

The Chilling Effect of Pain

Myra Christopher, President and CEO, Center for Practical Bioethics

Without question, it would be considered not only unprofessional but unconscionable for a physician to refuse to set a broken limb. The physician would be subject to scorn from his or her peers and to possible discipline by the state medical board. However, if the same physician set the limb but did little or nothing to treat the accompanying pain, it is highly likely that there would be no negative consequences for the physician. The negative consequences would be borne by the patient alone.

The undertreatment of both chronic and acute pain is a serious public health issue in our society and, as implied above, the Center for Practical Bioethics also believes it is a significant ethical issue. The root of this problem is complex; however, various studies indicate that one of the main reasons physicians give for undertreating pain is the “chilling effect,” that is, the fear of scrutiny by law enforcement or regulatory agents when prescribing controlled pain medications.

Furthermore, following the highly publicized 2004 conviction of William Hurwitz, MD, a pain management physician in Virginia, there was a perception among physicians that investigations of physicians were increasing dramatically and that pain management doctors were being specifically targeted. In an online survey the Center sent to physician members of the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM), 67% of respondents said they felt “Drug Enforcement Administration (DEA) investigations and prosecutions of physicians for violations involving controlled pain medications had been ‘more frequent’ over the past 3 to 5 years.” More than one-third (35%) said they were “very

concerned” or “extremely concerned” that their pain management practices might be investigated at some time in the future because they were prescribing controlled pain medications (Center for Practical Bioethics, unpublished data, 2006).

The Balanced Pain Policy Initiative

“Good ethics start with good facts” is an unofficial mantra at the Center. In 2006 the Center, in partnership with the Federation for State Medical Boards (FSMB) and National Association of Attorneys General (NAAG), convened a national task force and created The Balanced Pain Policy Initiative. The task force comprises high-level representatives from AAPM, APS, the American Cancer Society, the American Academy of Family Physicians, the American Pain Foundation, the DEA, and the Pain and Policy Studies Group, among others. For its initial collaboration effort, members of the task force decided to research the validity of physicians’ concerns that can result in the chilling effect.

Nearly one thousand (986) criminal and administrative cases filed against 725 physicians charged with mishandling or diverting controlled substances between 1998 and 2006 were analyzed. The results of this analysis, published in *Pain Medicine* in September 2008,¹ concluded that criminal or administrative charges and sanctions for prescribing opioid analgesics are rare. There appears to be little concrete evidence that pain specialists have been singled out for prosecution or administrative discipline for such offenses.

The number of DEA investigations of physicians suspected of violations related to prescribing controlled substance medications (including opioid

analgesics) has increased in recent years. Between 2003 and 2006, DEA criminal investigations increased 31.6%. This seems dramatic, however the actual numbers are relatively low—rising from 193 criminal investigations in 2003 to 254 investigations in 2006—and reflect only the number of investigations, not actual charges.¹

The Center for Practical Bioethics and our partners are acutely aware, however, that regardless of the relatively few cases identified in our study, physicians are likely to react with alarm to media reports on the subject and are sensitive to their experiences with investigations that were ultimately dismissed. One of the conclusions stated in the *Pain Medicine* article was that regulators and law enforcement agents need to improve how they craft public messages, including those to physicians, and how they handle investigations of medical practice.

The Law Enforcement Roundtable

A coalition led by the Center is trying to improve the treatment of pain by fostering collaboration among medicine providers, law enforcement agents, consumer advocates, and policymakers. In fall 2007 the Center, along with its primary partners FSMB and NAAG, convened the Law Enforcement Roundtable. This diverse group includes representatives from the DEA, state licensing boards, US attorneys, district attorneys, representatives from the American Bar Association, private practice attorneys, legal scholars, and drug diversion investigators, along with pain specialists, third-party payers, policymakers, and patient advocates. The group met twice, first in Dallas and then in Washington, DC. Over two days

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marked by frank discussion with a spirit of openness and candor, the Roundtable discussed tools to achieve everybody's goal: a balanced pain policy. The result of their deliberations is a policy brief published in February 2009 titled *Balance, Uniformity and Fairness: Effective Strategies for Law Enforcement for Investigating and Prosecuting the Diversion of Prescription Pain Medications While Protecting Appropriate Medical Practice*.²


The brief outlines six key strategies:

1. **Distinguish between criminal behavior and medical negligence.** The Roundtable developed a simple, five-step procedural template to help law enforcement agents assess a doctor's behavior and determine when to refer investigations to medical licensure boards for evaluation and when to pursue criminal charges.
2. **Balance publicity.** The Roundtable recommends that law enforcement agents follow the guidelines of the Department of Justice Media Relations Rules and those of the American Bar Association.
3. **Access experts.** Law enforcement, particularly at the local and state levels, often does not have a well-qualified pain medicine expert to consult. Leading pain societies plan to develop a roster of national experts who agree to be available to law enforcement for informal "curbside consultation."
4. **Use technological aids.** Electronic prescription-monitoring programs can provide important information for doctors in identifying drug-seeking behavior and are preferable to outdated triplicate prescription forms, but they are not a law enforcement tool and should only be available to law enforcement agents as part of the investigation of an active case and only with appropriate procedural safeguards.
5. **Collaborate with other agencies.** When legally possible and ethically appropriate, law enforcement agents; state, local, and federal investigators; medical boards; and third-party payers should share information regarding the investigation of a suspect physician. Physicians whose behavior arguably

falls into a "gray area" between criminal and regulatory should be deferred to state medical boards for evaluation and corrective action.

6. **Educate.** Education on all sides is critical. Law enforcement agents should seek to learn the basics of good pain management for chronic pain sufferers and critically ill patients. It is also important to educate consumers about the role opioids and other pain medicines play in a quality medical practice and the importance of ensuring that their prescriptions are for their use only.

Finding Common Ground

No medical practitioner wants to see a loved one experience unnecessary pain, nor would he want to see the future of a child or grandchild dashed by an addiction to prescription drugs. The undertreatment of pain and the abuse of prescription drugs are critical public health issues, and a tension exists between the two. Tension can be either negative or positive. The Center for Practical Bioethics and our partners believe the Balanced Pain Policy Initiative shows that, by recognizing this tension and committing to work together in a spirit of collaboration, openness, and candor on the part of all involved—pain medicine experts, those responsible for law and regulatory enforcement, consumer advocates, and policymakers—we can find common ground and work toward positive change. 

References

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Myra Christopher is president and CEO of the Center for Practical Bioethics in Kansas City, MO. She can be contacted at the Center for Practical Bioethics, 1111 Main Street, Suite 500, Kansas City, MO, 64105, or by e-mail at mchristopher@practicalbioethics.org.