state-of-the-art pain management.³¹⁰ In responses by nearly half of the nation’s 627 state medical board members to a 1991 survey on knowledge of and attitudes toward pain management practice, forty-three percent believed that most cancer patients receive adequate pain relief while five percent are of the opinion that most cancer patients are overmedicated.³¹¹ In the

307. *See id.*

308. *See id.* at 1382.

309. *See id.* Since these “experts” had never seen any of the seven patients or even troubled to review their medical records, they were not in a position to know that not only had none of them suffered any adverse consequences from these potentially “lethal” doses, but each had benefited from Dr. Hoover’s care and treatment of their chronic pain. *See id.* at 1381.

310. *See* David E. Joranson, et al., *Opioids for Chronic Cancer and Non-Cancer Pain: A Survey of State Medical Board Members*, 79 FEDERATION BULLETIN 15 (June 1992).

311. *See id.* at 28. The fact that not all state licensing boards are predominantly comprised of members with such inaccurate views is demonstrated by the following language in guidelines recently promulgated by one state licensing board:

The CBME (Colorado Board of Medical Examiners) firmly believes that physicians have a duty to provide maximal comfort levels and alleviate suffering in their dying patients in a skillful and compassionate manner. The Board is concerned that fear on the part of physicians may result in ineffective pain control and unnecessary suffering in terminal patients.

COLORADO BOARD OF MEDICAL EXAMINERS, GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR INTRACTABLE PAIN 1 (1996).

same survey, forty-seven percent of the respondents reported that although prescribing opioid analgesics for chronic, intractable, non-cancer pain was not technically illegal, it should be discouraged.³¹² Seventy-one percent defined addiction (incorrectly) as physical or psychological dependence.³¹³ These statistics are troublesome for a number of reasons. First, they indicate a failure or refusal on the part of board members to read the voluminous literature of their own profession documenting the widespread undertreatment of pain. Second, these licensing board members seem to be declaring that it is better for patients with a form of chronic, nonmalignant pain, which can be relieved only through the administration of opioid analgesics, to continue to suffer, rather than authorize broader use of these drugs.

2. *Must a War On Drugs Preclude a War on Pain?*

As a matter of federal public policy, the United States has been waging a war on drugs for decades through both Republican and Democratic administrations.³¹⁴ This war is purportedly being fought only against the illicit importation, distribution and consumption of narcotics for non-therapeutic purposes.³¹⁵ The rhetoric promulgated by the publicists of this war generally fails to take note of the fact that what is not being condemned and criminalized is the appropriate medical use of narcotics for therapeutic and palliative purposes.³¹⁶

312. See Joranson, *supra* note 310, at 33.

313. See *id.* at 30. More enlightened and progressive boards, such as the one in Colorado, take the position that: "The prescribing of opioid analgesics for patients with intractable non-cancer pain may also be beneficial, especially when efforts to remove the cause of pain or to treat it with other modalities have been unsuccessful." COLORADO BOARD OF MEDICAL EXAMINERS, *supra* note 311, at 1. On the issue of addiction, that Board declares: "Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. . . . Patients with chronic pain should not be considered addicts merely because they are being treated with opiates." *Id.* at 3.

314. For a detailed account of the early history of America's war on drugs, see DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* (1973). For background on the recent, openly declared "war on drugs," see DOUGLAS N. HUSAK, *DRUGS AND RIGHTS* (1992).

315. See generally Paul Finkelman, *The Second Casualty of War: Civil Liberties and the War on Drugs*, 66 S. CAL. L. REV. 1389, 1396 (1993).

316. For example, in a 1996 statement Secretary of Health and Human Services Donna Shalala declared that: "a clear message must be sent to all Americans that drugs are dangerous and wrong." See Eric E. Sterling, *Drug Policy:*

Prominent figures such as the first “drug czar” William Bennett, have suggested that drugs are the single greatest threat to the moral fabric of American society.³¹⁷ This reflects a powerful public perception, to which the medical profession has not been immune. It suggests that narcotics are at best a necessary evil that should be employed as infrequently and sparingly as possible lest the medical community as prescribers be morally and legally responsible for creating addicts.³¹⁸ The phenomena of opiophobia and the war on drugs feed upon each other and explain why physicians have, in many instances, been so quick to label a chronic pain patient’s persistent search for relief as illegitimate “drug-seeking behavior” as opposed to what it more often is—legitimate pain relief seeking behavior.³¹⁹ Characterizing a patient’s chronic pain as illegitimate implicitly makes the claim that expressions of persistent pain are not genuine. Such physician behavior may also constitute an effort to blame the victim of substandard care. Pseudoaddiction is an iatrogenic syndrome in which the undertreatment of pain actually engenders conduct on the part of patients that is similar to those who are addicted.³²⁰ It also suggests that prescribing narcotic analgesics (or increasing the dosage of those already prescribed) would have no legitimate therapeutic

A Smorgasbord of Conundrums Spiced by Emotions Around Children and Violence, 31 VAL. U. L. REV. 597, 645 (1997), citing Donna E. Shalala, Secretary of Health and Human Services, Statement at Press Conference to Release Monitoring the Future Survey (Dec. 19, 1996) (transcript on file with the *Valparaiso University Law Review*).

317. See WILLIAM BENNETT, NATIONAL DRUG CONTROL STRATEGY 9 (1990).

318. See David F. Musto, *Physicians’ Attitudes Toward Narcotics*, 11 ADV. PAIN RES. & THERAPY 51, 59 (1989).

319. Several contributing and interrelating factors are at work here. First, by labeling a person’s pursuit of effective pain relief as mere “drug-seeking behavior,” the physician essentially denies them the status of patient, thereby ostensibly absolving themselves of any further professional responsibility to respond to the individual’s needs. Second, physicians are simply following the admonitions of medical boards and drug regulation agencies when they distance themselves from such persons, who threaten to cast the pall of “script doctor” on their practice. Third, offering the appearance of being liberal in the prescribing of opioid analgesics virtually guarantees regulatory scrutiny, whereas offering the appearance of being unduly conservative in one’s prescribing practice virtually guarantees obscurity if not invisibility. There are no reported instances of a physician having been reported by a pharmacist or investigated by the DEA for being a chronic underprescriber of opioid analgesics. See, e.g., James R. Cooper et al., *Prescription Drug Diversion Control and Medical Practice*, 268 JAMA 1306 (1992).

320. See generally David E. Weissman & J.D. Haddox, *Opioid Pseudoaddiction—An Iatrogenic Syndrome*, 36 PAIN 363 (1989).

purpose, but would only be responding (inappropriately) to the patient's actual or incipient addiction or drug abuse.³²¹ The presumption of innocence and the right to due process are hallmarks of the American criminal justice system. Therefore, our society maintains that it is better that ninety-nine guilty persons go free than that one innocent person be wrongly convicted. Conversely, the hallmark of the regulatory system for prescribing Schedule II narcotics appears to be that it is better that ninety-nine patients with genuine pain continue to suffer than that one drug-seeking individual obtain a prescription to which he or she is not entitled. In justification of this strong claim, consider the situation in Colorado.

The Colorado Prescription Drug Abuse Task Force, promulgates "guidelines" for health care professionals with prescribing authority for Schedule II narcotics.³²² These guidelines constitute what might be characterized as a "draft notice" that every health care professional in Colorado with prescribing authority has been conscripted into the war on drugs.³²³ The guidelines begin with the following language:

The abuse of prescription drugs, especially controlled substances, is a serious social and health problem in Colorado and the United States. As a health professional, you share responsibility for solving the prescription drug abuse and diversion problem.

* Your social responsibility is to uphold the law and help protect society from drug abuse.

* Your professional responsibility is to prescribe controlled substances appropriately, guarding against abuse while assuring that your patients have medication

321. Too many physicians approach patient complaints of pain, even patients with terminal illness, with skepticism. Because of this, public policy on drug control directly clashes with emerging standards of medical ethics. In the words of one prominent physician in the movement to improve pain management and palliative care, Susan Tolle: "Pain and suffering are subjective symptoms, hence it is only the patient who can tell us about the quality and quantity of his pain." Melissa L. Buchan & Susan W. Tolle, *Pain Relief for Dying Persons: Dealing with Physicians' Fears and Concerns*, 6 J. CLINICAL ETHICS 53, 58 (1995).

322. See generally COLORADO PRESCRIPTION DRUG ABUSE TASK FORCE, COLORADO GUIDELINES OF PROFESSIONAL PRACTICE FOR CONTROLLED SUBSTANCES FOR HEALTH CARE PROFESSIONALS WHO PRESCRIBE (3d ed. 1997).

323. See *id.*

available when they need it.

* Your personal responsibility is to protect your practice from becoming an easy target for drug diversion, which could result in legal actions against you and damage your professional esteem.³²⁴

Absent from this document is any acknowledgement of the major public health problem posed by the epidemic of undertreated pain.³²⁵ There is also no mention of the physician's ethical responsibility to relieve the pain and suffering of patients by conscientiously providing opioid analgesics as needed in the fulfillment of that responsibility.³²⁶ This ancient duty is lost in the rhetoric about preventing drug abuse and avoiding "damage [to] professional esteem."³²⁷

While it is certainly in the public interest to prevent the diversion of drugs from therapeutic to non-therapeutic purposes, it is also in the public interest to protect vulnerable patients. This may be done by insuring that those who are afflicted with painful conditions do not suffer unnecessarily because physicians fail to prescribe appropriate amounts of narcotic analgesics. Yet, when considering the behavior of many state medical licensing boards, there is a very one-sided approach. Despite factual evidence suggesting that there are many more physicians who underprescribe narcotic analgesics for their patients, than there are physicians who divert drugs for illegal purposes, prior to 1999, there had not been a single reported case in which a licensing board has taken disciplinary action against a physician for allowing patients to suffer unnecessarily.³²⁸ However, there is a plethora of reported cases in which licensing boards have sought to discipline physicians for overprescribing narcotic analgesics.³²⁹

324. *Id.*

325. *See id.*

326. *See id.*

327. The most recent version of these guidelines, which is still in draft form as of this writing, does acknowledge the existence of the Colorado Board of Medical Examiners Guidelines on pain management, but fails to suggest how the very different points of emphasis of the two sets of guidelines might be reconciled. *See* COLORADO PRESCRIPTION DRUG ABUSE TASK FORCE BOARD, COLORADO GUIDELINES OF PROFESSIONAL PRACTICE FOR CONTROLLED SUBSTANCES FOR HEALTH CARE PROFESSIONALS WHO PRESCRIBE (4th ed. forthcoming 1999).

328. *But see, e.g.,* SUPPORT, *supra* note 63.

329. *See infra* notes 330-349 and accompanying text.

In 1999, the Oregon Board of Medical Examiners became the first state medical licensing board to take disciplinary action against a physician for the failure to provide appropriate pain relief.³³⁰ Paul A. Bilder, M.D., a 52-year old pulmonary specialist, was charged with six counts of unprofessional or dishonorable conduct and gross or repeated acts of negligence in his care of gravely ill or dying patients.³³¹ In each instance, he had failed or refused to provide opioid analgesics, which were necessary to relieve terminal pain or to properly sedate a patient who was undergoing intubation.³³² Dr. Bilder entered into a stipulated order with the Board in which he acknowledged the deficiencies in his care of these patients and agreed to complete the one-year Physicians Evaluation Education Renewal (PEER) program during the next year, as well as course on physician-patient communication.³³³ Finally, he must continue working with a psychiatrist who will provide the Board with regular reports throughout the next year.³³⁴

Another recent case, this one in California, demonstrates how conflicted state medical boards have become on the issue of pain management in clinical practice. In July of 1994, the California Medical Board issued a formal statement on "Prescribing Controlled Substances for Pain Management."³³⁵ This statement followed a year of testimony at hearings held by the Board's Task Force on Appropriate Prescribing and a day long "Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing" sponsored by then California Governor Pete Wilson.³³⁶ In the statement, the Board acknowledged "that pain, whether due to trauma, surgery, cancer and other diseases, is often undertreated" and that "[u]nrelieved pain has a harsh and sometimes disastrous impact on the quality of life of people and their families."³³⁷ The Board then stated "[p]ain management should be a high priority in California" and "principles of quality medical prac-

330. Erin Hoover Barnett, *Case Marks Big Shift in Pain Policy*, *THE OREGONIAN*, Sept. 2, 1999, available in <http://www.oregonlive.com:80/news/99/09/st090201.-html>.

331. *See id.*

332. *See id.*

333. *See id.*

334. *See id.*

335. *See* Medical Board of California Action Report 4 (Oct. 1994).

336. *See id.*

337. *Id.*

tice dictate that citizens of California who suffer from pain should be able to obtain the relief that is currently available.³³⁸ In conjunction with this statement the Board issued "Guidelines for Prescribing Controlled Substances for Intractable Pain," which includes the following general admonition:

The Board strongly urges physicians to view pain management as a priority in all patients. . . . Pain should be assessed and treated promptly, effectively and for as long as the pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment.³³⁹

Four years after the statement and guidelines were issued, Beverly Bergman filed a complaint with the Board following the painful death of her father from cancer.³⁴⁰ Bergman was protesting the undertreatment of her father's pain by his doctor, Dr. Win Chin.³⁴¹ Following an investigation of the complaint, the Board wrote to Bergman in August of 1998, stating that although "pain management for your father was indeed inadequate," no disciplinary action would be taken against the physician.³⁴²

Responses to the California Board's refusal to take any disciplinary action against a physician who allows a dying patient to suffer severe pain reflect two quite disparate viewpoints. David Joranson³⁴³ and June Dahl,³⁴⁴ both affiliated with the Pain and Policy Studies Group of the University of Wisconsin, take the position that it would be "unduly harsh" to punish physicians for failure to apply knowledge and skills their training never afforded them.³⁴⁵ Susan Tolle,³⁴⁶ Joanne Lynn,³⁴⁷ and Kathleen Foley³⁴⁸ take the position that

338. *Id.*

339. *Id.* at 8.

340. *See* Stolberg, *supra* note 98, at F1.

341. *See id.*

342. *See id.*

343. *See* Merrit et al., *supra* note 199, at 6.

344. *See id.*

345. *See id.*

346. *See supra* note 321.

347. *See* Stolberg, *supra* note 98, at F1.

348. *See supra* note 262 (response to question from the audience, Department of Neurology Grand Rounds, University of Colorado Health Sciences Center, June 16, 1999)

medical boards should treat the substandard practice of pain management in the same manner as they treat any other form of substandard or unprofessional practice and take appropriate disciplinary action.

One commentator has suggested this one-sided approach by state medical licensing boards to physician prescribing practices—obsession with the potential for overprescribing, indifference to numerous examples of underprescribing—sends a strong and disturbing message that unrelieved pain is “irrelevant to the disciplinary board.”³⁴⁹ The Board’s inaction regarding doctors’ substandard practice and direct violation of officially adopted clinical practice guidelines, as in the California case, suggests that such guidelines can be ignored with impunity and without risk of sanction. It is, of course, too early to discern whether it is the Oregon or the California boards that will provide the models for other state boards. One possible explanation for the disparate treatment is that the Oregon board had six reported cases attributable to the same physician, thereby constituting persuasive evidence of a pattern and practice of unprofessional or negligent conduct, whereas the California board had only one case upon which to justify disciplinary action.

D. The Low Priority of Pain Relief in the Health Care Setting

The fact that maximally effective pain management has not traditionally been a priority, even in hospitals where pain is most likely to occur in the context of serious illness, has not been seriously contested.³⁵⁰ Why it is not a priority is a question still in search of an answer. A few partial explanations follow. One is that the hospital culture is profoundly influenced by the medical staff, and physician ambivalence toward the aggressive relief of pain has permeated our exploration of the barriers. Medicine’s indifference to pain and suffering can be seen, in part, as a reflection of its focus on human physiology and the disease process, and its concomitant relegation of the personhood of the patient to another dimension that is not one of its major responsibilities.³⁵¹ This dichotomy also

349. See C. Stratton Hill, Jr., *Government Regulatory Influences on Opioid Prescribing and Their Impact on the Treatment of Pain of Nonmalignant Origin*, 11 J. PAIN & SYMPT. MGMT. 287, 293 (1996).

350. See *supra* note 50.

351. According to some critics of modern medicine, not only the personhood

helps to explain the tendency of physicians to distinguish between "real pain," pain that is commensurate with objective, physiological findings of tissue damage, and "unreal pain," pain which is of psychogenic origin or the fictional account of a malingering or drug-seeking patient.³⁵² Such attitudes are artifacts of the hegemony of the curative model of medicine discussed in Section V. Only when a patient has been clinically "certified" to be within six months of death and care has been formally transferred to hospice, will the palliative model be allowed to make control of their pain a priority.³⁵³ Another aspect of this phenomenon is that many therapeutic medical interventions actually cause pain. Hence, when a patient seeks medical treatment, they are, or so it might be presumed, consenting to the pain or discomfort inherent in the treatment modalities that are indicated.³⁵⁴ Reports of pain by the patient are usually viewed as data to be dutifully recorded in the progress notes of the medical record and utilized in the assessment of the patient's underlying condition and response to therapeutic interventions. Complaints of pain, only secondarily, will be deemed to create an imperative for prompt and effective management of the pain.³⁵⁵ This is particularly the case when the patient's complaints of pain lie outside of expected pain trajectories for a particular condition. Indeed, it is not unusual for patients with an atypical trajectory to be labeled "uncooperative" or "difficult."³⁵⁶ Ongoing complaints of pain may actually be interpreted by clinicians as a failure or refusal to appreciate their therapeutic efforts, thereby further antagonizing the staff and isolating the patient.³⁵⁷ Thus, well before the era

of the patient, but the threat of death from severe or terminal illness can be reduced or "deconstructed" into a series of manageable biomedical problems, such as the stabilization of blood pressure, pulse, and respiration. See MORRIS, *supra* note 148, at 237.

352. See Mariet A. E. Vrancken, *Schools of Thought on Pain*, 29 SOC. SCIENCE & MED. 435, 436 (1989).

353. For a discussion of the referral process to hospice, see DENICE C. SHEEHAN & WALTER B. FORMAN, *HOSPICE AND PALLIATIVE CARE* 11-19 (1996).

354. See FAGERHAUGH & STRAUSS, *supra* note 49, at 19-20.

355. One aspect of the new movement to promote institutionalization of a commitment to effective pain management is the regular charting of pain as "the fifth vital sign" along with such other vital signs as temperature, pulse, respiration and blood pressure. See Betty R. Ferrell et al., *An Institutional Commitment to Pain Management*, AM. PAIN SOC. BULLETIN, Apr.-May 1994, at 16.

356. See FAGERHAUGH & STRAUSS, *supra* note 49, at 22.

357. See *id.*

of cost containment and managed care,³⁵⁸ the behaviors of clinicians, particularly in the acute care setting, suggested a belief that a choice had to be made between treating a medical condition and alleviating pain and suffering. This widely held belief also provides an explanation for the unique success of hospice in making the gravely ill and dying comfortable. Hospice has no curative agenda. Since its patient population is wholly comprised of those who are acknowledged to be dying, the focus can legitimately be narrowed to pain relief, symptom management, and meeting the patient's and family's psychosocial needs.³⁵⁹

E. Reasons Do Not Equal Excuses—Moral Courage and the Duties of Caregivers

The barriers to appropriate pain management considered in this section provide plausible reasons why so many patients experience undertreated pain. Too many clinicians are ignorant of effective pain assessment techniques and pain management strategies, indifferent to the persistent pain of their patients, fearful of regulatory scrutiny of their prescribing practices, and confused about important concepts such as addiction (psychological dependence), physical dependence and tolerance. Collectively, these barriers have caused, or at the very least contributed to, an enduring epidemic of pain and suffering that untreated pain leaves in its wake.³⁶⁰

358. It is probably too early to draw any firm conclusions about the ultimate impact of cost containment considerations and managed care on the provision of quality pain relief. For an analysis of some of their issues and implications, see Diane E. Hoffman, *Pain Management and Palliative Care in the Era of Managed Care: Issues for Health Insurers*, 26 J.L., MED. & ETHICS 267 (1998); Timothy S. Jost, *Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets*, 26 J.L., MED. & ETHICS 290 (1998).

359. A point of clarification is important here. Hospice is a setting in which optimal palliative care is routinely provided. The clinical goals of hospice, in general, are not distinguishable from the goals of palliative care as they have been articulated by organizations such as the American Board of Internal Medicine. See AMERICAN BOARD OF INTERNAL MEDICINE, *supra* note 91, at 41. Hence there is no absolute barrier to the provision of palliative care in an acute care hospital that is of comparable quality to that provided in the best of hospice settings. Rather, the barriers are institutional and economic.

360. There are also patient-related barriers to good pain management. The general public too is both ignorant and fearful of opioid analgesics, and reluctant as patients to be viewed as demanding of more in the way of care than has been offered. One can hardly expect lay persons to be more knowledgeable and sophisticated about an emerging aspect of clinical practice than health care

But none of these factors, individually or collectively, rises to the level of an excuse for this deficiency in clinical practice. Health care professionals, physicians and nurses in particular, claim to have as one of their fundamental ethical norms and professional goals the principle of beneficence—taking positive steps to help those with whom they have a professional relationship. While curing disease when possible is an indisputable goal of health care, as well as ameliorating symptoms of chronic disease for which there is no cure, caring for both the curable and the incurable conditions that afflict persons is a concomitant professional responsibility.³⁶¹ However, it is one, which has been reaffirmed by the medical establishment only recently, when its back was up against the wall with regard to care of the dying.³⁶²

professionals. For a discussion of these patient-related barriers, see Charles S. Cleeland, *Documenting Barriers to Cancer Pain Management*, in CURRENT AND EMERGING ISSUES IN CANCER PAIN: RESEARCH AND PRACTICE 321, 325-327 (C.R. Chapman & Kathleen M. Foley eds., 1993); Joseph J. Fins, *Public Attitudes About Pain and Analgesics: Clinical Implications*, 13 J. PAIN & SYMPT. MGMT. 169 (1997).

361. In 1996, a distinguished international panel of health care professionals assembled by the Hastings Center issued a report on the goals of medicine, in which the panel sought to articulate the values at the core of medicine which must inform policymakers in undertaking health care reform. See International Project of the Hastings Center, *The Goals of Medicine: Setting New Priorities*, in HASTINGS CTR. REP. S1 (Nov.-Dec.1996). The goals of medicine were identified as:

The prevention of disease and injury and promotion and maintenance of health.

The relief of pain and suffering caused by maladies.

The care and cure of those with a malady, and the care of those who cannot be cured.

The avoidance of premature death and the pursuit of a peaceful death.

Id. What is striking about the goals as stated is the remarkable balance between the curative and the palliative approaches to patient care, strongly suggesting that the hegemony of the curative model that is the hallmark of modern medical education and practice reflects a medical ethos that is inconsistent with medicines core values.

362. A prominent palliative medicine specialist provides a powerful narrative from early in his clinical training. See Charles F. Von Gunten, *Why I Do What I Do*, in AMERICAN BOARD OF INTERNAL MEDICINE, CARING FOR THE DYING: IDENTIFICATION AND PROMOTION OF PHYSICIAN COMPETENCY, PERSONAL NARRATIVES 47-48 (1996). This case exemplifies what has been the prevailing attitude of the medical profession with regard to patients with intractable suffering, i.e., “there is nothing to do,” and hence no professional responsibility to acquire knowledge, develop skills, or change attitudes toward these most challenging and distressing patients and their need for compassionate care. See *id.*

The groundswell of public support that has resulted in the passage of a physician-assisted suicide referendum in the state of Oregon,³⁶³ and the near passage of similar laws in the states of California and Washington, has been driven in significant part by a growing public awareness of medicine's acknowledged failures in the care of gravely ill and dying patients.³⁶⁴ Because the public has

At 9:00 pm on a bitter cold, wintry Chicago night I received a page from an ENT [ear, nose and throat] resident. He was admitting a young man with head and neck cancer to my service who was "endstage" and expected to die. He said there was "nothing to do." As I was overwhelmed by new admissions, a large clinical service, and had not yet learned to cope with the VA [Veterans Administration] system where I was a new intern, I saw the patient last. When I arrived in his room at about 2:00 am, he was alone. His head was the size and shape of a pumpkin due to edema. He was restless and short of breath and he looked terrified. Because his tongue was swollen, he couldn't talk. I didn't know what to do for him, so I patted him on the shoulder, said something *inane* and left and at 7:00 am he died.

The memory haunts me because now I know I could have helped him feel better in many ways. I failed to care for him properly because I was ignorant of palliative medicine. If I am known as a doctor who specializes in the care of the dying, then maybe a frightened, overwhelmed intern will know to call me for help rather than walk away because he mistakenly thinks there is "nothing more that can be done." . . . I want there to be a lasting impact of this branch of medicine upon contemporary medical practice as a whole. The physician scientist model of the modern physician is too limited in scope. At a fundamental level, I think this model of medical care is responsible for the disaffection and anxiety that the public has about their medical care.

Id.

363. See OR. REV. STAT. §§ 127.800-897 (1995 & Supp. 1998).

364. Two articles authored by large numbers of prominent physicians acknowledge these deficiencies. In the earlier of the two, 12 distinguished physicians state:

One of the most pervasive causes of anxiety among patients, their families, and the public is the perception that physicians' efforts toward the relief of pain are sadly deficient. Because of this perceived professional deficiency, people fear that needless suffering will be allowed to occur as patients are dying. To a large extent, we believe such fears are justified.

Wanzer et al., *supra* note 99, at 847. The second article, authored by the very long list of principal investigators in the SUPPORT study, concluded:

The picture we describe of the care of seriously ill or dying persons is not attractive. One would certainly prefer to envision that, when confronted

tended to give the medical profession the benefit of the doubt, people have erroneously assumed that physicians are relieving the pain and suffering of serious illness as effectively as the current state of medical science and technology permits. If so much suffering continues to permeate the dying process, then the only humane response is to empower physicians to provide lethal doses of narcotics when a competent, terminally ill patient requests them in order to escape unbearable pain and suffering. The response of the AMA and similar professional groups has been to affirm the professional responsibility of physicians to relieve suffering to the fullest extent possible, and to acknowledge that state-of-the-art pain management and palliative care enables physicians to do a much better job in this area than in fact they are doing.³⁶⁵ However, what is not directly acknowledged either by the AMA or by state medical licensing boards is that if medical ethics demands that physicians provide effective pain relief, yet studies show that many physicians do not, then what we are confronted with is not merely a clinical failure, but an ethical one as well. Medicine is intrinsically a moral and humanistic undertaking. Persistent and widespread failure to relieve pain that can be relieved raises fundamental ethical questions (whether or not they are acknowledged) about the character of such practitioners.³⁶⁶ Lamentably, such questions are rarely, if ever posed, not even by those in the burgeoning field of biomedical ethics, whose primary role is presumably to be acutely sensitive to the ethical nuances of clinical practice.³⁶⁷ Instead, the discussion immediately turns to the barriers to effective pain management, rather than to the question of why so many physicians lack the moral courage to rise above those barriers and address the unnecessary suffering of their patients. It is not the absence of modalities

with life-threatening illness, the patient and family would be included in discussions, realistic estimates of outcome would be valued, pain would be treated, and dying would not be prolonged.

SUPPORT, *supra* note 63, at 1597.

365. See AMERICAN MEDICAL ASSOCIATION, REPORT OF THE BOARD OF TRUSTEES ON QUALITY CARE AT THE END OF LIFE 12 (1995).

366. For an extensive exposition of the role of virtue in medicine, see EDMUND D. PELLEGRINO & DAVID C. THOMASMA, THE VIRTUES IN MEDICAL PRACTICE (1993). For a discussion and critique of virtue-based ethics in medicine, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, BIOMEDICAL ETHICS 62-69 (4th ed. 1994).

367. For a critique of the failure of bioethics to confront the ethical implications of undertreated pain, see Rich, *supra* note 33.

of pain relief that causes the problem, it is the failure of will on the part of too many physicians to resist opiophobic forces that would condone, or at least tolerate suffering rather than resort to prescribing the high dosages of narcotics that many of the gravely ill and dying may require.³⁶⁸

The recounting of these barriers has become not only tedious but also pernicious in the sense that they have come to be treated like artifacts of the natural world, as inevitable and immutable as the progression of the seasons or the order of the planets in the solar system. Quite the contrary, as the preceding analysis has shown, these barriers are the product of an opiophobic culture and a curative model of medicine that have long tolerated unnecessary pain and suffering in the clinical setting. Rather than continuing the rhetoric of the last quarter century that speaks of scaling these barriers, with no accountability on the part of the health care system for reform, we should design strategies for eradicating them which entails the active involvement of the medical profession as a whole. Nothing would bring these long-standing barriers down more quickly than a concerted effort on the part of organized medicine.³⁶⁹

368. In case it may appear that too much blame is being laid upon the profession of medicine, a few points must be emphasized. First, physicians control the content of the medical school curriculum and all aspects of residency training programs, as well as the bodies which accredit both and prepare the examinations that measure physician competency. Also, physicians often control the medical licensing boards in the states, which are the primary means by which the prescribing practices of physicians are assessed. Finally, through the organized medical staff of the hospital, physicians have significant if not controlling influence on the quality of care patients receive. If the physicians on the curriculum committee, the licensing board, or the medical staff wished good pain management to become a priority in medical education and patient care, it is hard to imagine what could stand in the way of the much needed reform measures which they chose to initiate.

369. By way of example and not limitation, the following are a few modest proposals that would demonstrate a serious intent to bring about change: 1) medical schools could be required, in order to maintain their accreditation, to institute a pain curriculum designed to insure that no student obtains an MD degree who does not possess the core competencies identified by the American Board of Internal Medicine and the American Medical Association Education of Physicians in End-of-Life Care Project; 2) medical licensing boards could uniformly adopt the Model Pain Management Guidelines of the Federation of State Medical Licensing Boards, and in turn be required to ascertain that each of their licensees possesses the knowledge, skills and attributes necessary to comply with such guidelines; 3) hospitals could be required, in order to maintain their JCAHO accreditation, to demonstrate that they have promulgated, implemented,

David Morris, one of the remarkably few authors to suggest that there are profound ethical questions underlying the failure or refusal to relieve pain when the means to do so are readily available, arrives at the following conclusion:

The ethics of pain management, unfortunately, may not receive proper attention until the first doctor is successfully sued for failing to provide adequate relief. At that point, the need for a full and reflective dialogue on ethical questions about pain will be preempted—as so often happens in American life—in favor of the slowly grinding mills of the law.³⁷⁰

Two critical points are inherent in Morris's suggestion, one obvious and one subtle. The more obvious point is that litigation, and more particularly medical malpractice liability, changes physician behavior.³⁷¹ The more subtle point is that medical jurisprudence, particularly medical malpractice litigation, has the power to shape ethical perceptions and ethical practices in medicine. The next section considers the development of the doctrine of informed consent, which provides a paradigm case of medical jurisprudence (malpractice liability) transforming both medical practice and principles of medical ethics. While the evolution of informed consent has been copiously documented from a legal perspective,³⁷² the implications of that evolution for medical ethics

and monitored compliance with a set of policies, procedures and protocols designed to insure that effective pain management has been made a priority in patient care, and that physicians and nurses on the staff will be held accountable for adhering to them.

370. MORRIS, *supra* note 148, at 192.

371. Physicians surveyed in one major study believed that the malpractice threat was important in maintaining compliance with the standard of care. See REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 9-24 (1990); see also Peter A. Bell, *Legislative Intrusions in the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 975-90 (1984) (examining the psychological affect of tort sanctions on physicians' behavior). But see Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555 (1985) (proposing arguments in favor of doing away with tort law liability).

372. See RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 53-232 (1986); CHARLES W. LIDZ ET AL., INFORMED CONSENT 10-23 (1984).

have not.³⁷³ It is first necessary to understand, through the example of informed consent, the potent transformative influence of law on the ethics of clinical practice. We can then follow Morris's lead and inquire into the possibility that the emerging standard of care in the area of pain management and palliative care may provide a new basis upon which to challenge physicians (as well as other licensed health care professionals) who continue to allow patients to suffer from undertreated pain.³⁷⁴ In this way the law can shape clinical practice to an extent that moral suasion and admonition has failed to accomplish.³⁷⁵

373. Curiously, two books that purport to recount and analyze the influence of law on bioethical decisionmaking fail to consider the doctrine of informed consent in clinical practice (as opposed to clinical research) and its emergence in the crucible of medical malpractice litigation. See ROGER B. DWORKIN, *LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING* (1996); DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* (1991).

374. It is interesting to note that among the voluminous responses to the SUPPORT study, only one written by an attorney-bioethicist proposed a solution to the problems revealed that would hold physicians legally accountable for their persistence. In pertinent part, the proposed remedial measures include the following:

Medical licensing boards must make it clear to licensees that painful deaths are presumptively ones that are incompetently managed and should result in license suspension or revocation in the absence of a satisfactory justification. Another reasonable step is to establish a system of not-for-profit public interest health care law firms whose sole mission is to promote patient rights by educating the public and the medical community about those rights, and by bringing lawsuits on behalf of patients whose rights are not honored in the hospital setting. . . . Lawyers are likely to get the ear of physicians who have been deaf to the pleas of patients, families, and nurses. . . . And to the extent that law continues to dominate medical ethics in the United States, changes in the ethical behavior of physicians will continue to require legal action.

George J. Annas, *How We Lie*, 25 HASTINGS CTR. REP. Nov.-Dec. 1995, at S12, S13-S14.

375. In subtly alluding to the impotence of ethical entreaties to physicians to attend more carefully and diligently to the pain and suffering experienced by patients, David Morris reflects a point of view expressed by Leon Kass at about the same time. Kass observed, in the spirit of Aristotle, that "ethics is impotent without politics—without careful attention to law and custom and the ordering of civic life." Leon R. Kass, *Practicing Ethics: Where's the Action?*, 20 HASTINGS CTR. REP., Jan.-Feb. 1990, at 5, 10.

IX. ENFORCING THE DUTY TO PROVIDE PAIN RELIEF

A. *The Standare of Care*

Generally, the standard of care for any particular type of medical care is stated in terms similar to the following:

Each physician may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States. A physician should have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment.³⁷⁶

Such language poses interesting questions with regard to pain management. Let us consider the issue from the perspective of the following hypothetical situation.³⁷⁷ A patient is diagnosed with metastatic pancreatic cancer and given a prognosis of survival of no more than six months.³⁷⁸ Her pain is effectively managed by the inpatient pain service of the hospital where exploratory surgery led to the diagnosis, but as she approaches discharge her attending physician dismisses the pain service from the case and drastically reduces the dosage of opioid analgesics. On the day of discharge the patient is quite worried because her pain has not been as well controlled as when the pain service was involved. She reasonably anticipates that as the disease progresses, her pain will only become worse. The physician admonishes her to be strong, that keeping

376. Hall v. Hilbun, 466 So. 2d 856, 871 (Miss. 1985).

377. This hypothetical case was the basis for a mock trial that was produced by the author and videotaped as an educational instrument for health care professionals with the support of the American Society of Law, Medicine & Ethics Mayday Scholars Program. See Videotape: Pain Management and Professional Liability: The Case of *Jones v. Ackerman* (on file with the Program in Health Care Ethics, Humanities and Law, University of Colorado Health Sciences Center).

378. A definitive diagnosis of advanced pancreatic cancer is clinically significant in two respects that are particularly relevant to our analysis. First, the prognosis is extremely poor, with death extremely likely within months. Second, if not properly managed, death from pancreatic cancer is likely to be extremely painful.

her on large doses of narcotics for the months she has remaining would turn her into an addict or a zombie who was “out of it” most of the time and unable to have any meaningful interaction with her family. No mention of hospice is made. Trusting his statements, she continues the pain medication he recommended, but is unable to tolerate the increasing level of pain. Repeated calls to the physician result in some tinkering with her prescriptions, but no significant increase in the dosage of opioid analgesics and hence no decrease in her suffering. Finally, her sister, who has moved in with her and become her primary caregiver, calls the patient representative of the hospital where the patient was diagnosed, and demands that she be readmitted and put under the care of the pain service. The next day the patient is readmitted to the hospital by her attending physician with a diagnosis of intractable pain and put under the care of the pain service. Within twenty-four hours the patient is comfortable for the first time since the pain service was discharged, and the patient and her sister are taught how to continue to maintain at home the intrathecal catheter through which the significantly increased dosages of opioid analgesics are now being provided.³⁷⁹

Two weeks after the second discharge, the patient dies comfortably at home. In the weeks after the patient’s death, her sister is increasingly outraged by the contrast between the palliative care provided by the pain service and the seemingly insensitive and opiophobic treatment by the attending physician. She concludes that but for the attending physician’s arrogance (in dismissing the pain service) and incompetence (in failing to know what constituted and how to provide effective pain management) her sister would have had a comfortable and dignified final two months of life. The sister confers with an attorney and ultimately files a medical malpractice action against the attending physician alleging that his care of her sister in the final months of her life was below an acceptable standard of care. In addition, the physician’s inadequate care resulted in months of severe and unnecessary pain and suffering for her sister and for herself as her sister’s devoted and loving caregiver.

If we are to believe the literature on pain management, the

379. See generally Michael J. Cousins & Laurence E. Mather, *Intrathecal and Epidural Administration of Opioids*, 61 ANESTHESIOLOGY 276 (1984) (summarizing data on the pharmacology of spinal administration of opioids).

currently prevailing practice among physicians generally (as opposed to specialists in pain management) is to undertreat pain. The defendant physician might argue that the complaint seeks to hold clinicians such as him to a higher standard of care than is actually practiced by most physicians. The mere fact that a dying patient suffered severe pain in her last months does not mean he was guilty of medical malpractice. While it is correct that a majority of jurisdictions traditionally take the position that the usual and customary practice sets the standard of care for physicians,³⁸⁰ a minority of jurisdictions take the position that adherence to customary practice should not insulate a physician from malpractice liability if the plaintiff can provide persuasive evidence that the physician has failed or refused to apply readily available measures which would have prevented harm to the patient.³⁸¹

B. The Judicially Imposed Standard of Care

Quite early in this century Justice Holmes observed: "What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not."³⁸² It is, of course, one thing to refuse to allow nonesoteric commercial enterprises to have the final word on what should constitute due care in the conduct of their affairs, but should the same principle apply to the highly technical and sophisticated practice of medicine? Beginning at mid-century, a growing number of courts answered that question in

380. See *Holt v. Godsil*, 447 So. 2d 191, 192 (Ala. 1984).

381. In one of the more recent examples of this approach, the Wisconsin Supreme Court stated:

[S]hould customary medical practice fail to keep pace with developments and advances in medical science, adherence to custom might constitute a failure to exercise reasonable care. . . . We agree with the parties and the Medical Society that while evidence of the usual and customary conduct of others under similar circumstances is ordinarily relevant and admissible as an indication of what is reasonably prudent, customary conduct is not dispositive and cannot overcome the requirement that physicians exercise ordinary care.

Nowatske v. Osterloh, 543 N.W.2d 265, 271-72 (Wis. 1996); see also *Toth v. Community Hosp. at Glen Cove*, 239 N.E.2d 368, 373 (N.Y. 1968) ("Evidence that the defendant followed customary practice is not the sole test of professional malpractice.").

382. *Texas & Pac. Ry. v. Behymer*, 189 U.S. 468, 470 (1903).

the affirmative. In doing so, they frequently quoted the language of Justice Holmes and Judge Hand in early tort cases involving common carriers. For example, in the seminal case of *Darling v. Charleston Community Hospital*,³⁸³ in which the principle of corporate negligence for health care institutions was first recognized, the Illinois Supreme Court stated: "By the great weight of modern American authority a custom either to take or omit a precaution is generally admissible as bearing on what is proper conduct under the circumstances, but it is not conclusive."³⁸⁴ The court went on to quote Justice Learned Hand's opinion in *The T.J. Hooper*.³⁸⁵

The notion that an entire medical specialty, or at least all of the members in a particular locale would never be guilty of negligence, i.e., by adhering to a "substandard" standard of care, was vociferously debunked by a Louisiana appellate court in a case involving a radiologist:

We are firm in the opinion that it is patently absurd, unreasonable and arbitrary to hold that immunity from tort liability may be predicated upon a degree of care or procedure amounting to negligence notwithstanding such procedure is generally followed by other members of the profession in good standing in the same community.³⁸⁶

Inherent in the court's analysis is the position that it would be both unreasonable and unconscionable for a court to create an irrebuttable presumption that a standard practice among physicians can never constitute a failure to exercise reasonable care with regard to patients.³⁸⁷ The most often-cited case in which a court essentially condemned an entire medical specialty is *Helling v. Carey*.³⁸⁸ In this case, an ophthalmologist cared for a patient for nearly ten years before diagnosing primary open angle glaucoma.³⁸⁹ During this period there was a simple, painless, and inexpensive

383. 211 N.E.2d 253 (Ill. 1965).

384. *Id.* at 257 (quoting 2 HARPER AND JONES, THE LAW OF TORTS § 17.3, at 977-78 (1965)).

385. 60 F.2d 737, 740 (2d Cir. 1932). *See supra* note 212 and accompanying text.

386. *Favalora v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544, 551 (La. Ct. App. 1962).

387. *See id.*

388. 519 P.2d 981 (Wash. 1974).

389. *See id.*

test for glaucoma.³⁹⁰ The defendant's failure to utilize this test was supported by the uncontroverted testimony of the medical experts, all of whom took the position that the standard of care among ophthalmologists was not to routinely administer that test to patients under the age of forty.³⁹¹ The plaintiff was thirty-two at the time her glaucoma was diagnosed.³⁹² After quoting Justice Hand, the Washington Supreme Court then paraphrased him in the articulation of its holding:

Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable.³⁹³

The plaintiff had not produced any expert testimony in support of the testing of patients under age forty for glaucoma.³⁹⁴ However, a survey of Washington ophthalmologists revealed that prior to *Helling* between 20.3% and 30.1% of the respondents reported that they tested for glaucoma regularly.³⁹⁵ Such numbers would certainly constitute a "respectable minority" of physicians who were operating within what might be characterized as an

390. *See id.*

391. *See id.*

392. *See id.* at 982.

393. *Id.* at 983.

394. *See id.* at 982.

395. *See* Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345, 383 (1981).

emerging but not yet officially recognized standard of care.³⁹⁶ In the practice of pain management, there is also a “respectable minority” of physicians who currently practice within an emerging standard where most pain can be effectively managed, and reasonable prudence mandates that efforts be directed toward that end to minimize or eliminate unnecessary suffering.³⁹⁷

C. *Informed Consent: The Paradigm Case of a Judicially-Imposed Standard of Care*

Prior to the middle of this century, physicians had neither a legal duty nor any recognized ethical responsibility to obtain the informed consent of their patients prior to performing an invasive

396. In the early 1950s, an emerging or developing standard of care caught physicians (and their young patients) in tragic circumstances. See *Toth v. Community Hosp. at Glen Cove*, 239 N.E.2d 368, 372-73 (N.Y. 1968). That was the period when physicians recognized the relationship between the administration of sustained high doses of oxygen to infants born prematurely and the development of retrolental fibroplasia (RLF). See *id.* Physicians gradually dismissed the view that these high doses were necessary to prevent brain damage, despite developing evidence that the risk of RLF in this population from high levels of oxygen was greater than the risk of brain damage from decreased levels. See *id.* Applying the approach of *Helling* in an RLF case, a New York court declared that: “There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, [high oxygen doses to premature infants] should not be required to take whatever precautionary measures he deems appropriate.” *Id.* at 273.

397. The grounds for saying that there is still only a minority of physicians who believe and practice in this way are the alarming statistics indicating that large numbers of patients with pain problems which would be quite manageable if state-of-the-art techniques were applied continue to report significant pain. See Jamie H. Von Roenn et al., *Physician Attitudes and Practice in Cancer Pain Management*, 119 ANNALS INTERNAL MED. 121, 124 (1993), which concludes with the following grim prognosis:

Despite the fact that, for at least two decades, most major medical journals and the lay media have recognized that many patients have needless pain, this survey of specialists in cancer care suggests that 1) education in pain management remains substandard and, as a result, the practice of pain management is often substandard; 2) communication between physicians and patients about pain continues to be hampered by poor or nonexistent assessment and patient misinformation; and 3) some physicians are still reluctant to use the most effective analgesics and adjuvant medications for pain management. Change will occur only with the concerted and collaborative efforts of health care professionals, policy makers, and patient and family consumers.

Id. at 126.

procedure that entailed significant and identifiable risks.³⁹⁸ In order to avoid liability for battery, a physician was not required to obtain the patient's informed consent to the procedure; an uninformed consent would suffice.³⁹⁹ In the 1950s, a novel cause of action began to be asserted in malpractice suits against physicians—the failure to obtain informed consent.⁴⁰⁰ Since the long-standing custom and practice in the profession had been one of silence,⁴⁰¹ it was virtually impossible to produce expert medical testimony that the standard of care required that a physician disclose the risks and benefits of a proposed treatment, and alternatives (including doing nothing) and their risks and benefits, so that the patient could give an informed consent.⁴⁰² Thus, we can reasonably surmise that most efforts to persuade courts to adopt this novel theory of malpractice liability did not survive a timely motion

398. As the President's Commission study of informed consent noted:

The physician's duty to disclose information about treatment is what distinguishes the informed consent doctrine from the earlier requirement of consent to treatment, in which a physician satisfied his or her obligation to patients if patient's merely understood in a general way the nature of the medical procedures that would take place. By contrast, the informed consent doctrine requires that patients be provided with a greater quantity of information to enable them to make intelligent choices about treatment.

PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 3 MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 194 (1982).

399. See *Schloendorff v. Society of New York Hosp.* 105 N.E. 92, 93 (N.Y. 1914). Judge Cardozo's resplendent language in *Schloendorff* that: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" was nothing more than a recognition that a patient's uninformed consent was required. *Id.* Standard medical practice not only eschewed informing patients of the details of their conditions and the risks inherent in the procedures they recommended, but actually discouraged such disclosures on the grounds that they would discourage patients from undergoing necessary treatment and undermine the efficacy of those treatments by increasing the level of anxiety. For a detailed account by a physician of the medical profession's antipathy toward dialogue between physician and patient, see KATZ, *supra* note 134.

400. For a comprehensive history of the development of the doctrine of informed consent, see generally FADEN & BEAUCHAMP, *supra* note 372.

401. See generally KATZ, *supra* note 134.

402. The Hippocratic corpus is replete with admonitions to physicians to tell the patient as little as possible about the nature of his or her condition and treatment. See generally THE MEDICAL WORKS OF HIPPOCRATES (John Chadwick & W.N. Mann trans., 1950).

to dismiss for failure to state a claim upon which relief could be granted. In order for a plaintiff to succeed in such a claim in the absence of any general acceptance of such a practice by medical practitioners, courts had to be persuaded to find as a matter of law that the custom of silence and nondisclosure was in some sense substandard practice. Remarkably, the courts gradually began to accept that rationale.

*Salgo v. Leland Stanford Jr. University Board of Trustees*⁴⁰³ was the first case to actually use the term “informed consent.”⁴⁰⁴ The court stated that “[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”⁴⁰⁵ The court then identified the desired objective as “the full disclosure of facts necessary to an informed consent.”⁴⁰⁶ As Jay Katz observes in his analysis of the opinion in *Salgo*, some of its language was actually drawn from an *amicus curiae* brief filed by the American College of Surgeons, which acknowledged that a physician, particularly when advocating the use of a relatively new procedure, such as aortography was in the mid-1950’s, has a duty to advise the patient of the risks inherent in the procedure.⁴⁰⁷

Three years later in *Natanson v. Kline*,⁴⁰⁸ the Kansas Supreme Court more fully articulated the physician’s duty to obtain the patient’s informed consent.⁴⁰⁹ In *Natanson*, Irma Natanson commenced action against radiologist Dr. John Kline for severe, disfig-

403. 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

404. *See id.*

405. *Id.*

406. *Id.* at 181. The factual background of the *Salgo* case involves a 55-year old man suffering from painful leg cramps and intermittent limping who underwent an aortography in an effort to locate a suspected block in the abdominal aorta. *See id.* at 172-74. The morning after the procedure, which involved the injection of a solution of sodium urokon dye, Salgo discovered that both of his legs were paralyzed. *See id.* at 174-75. Among his claims of malpractice, he alleged that he should have been, but was not warned of the risk of paralysis. *See id.* at 181.

407. *See* KATZ, *supra* note 134, at 61-62. Demonstrating an admirable solicitude for patient autonomy and welfare, the American College of Surgeons in its *amicus curiae* brief was, in effect, declaring the usual and customary practice of the profession in the area of risk disclosure to be substandard. *See* American College of Surgeons’ Brief as Amicus Curiae in Support of Defendant and Appellant Frank Gerbode, *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957) (No. 17045). The literature and clinical practice guidelines on pain management do precisely the same thing.

408. 350 P.2d 1093 (Kan. 1960).

409. *See id.*

uring injuries that resulted from his administration of cobalt therapy following her mastectomy.⁴¹⁰ The trial court had denied her request for an instruction to the jury that physicians have a duty to warn patients of the risks of treatments, which they recommend.⁴¹¹ Justice Schroeder, writing for the court, employed language clearly drawn from Justice Cardozo's opinion in *Schloendorff*⁴¹² that was thereafter quoted by many other courts which came to recognize informed consent as an integral part of the physician's professional responsibility to patients:

Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.⁴¹³

However, the opinion allowed ample room for physician discretion. After recognizing a duty to disclose important information to the patient, the court then held that the determination of what information must be disclosed is that which a reasonable medical practitioner would, in the sound exercise of medical judgment, choose to make known under the same or similar circumstances.⁴¹⁴

Interestingly, one of the cases that the *Natanson* court mentioned with approval was a Minnesota decision, *Bang v. Charles T. Miller Hospital*,⁴¹⁵ which did not appear to give physicians quite so much discretion in determining what must be disclosed to pa-

410. See *id.* at 1095.

411. See *id.* at 1099.

412. See *supra* note 399 and accompanying text.

413. See *Natanson*, 350 P.2d at 1104. This language supports much more than just a patient's right to informed consent or refusal. It is broad enough to constitute a right to refuse any and all treatment, including that which is necessary to sustain life, as was later recognized by both state and federal courts. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Garger v. New Jersey*, 429 U.S. 922 (1976); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

414. See *Natanson*, 350 P.2d at 1107.

415. 251 Minn. 427, 88 N.W.2d 186 (1958).

tients.⁴¹⁶ In that case, a surgeon failed to disclose to a patient who was about to undergo a transurethral resection of the prostate that the procedure as performed would involve tying off the sperm ducts, while other treatments would not.⁴¹⁷ In finding a breach of the duty to disclose, that court stated:

It is our opinion that a reasonable rule is that, where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation.⁴¹⁸

The limitations inherent in this characterization of the duty can perhaps best be seen by returning to our central focus—a proposed duty to effectively manage pain. If the typical physician has been shown in study after study to undertreat pain, then finding a duty to provide pain relief while at the same time limiting the extent of that duty to the type of pain relief that a reasonable medical practitioner would give under the same or similar circumstances is tantamount to taking back with the left hand what one has just bestowed with the right. If, as Katz has demonstrated, there has been a centuries-old medical custom of nondisclosure, then a newly-fashioned duty to disclose cannot be grounded on what a reasonable medical practitioner would disclose under the same or similar circumstances. The fatal flaw in this reasoning was recognized by a federal court in the final informed consent case that we will consider.

Judge Robinson's opinion in *Canterbury v. Spence*⁴¹⁹ is perhaps the best known in the jurisprudence of informed consent. Most importantly for our purposes, he directly confronted the problem just noted with regard to the *Natanson* case with admirable candor:

There are, in our view, formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice. To

416. *See id.*

417. *See id.* at 187-89.

418. *Id.* at 190.

419. 464 F.2d 772 (D.C. Cir. 1972).

begin with, the reality of any discernable custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt. We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence. . . . Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.⁴²⁰

Applying this language to a purported duty to effectively manage pain, a court might well conclude that the medical literature over the last quarter century constitutes not merely a preponderance, but clear and convincing evidence that under prevailing medical practice there is a custom of undertreating pain. What is necessary, therefore, in order to protect patients from the persistent inability or refusal by physicians to acquire and apply state-of-the-art pain management knowledge and skills is a standard of care set for physicians by law.⁴²¹ In the case of pain management, however, the courts have more to work with than the proverbial *tabula rasa* with which they were confronted when they undertook to interject informed consent into the silent world of doctor and patient. In undertaking to define what the standard of care should be for pain management, the courts can mine the rich resources of the clinical practice guidelines crafted by the most knowledgeable and experienced pain management and palliative care practitioners in the United States.⁴²²

420. *Id.* at 783-84.

421. While on first impression the idea that a court is in any sense qualified to set a standard of care for physicians might seem quite absurd, in certain situations, such as that regarding pain management, further reflection reveals a plausible rationale. Those most knowledgeable in pain management have established nationally-recognized guidelines. The reasons offered by practitioners for not following the guidelines are not based on any scientific basis but rather on ignorance and fear. What we have then, is a concerted refusal by a significant portion of the medical community to follow clinical practice guidelines which are intended to minimize harm (from unnecessary pain and suffering) to patients. The force of law appears to be what is required to "persuade" these recalcitrant practitioners to conform to an acceptable standard of practice.

422. See generally AHCP, *supra* note 121.

D. *Clinical Practice Guidelines and the Standard of Care*

Judicial standard-setting such as what took place in *Helling v. Carey* has been criticized. For example, the court seemed to pay little or no attention to the implications of the high rate of false positive results of tonometry.⁴²³ Furthermore, clinical experience suggests that early detection and treatment does not necessarily prevent or even significantly retard the progression of glaucoma.⁴²⁴ Except in non-technical situations such as informed consent, it is suggested that courts run the risk of reaching beyond their competence when they seek to set standards of technical performance for other professions.⁴²⁵ However, judicial standard-setting need not necessarily be flawed in this way. There are circumstances, and pain management is perhaps the most obvious, in which clinical practice guidelines have been formulated, but they have not yet influenced the custom and practice of physicians to any significant degree. When there is persuasive evidence that clinical practice guidelines developed by nationally-recognized experts in the field exist, those guidelines can and should be recognized as the standard of care.⁴²⁶ The fact that physicians in general have failed to incorporate those guidelines into their custom and practice should not be dispositive of the issue of liability. This is especially true when the evidence shows that adherence to the guidelines in question would raise the quality of patient care from what is customarily provided.⁴²⁷

423. See BARRY R. FURROW ET AL., *HEALTH LAW* 177 n.1 (3d ed. 1997).

424. See Eric E. Fortess & Marshall B. Kapp, *Medical Uncertainty, Diagnostic Testing, and Legal Liability*, 13 *LAW, MED. & HEALTH CARE* 213, 217 (1985).

425. *Tarasoff v. Regents of the University of California* presents another notable example of judicial standard-setting in an aspect of clinical practice in which the California Supreme Court held that a therapist treating a mentally ill patient owes a duty of reasonable care to warn persons about whom the patient makes threatening statements of dangers created by the patients condition. See 551 P.2d 334, 343 (Cal. 1976). For an assessment of the impact of *Tarasoff* on clinical practice, see Daniel J. Givelber et al., *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, *WIS. L. REV.* 443 (1984).

426. Recent studies indicate that following clinical practice guidelines can improve the quality of pain relief patients receive, but achieving this beneficial outcome requires a concerted and sustained institutional initiative to change physician behavior. See, e.g., American Pain Society Quality of Care Committee, *Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain*, 274 *JAMA* 1874 (1995).

427. For an extensive analysis of the basis for the recognition by courts of clinical practice guidelines as the standard of care, see Richard E. Leahy, *Rational*

The era of managed health care into which we have moved with revolutionary speed during the last decade has spawned a plethora of clinical practice guidelines (CPGs). The general purpose of such guidelines is suggested by their definition, "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."⁴²⁸ There is a significant and ongoing debate as to whether CPGs should play an influential role in shaping the standard of care for any particular area of clinical practice.⁴²⁹ There is a general suspicion that CPGs developed by large, for-profit managed care organizations will constitute a concerted effort to ratchet down the prevailing standard of care in the service of cost reduction.⁴³⁰ However, in the case of pain management guidelines such as those produced by the AHCPR and the American Pain Society, the purpose is precisely the opposite. The prevailing, unjustifiably low standard of care would be elevated by the widespread adoption of these guidelines by medical practitioners.⁴³¹

Traditionally, as has been noted, the development and recognition of a standard of care for some aspect of clinical practice was directly linked to the custom and practice of the profession. Judicial deference was an inherent aspect of this approach, on the theory that only physicians are in a position to determine what constitutes acceptable medical practice.⁴³² What is particularly intriguing about recently developed national guidelines for pain management is that they are the work of a small subset of the medical profession, such as those who specialize in pain management, and they clearly do not reflect the practice patterns of most physicians. Neverthe-

Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines, 77 CAL. L. REV. 1483 (1989).

428. INSTITUTE OF MEDICINE, GUIDELINES FOR CLINICAL PRACTICE: FROM DEVELOPMENT TO USE 2 (Marilyn J. Field & Kathleen N. Lohr eds., 1992).

429. See, e.g., AMERICAN MEDICAL ASSOCIATION, LEGAL IMPLICATIONS OF PRACTICE PARAMETERS (1990); Edward B. Hirshfeld, *Should Practice Parameters Be the Standard of Care in Malpractice Litigation?*, 266 JAMA 2886 (1991).

430. See NATIONAL HEALTH LAWYERS ASSOCIATION, COLLOQUIUM REPORT ON LEGAL ISSUES RELATED TO CLINICAL PRACTICE GUIDELINES 23-24 (1995).

431. See, e.g., Stefan Grond et al., *Validation of World Health Organization Guidelines for Cancer Pain Relief During the Last Days and Hours of Life*, 6 J. PAIN & SYMPT. MGMT. 411 (1991); V. Ventafridda et al., *A Validation Study of the WHO Method for Cancer Pain Relief*, 59 CANCER 851 (1987).

432. See Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J. 528, 538-57 (1976).

less, the guidelines are intended to positively influence the behaviors of all physicians who care for patients with pain, and not simply those who aspire to become pain specialists.⁴³³ Consequently, judicial recognition of national CPGs for pain management would constitute a shift from the customary practice version of the standard of care. The concern would no longer be to determine what physicians generally do in caring for patients with pain, but to determine what they should be doing.⁴³⁴ When courts proceed in this fashion, they implicitly recognize, as did Judge Hand in *The T.J. Hooper*,⁴³⁵ that an entire profession may lag behind in its practices, but they are much less vulnerable than the *Helling* court to the critique that no medical authority in the record supported the judicial determination of the standard of care. For example, the court's recognition of the AHCPH Clinical Practice Guidelines as the national standard of care for pain management, would shift the inquiry of the trier of fact from what physicians customarily do to what they ought to do.⁴³⁶ A demonstrable failure to become conversant with and make a good faith effort to comply with such guidelines in the care of patients with pain would shift the burden of proof to the defendant physician to justify a material deviation from the guidelines.⁴³⁷ An actual example of such an approach follows.

433. There is a legitimate concern that the development of recognized specialty groups in pain management and palliative care will suggest that physicians generally need not develop and maintain proficiency in these aspects of clinical practice, but need only refer patients to or obtain consultations from such specialists when significant problems persist. With the ever-increasing shift toward managed care and its heavy reliance on primary care physicians, such an approach would exacerbate the problem of under-treated pain and poor quality end-of-life care. Consequently, prominent pain specialists share the view of Kathleen Foley who insists that: "All physicians should be familiar with the use of analgesics to manage acute and chronic pain in medical illness effectively. The patient's primary physician should assume this role." Foley, *supra* note 59, at 15.

434. Leahy makes precisely this point in his article on CPGs and the standard of care. See Leahy, *supra* note 427, at 1525.

435. 60 F.2d 737 (2d Cir. 1932).

436. Further impetus for and justification of the recognition of the AHCPH pain management guidelines as a national standard has been provided by the recent promulgation of model pain management guidelines by the Federation of State Medical Licensing Boards, inasmuch as these model guidelines specifically incorporate the AHCPH guidelines by reference. See FEDERATION OF STATE MEDICAL LICENSING BOARDS, MODEL GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN (1998). As more state medical boards adopt these or similar guidelines, an implicit recognition of the AHCPH guidelines as the national standard may clearly emerge.

437. See Leahy, *supra* note 427, at 1525.

E. *A Case in Point*—James v. Hillhaven Corp.

Given the documentation of a widespread practice among health care professionals of undertreating pain, it may be surprising to learn that there are no reported cases in which a physician has been held liable for allowing a patient to suffer because of a failure to provide appropriate pain relief.⁴³⁸ However, in February of 1999, what appears to be the first malpractice suit against a physician grounded primarily upon the physician's failure to properly manage a patient's pain, was filed in the Superior Court of California.⁴³⁹ The patient, now deceased, and his primary physician were also involved in a complaint of substandard care filed with the California Medical Board.⁴⁴⁰ The complaint against the physician, Eden Medical Center, and others sought general, special and punitive damages for medical negligence, willful misconduct, and negligent and intentional infliction of emotional distress upon the patient and his family, the plaintiffs in the action.⁴⁴¹ The complaint was not filed until after the medical board concluded that inadequate pain relief had been provided but declined to take any disciplinary action against the physician.⁴⁴²

A plausible explanation for the absence of such suits is that lay persons generally assume that most health professionals actually do manage pain as effectively as possible without creating unreasonable risk of harm from the side effects of narcotic analgesics. Consequently, unrelieved pain and suffering from illness or infirmity is presumed to be genuinely "intractable," in other words, beyond the powers of medical science to safely and effectively alleviate and with which the patient must learn to cope.⁴⁴³

438. A possible exception is *Gaddis v. United States*, 7 F. Supp.2d 709 (D. S.C. 1997). This medical malpractice judgment in excess of \$1 million against the Veterans Administration did include an award of \$125,000 for pain and suffering based largely upon the defendant's failure to provide sufficient pain medication during the final days of the patient's life. *See id.* at 717. However, the primary claim and the bulk of the total damage award was based upon a failure to timely diagnose and properly treat the patient's throat cancer. *See id.*

439. *See Bergman v. Chin*, No. H205732-1 (Cal. App. Dep't. Super. Ct. Feb. 16, 1999).

440. *See id.*

441. *See id.*

442. *See id.*

443. Patient satisfaction surveys have at times failed to establish a correlation between significant levels of pain and patient dissatisfaction with care, suggesting that yet another barrier to improving pain management is exceeding the low

An unreported case has achieved a certain degree of notoriety by virtue of its mention in a medical journal.⁴⁴⁴ The patient in this case, Henry James, was an elderly resident of a nursing home owned by the defendant corporation who was dying of metastatic prostate cancer.⁴⁴⁵ He came to the North Carolina facility with a prescription for morphine to control his pain.⁴⁴⁶ A nurse employed by the defendant concluded that Mr. James was "addicted to morphine."⁴⁴⁷ She made the determination that the patient should receive only a mild tranquilizer for such distress as he might encounter in his dying without consulting with the prescribing physician or any other medical professional.⁴⁴⁸ Following his death, Mr. James's family sued the nurse and her employer alleging that her refusal to provide the prescribed morphine caused him to suffer significant and unnecessary pain, suffering, and mental anguish and constituted "inhuman treatment."⁴⁴⁹

At trial, the plaintiff presented testimony by medical experts from the National Institutes of Health substantiating the appropriateness of administering sustained doses of morphine for the management of cancer pain.⁴⁵⁰ Additional expert testimony was presented by a nurse specializing in quality assurance for long term care facilities, who indicated that among the well-recognized rights of patients, particularly those who are terminally ill, is appropriate pain management.⁴⁵¹

patient expectations of pain relief. See, e.g., Christine Miaskowski et al., *Assessment of Patient Satisfaction Utilizing the American Pain Society's Quality Assurance Standards on Acute and Cancer-Related Pain*, 9 J. PAIN & SYMPT. MGMT. 5, 9-10 (1994).

444. See *Estate of Henry James v. Hillhaven Corp.*, No. 89 CVS 64 (N.C. Super. Ct. Jan. 15, 1991). See, e.g., Robyn S. Shapiro, *Liability Issues in the Management of Pain*, 9 J. PAIN & SYMPT. MGMT. 146, 147 (1994).

445. See Shapiro, *supra* note 444, at 147.

446. See *id.*

447. See *id.*

448. See *id.*

449. See *id.*

450. See Telephone interview with Mickey Herrin, Esq., Defense Counsel for Hillhaven Corp. (May 1996.)

451. See Shapiro, *supra* note 444, at 147. Among the national professional organizations that have recognized the duty to provide effective pain relief to dying patients is the JCAHO. See Accreditation Manual, Patient Rights, RI.1.1.2.2.2; AMA CODE OF MEDICAL ETHICS, § 2.20 (American Nurses Association, Compendium of Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients). Both the AMA and ANA pronouncements go so far as to affirm the appropriateness, when necessary, of administering large doses of narcotic analgesics, even if they might hasten death. See *id.*

The jury returned a verdict of \$7.5 million in compensatory damages and another \$7.5 million in punitive damages.⁴⁵² Motions by the defendant to set aside the verdict and for a new trial had been taken under advisement by the trial judge when the insurance carrier for Hillhaven promptly settled the case for an undisclosed amount that was approved by the court.⁴⁵³

The case of Henry James bears a striking resemblance to a scenario recounted by Margaret Sommerville in an address to the 7th World Congress on Pain.⁴⁵⁴ The critical difference between the two is that the patient in the latter was in a hospital rather than a nursing home. In addition, the health care professional whose conduct was at issue was a physician rather than a nurse. As Sommerville relates the story, a physician on night call at a Canadian hospital was summoned to the bedside of a man in severe pain from metastatic prostate cancer.⁴⁵⁵ When she examined his chart, the only pain medication that had been ordered was Tylenol.⁴⁵⁶ She changed the order to morphine, which brought his pain under control, and instructed the nursing staff to administer it on a continuing basis to keep the patient comfortable.⁴⁵⁷ Two nights later she was again taking night call and was summoned by a nurse to the same patient.⁴⁵⁸ On her way to see the patient, the physician commented that a higher dose of morphine would probably be necessary.⁴⁵⁹ The

452. See Shapiro, *supra* note 444, at 147.

453. See *Estate of Henry James v. Hillhaven Corp.*, No. 89 CVS 64 (N.C. Super. Ct. Jan. 15, 1991). What is striking about the jury's verdict in the *James* case is not just its sheer magnitude, but the sense of moral outrage which the punitive damage award expresses. In assessing the settlement value of the case, the defendants, their counsel, and the insurance company sought to answer a straightforward question: what could a few months of pain be worth? The jury's answer suggests a monumental disparity in the significance attached to the practice of undertreated pain between the general public and health professionals and those who regulate, employ, insure, and represent them. The jury's clear message that undertreated pain, particularly in the case of patients who only have a few months to live, is a moral outrage lends credence to Eric Cassell's much earlier observation that the relief of suffering is considered by the lay public, but not by physicians, to be one of the primary ends of medicine. See Cassell, *supra* note 4, at 639.

454. See Sommerville, *Death of Pain: Pain, Suffering, and Ethics*, *supra* note 209, at 43.

455. See *id.*

456. See *id.*

457. See *id.*

458. See *id.*

459. See *id.*

nurse told her the patient was not on morphine, but Tylenol.⁴⁶⁰ Remarkably, the very next day the patient's attending physician had reversed the order for morphine.⁴⁶¹ The patient was back on Tylenol, and the physician actually went so far as to write a note in the chart that he would not have his patients turned into drug addicts.⁴⁶² A complaint to hospital administration by the night call physician produced nothing but a timid response that they were aware of this physician's attitude toward narcotic analgesics.⁴⁶³ However, the doctor had resisted any suggestion that he modify his pain management practices.⁴⁶⁴

Professor Sommerville, a Canadian attorney, suggests that a "radical" response to such unconscionable situations would be malpractice litigation.⁴⁶⁵ The case of Henry James suggests that initiating a malpractice suit alleging a duty to appropriately manage pain is not all that radical given the history of American medical jurisprudence. It would simply be the latest instance in which medicine's failure to set, in a timely way, a standard of care consistent with reasonable prudence and humane care resulted in judicial standard-setting.

In the hypothetical case outlined at the beginning of this section,⁴⁶⁶ the strength of the plaintiff's case from a clinical perspective draws upon several elements. First, because the patient was made comfortable when under the care of the pain service during both hospitalizations, roughly two months apart, the defense cannot credibly claim that her pancreatic cancer, at any point along the continuum, was producing pain that was in any practical sense unmanageable. Furthermore, the effective control of her pain at home during the last two weeks of her life clearly indicates that she did not require hospitalization in order to achieve pain relief. In each instance, the hospital was merely the conduit through which the patient gained access to clinicians with the knowledge, skills, and attitudes that were necessary to provide her with the required type of pain relief.

If the plaintiff undertakes to establish the care provided by the

460. *See id.*

461. *See id.*

462. *See id.*

463. *See id.*

464. *See id.*

465. *See id.* at 49.

466. *See supra* Section IX.A.

members of the pain service as the applicable standard, one possible element of the defense will be that such a standard is too high when applied to all physicians, rather than to only those who specialize in pain management and palliative care. However, in discharging the pain service and changing the pain management regimen, the patient's attending physician was implying that he knew more than, or at least as much as those on the pain service about what the patient required. As a result, the physician may well be estopped from asserting at trial that it is unreasonable to hold him to a standard of care which they were capable of, and in fact did provide to the patient. He also had ample evidence, during the period between the two hospitalizations, which his regimen was not providing the patient with adequate pain control. At the very least, due diligence would require that the physician acknowledge the ineffectiveness of his treatment and seek further consultation on the case from the pain service. Another option which the attending physician failed to offer the patient was a referral to a local hospice, which in all likelihood would also have been able to provide her with an appropriate level of comfort care in her home in the months before her death.

The patient should have little difficulty producing an expert in the field of pain management who will testify that the most important distinction between the palliative care provided by the pain service and that provided by the defendant physician is that the former was consistent with the AHCPDR clinical practice guidelines,⁴⁶⁷ while the latter was *not*. If the jurisdiction is one in which the medical board has adopted guidelines similar to the Federation model,⁴⁶⁸ the language may be sufficient to support the argument that they have implicitly incorporated the national guidelines as the applicable standard for all physicians in the state.

Ultimately, the strength or weakness of the plaintiff's case may be of less significance than the posture of the jurisdiction in which it arises with regard to recovery of damages for pain and suffering in medical malpractice cases. This is true especially when, as here, the claim is being brought on behalf of a now-deceased patient. Tort reform in many jurisdictions has created significant disparities in the viability of a claim such as the one we are considering.⁴⁶⁹ The

467. See generally AHCPDR, *supra* note 121.

468. See FEDERATION OF STATE MEDICAL LICENSING BOARDS, *supra* note 436.

469. See generally Eleanor D. Kinney, *Learning from Experience, Malpractice Reforms*

next section considers this issue.

X. THEORIES OF RECOVERY

We can see from the *James* case that North Carolina is an example of a jurisdiction in which the changes wrought by tort reform legislation do not preclude a sizeable recovery for non-economic damages such as pain and suffering in an action initiated by a personal representative after the death of the injured party from causes unrelated to the injury.⁴⁷⁰ Such jurisdictions have not capped pain and suffering awards at some arbitrary figure such as \$500,000 or in some instances even as low as \$250,000.⁴⁷¹ Nor do they preclude a claim for pain and suffering from surviving the death of the injured party so that it can be pursued by the personal representative.⁴⁷² In a jurisdiction that had modified traditional tort law in these two ways, Henry James's claim would have died with him, and the only possible recovery would be for the pain and suffering of his family in observing his last painful months of life. There would be little enthusiasm on the part of prospective counsel for pressing a novel medical malpractice claim in one of these reform jurisdictions.

If under-treated pain gains recognition as a material departure from an emerging standard of care, there may be a persuasive public policy justification for amending those statutory provisions that unduly restrict claims based upon a departure from it. After all, the only meaningful recovery for the victims of the undertreated pain of a terminal illness is one based upon unnecessary pain and suffering, and the only practicable way that such a claim can be pursued is through a personal representative of the estate. The jury in the *James* case, through the magnitude of its verdict, sent a strong message that should be acknowledged by legislators in states that are currently hostile environments for similar cases. That unequivocal message is that when a patient has only a few months of life remaining, freedom from unnecessary pain and suffering is a matter of extreme consequence to the patient and those who are close to them. A few months of such pain, when it is avoidable

in the 1990's: *Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99 (1995).

470. See *supra* notes 452-53 and accompanying text.

471. See *supra* note 452 and accompanying text.

472. See *supra* note 439 and accompanying text.

through the application of readily available state-of-the-art palliative medicine, is a civil wrong for which significant damages ought to be recoverable for those representing the interests of the victim of medical malpractice.

XI. CONCLUSION

The heated debate over physician-assisted suicide has finally, or so it seems, forced the medical profession to examine the extent to which it has tolerated a deplorable amount of ignorance, misinformation, and paranoia to prevent the emerging standard of practice for pain management and palliative care from informing, indeed, transforming clinical practice patterns. But the prevailing perception is that there is only a clinical problem to be sorted out entirely within the profession. If such a proposition had been put to the public and policy makers by the health care profession twenty-five years ago, when data suggesting the nature and extent of the problem first emerged, a regulatory and legal moratorium might have been justified. But as we have seen, there has been a quarter century in which the voices of reform within health care have been crying in a wilderness of denial, disinterest and entrenchment in the failed practices of the past. Now one can justifiably argue that meaningful change, i.e., adherence to a recognized standard of care in which unrelieved pain is extremely rare in any patient care setting, can only happen when medical ethics and medical jurisprudence are brought to bear in such a way as to create genuine professional and institutional accountability. The objective of such reform measures must be to make abundantly clear that allowing patients to suffer unnecessarily constitutes an unprofessional and unethical medical practice that will not be tolerated by the larger society which medicine exists to serve.

One of the most important legacies of the litigation over the purported right to physician-assisted suicide may be the significance which a majority of the justices attached to effective pain relief for dying patients in *Washington v. Glucksberg*.⁴⁷⁵ The opinions of

475. 521 U.S. 702 (1997). Although accounts in the popular press generally focused on the unanimous decision of the Court against a right to physician-assisted suicide, a number of legal commentators discussed the pain management aspect of the concurring opinions in the major medical journals. See George J. Annas, *The Bell Tolls for a Constitutional Right to Physician-Assisted Suicide*, 337 NEW ENG. J. MED. 1098, 1098 (1997); Robert A. Burt, *The Supreme Court Speaks: Not*

five of the justices in the physician-assisted suicide *Glucksberg* case either directly stated or strongly intimated that state laws or other forms of state action which placed undue burdens upon a physician's ability to provide, or a patient's ability to secure palliative measures might not survive close judicial scrutiny.⁴⁷⁴ The broader implication is that this nation's highest court believes that providing patients with state-of-the-art pain relief is a matter of great consequence with moral, legal, and even constitutional dimensions.⁴⁷⁵

Assisted Suicide but a Constitutional Right to Palliative Care, 337 NEW ENG. J. MED. 1234 (1997); Lawrence O. Gostin, *Deciding Life and Death in the Courtroom: From Quinlan to Cruzan, Glucksberg and Vacco: A Brief History and Analysis of Constitutional Protection of the Right to Die*, 278 JAMA 1523 (1997).

474. Justice O'Connor's brief concurring opinion in this case contains the following important observation:

The parties and *amici* agree that in these States [Washington and New York] a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death. . . . In this light, . . . I agree that the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not be truly voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide.

Glucksberg, 521 U.S. at 736-37 (1997) (O'Connor, J., concurring). While Justice Ginsberg joined in this concurrence without further comment, *id.* at 789, other concurring justices expanded and elaborated on issue of pain relief raised by these cases. Justice Breyer, for example, added the following points:

As Justice O'Connor points out, the laws before us do not *force* a dying person to undergo that kind of pain. . . . Rather, the laws of New York and Washington do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill. . . . Were the legal circumstances different—for example, were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law's impact upon serious and otherwise avoidable physical pain (accompanying death) would be more directly at issue. And as Justice O'Connor suggests, the Court might have to revisit its conclusions in these cases.

Id. at 791 (Breyer, J., concurring). Justices Stevens, *id.* at 738, and Souter, *id.* at 752, also indicated that governmental impediments to the provision of effective palliative measures would, in and of themselves, warrant further judicial review.

475. For a discussion of moral and legal implications of unrelieved pain, see Seth F. Kreimer, *The Second Time as Tragedy: The Assisted Suicide Cases and the Heritage of Roe v. Wade*, 24 HASTINGS CONST. L.Q. 863, 887-901 (1997).

