

**NOTE: A PAINFUL CATCH-22: WHY TORT LIABILITY  
FOR INADEQUATE PAIN MANAGEMENT WILL MAKE  
FOR BAD MEDICINE**

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Several commentators have advocated for a new cause of action against medical care providers who fail to appropriately treat pain.<sup>1</sup> The commentators base their advocacy on recognition from new research and advances in pain treatment that provide a better understanding of how to adequately treat pain. The research provides guidelines for more successful treatment and management of pain, and establishes that previous fear about opioids<sup>2</sup> may have been overestimated. This new research also revealed that pain is grossly undertreated in the United States.<sup>3</sup>

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1. See Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J.L. MED. & ETHICS 28, 33-41 (2001) (addressing tort liability for inadequate pain management and discussing several possible theories for plaintiff recovery); Gilah R. Mayer, *Bergman v. Chin: Why an Elder Abuse Case is a Stride in the Direction of Civil Culpability for Physicians Who Undertreat Patients Suffering from Terminal Pain*, 37 NEW ENG. L. REV. 313, 314 (2003) (advocating that courts impose medical practice guidelines for the treatment of pain); Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1, 4-5 (2000) (advocating that new clinical practice guidelines be used as appropriate standard of care in inadequate pain management medical malpractice suits); Tonya Eippert, Note, *A Proposal to Recognize a Legal Obligation on Physicians to Provide Adequate Medication to Alleviate Pain*, 12 J.L. & HEALTH 381, 402 (1998) (proposing that courts recognize a medical malpractice claim when a physician fails to render adequate pain relief and objective evidence establishes the existence of pain); Jacob B. Nist, Note, *Liability for Overprescription of Controlled Substances: Can it be Justified in Light of the Current Practice of Undertreating Pain?*, 23 J. LEGAL MED. 85, 86 (2002) (discussing “the prevalence of prescription drug addiction” and proposing that physicians should only be held liable for inadequate treatment of pain if the physician acted in bad faith); Rima J. Oken, Note, *Curing Healthcare Providers’ Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917, 1923 (2002) (presenting model legislation holding healthcare providers liable for providing inadequate palliative care to their patients); Michael J. Reynolds, Note, *Morphine or Malpractice: Should Courts Recognize a Legal Duty to Prescribe Opiates for Treating Chronic Pain*, 15 ST. JOHN’S J. LEGAL COMM. 79, 81 (2000) (concluding it is necessary for the courts to provide a remedy for inadequate pain treatment).

2. The term “opioids” has replaced the terms “narcotics,” and “co-analgesics.” Opioids bind to opioid receptors in the central nervous system, which modify the sensory and affective aspects of pain.

3. See generally Kathleen Murphy-Ende, *Barriers to Palliative and Supportive*

The commentators present arguments on two fronts in their articles. First, now that new standards for the treatment of pain have been formulated and shown to work and that physician fear related to opioid addiction has been shown to be overstated, physicians who treat pain should be held to a duty to adequately treat their patient's pain. Second, the courts, through malpractice cases, should force the adoption of the new practices by imposing them now as the standards of care, thus holding physicians liable when a patient unnecessarily suffers pain.<sup>4</sup> One scholar advocates legislative changes, including tort liability, for failure to adhere to the new standards.<sup>5</sup> Several other scholars advocate for recognition of the new standards in courts and for holding physicians liable by expanding common law medical malpractice theories to include inadequate pain treatment.<sup>6</sup>

The basic premise of the scholar-advocates for tort liability in the area of inadequate pain treatment is the necessity of pressuring physicians to respond more quickly to advances in pain management techniques.<sup>7</sup> Each scholar notes that medical schools have failed to adequately train new physicians in pain management<sup>8</sup> and that physicians are traditionally biased toward undertreating pain because of unfounded fears of opioid addiction.<sup>9</sup> The scholars also argue that the pressure of potential tort liability is necessary to counteract other influences that discourage physicians from adequately prescribing opioids, such as potential criminal liability, civil liability, and state medical board disciplinary actions

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*Care*, 36 NURSING CLINICS OF N. AM. 843 (2001) (discussing the need for advances in pain management for end-of-life care); Marilyn Frank-Stromborg & Anjeanette Christensen, *A Serious Look at the Undertreatment of Pain: Part II*, 5 CLINICAL J. OF ONCOLOGY NURSING 276 (2001) (contrasting the need for complete pain management with the risk of overtreatment); Rich, *supra* note 1; Francis X. Mahaney, Jr., *Proper Relief of Cancer Pain is Worldwide Concern*, 87 J. NAT'L CANCER INST. 481 (1995).

4. See Furrow, *supra* note 1, at 33-34 (discussing courts' role in adopting new standards of care by imposing new guidelines in malpractice cases).

5. Oken, *supra* note 1, at 1992.

6. See Furrow, *supra* note 1, at 43; Mayer, *supra* note 1, at 316; Rich, *supra* note 1, at 2-3; Eippert, *supra* note 1, at 399-404; Nist, *supra* note 1, at 111; Reynolds, *supra* note 1, at 80.

7. See sources cited *supra* note 6.

8. Furrow, *supra* note 1, at 28; Mayer, *supra* note 1, at 313; Rich, *supra* note 1, at 14-21; Eippert, *supra* note 1, at 390-91; Nist, *supra* note 1, at 93; Oken, *supra* note 1, at 1933; Reynolds, *supra* note 1, at 88.

9. Furrow, *supra* note 1, at 28; Mayer, *supra* note 1, at 321; Rich, *supra* note 1, at 42-44; Eippert, *supra* note 1, at 386-88; Nist, *supra* note 1, at 87-88; Oken, *supra* note 1, at 1936-38; Reynolds, *supra* note 1, at 88-89.

for overprescribing.<sup>10</sup>

An additional issue alluded to by some scholars who advocate for broader tort liability relates to the care of patients who are terminally ill and in pain, but receive inadequate pain treatment.<sup>11</sup> In these circumstances, physicians have to consider the additional factor that opioids have the potential to kill the already-weakened patient.<sup>12</sup> Some scholars argue that physicians have an affirmative duty to relieve a terminal patient's pain despite the risk of hastening the patient's death.<sup>13</sup> They also argue that courts should impose this duty.<sup>14</sup> However, this implicates significant issues relating to physician-assisted suicide, a patient's right to die, and moral choices made by physicians when determining whether they are willing to take affirmative actions that could do harm. Although the Supreme Court held that "a patient has a constitutionally protected right to palliative care, even if such care has the ultimate effect of hastening death,"<sup>15</sup> the Court did not go so far as finding an affirmative duty to provide palliative care that could result in the untimely death of the patient.<sup>16</sup> At first glance, tort liability for inadequate pain treatment is appealing because it would theoretically pressure physicians to adopt the most current standards for pain treatment that should, in turn, help alleviate a patient's pain. However, tort liability does not account for the underlying causes of the problem; it simply exerts an additional pressure on physicians. In this case, additional pressure might not be an appropriate solution. Physicians are currently fearful of overprescribing opioids due to the potential for disciplinary actions and criminal proceedings, in addition to fears of possibly harming their patient.<sup>17</sup> A tort cause of action would do nothing to ease

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10. Furrow, *supra* note 1, at 28; Mayer, *supra* note 1, at 324-25; Rich, *supra* note 1, at 44-55; Eippert, *supra* note 1, at 401; Nist, *supra* note 1, at 85; Oken, *supra* note 1, at 1943-46; Reynolds, *supra* note 1, at 82-86.

11. Furrow, *supra* note 1, at 28; Mayer, *supra* note 1, at 313; Rich, *supra* note 1, at 6-14; Nist, *supra* note 1, at 87; Oken, *supra* note 1, at 1921; Reynolds, *supra* note 1, at 79-80.

12. See Myra Glajchen, *Chronic Pain: Treatment Barriers and Strategies for Clinical Practice*, 14 J. AM. BD. OF FAM. PRAC. 211, 216 (2001) (respiratory depression is an unwanted side effect of opioid therapy).

13. See Mayer, *supra* note 1, at 341; Oken, *supra* note 1, at 1992.

14. See Mayer, *supra* note 1, at 341; Oken, *supra* note 1, at 1992.

15. Oken, *supra* note 1, at 1956.

16. *Vacco v. Quill*, 521 U.S. 793, 801-03 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 736-38 (1997).

17. See generally David A. Fleming, *Relieving Pain: What Are Today's Ethical and Legal Risks?*, 99 MO. MED. 560, 560 (2002).

these fears. Rather, it would simply add an additional fear that could leave physicians feeling as though pain treatment is professionally untenable.

Other factors weigh against adding a cause of action for inadequate pain treatment. Inadequate pain treatment does not fit within the traditional notion of medical malpractice because a patient could not say that the physician caused the pain. Rather, the physician simply failed to alleviate the patient's pre-existing pain. In addition, pain is completely subjective—there is no diagnostic test a physician (or the courts) can use to verify the existence or amount of pain an individual is suffering<sup>18</sup>—thus, pain is not certain enough to allow tort liability. Finally, tort liability for inadequate pain treatment could result in fewer physicians practicing pain management and thereby increase the costs of pain treatment. The net result may be that some patients will not receive any treatment for their pain.

Part I of this note reviews current issues relating to pain treatment.<sup>19</sup> Part II examines theoretical justifications of proposed tort liability for inadequate pain management.<sup>20</sup> Part III examines how pain mismanagement does not fit within traditional notions of medical malpractice.<sup>21</sup> Part IV studies the issues relating to a physician's role as "gate-keeper" for opioids and suggests why tort liability could compromise this legislatively imposed role.<sup>22</sup> Part V examines the issue of pain management in the context of end-of-life care.<sup>23</sup> Part VI discusses current shifts in pain management philosophies and explains how these movements will effectuate the changes suggested by advocates of expanded tort liability.<sup>24</sup>

## I. THE TREATMENT OF PAIN

The underlying problem is that medical professionals have not kept their pain management practices and beliefs up to date with

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18. See JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, IMPROVING THE QUALITY OF PAIN MANAGEMENT THROUGH MEASUREMENT AND ACTION 4 (Mar. 2003), available at [http://www.jcaho.org/news+room/health+care+issues/pain+mono\\_jc.pdf](http://www.jcaho.org/news+room/health+care+issues/pain+mono_jc.pdf) [hereinafter JCAHO Pain Assessment].

19. See *infra* Part I.

20. See *infra* Part II.

21. See *infra* Part III.

22. See *infra* Part IV.

23. See *infra* Part V.

24. See *infra* Part VI.

the current research regarding pain treatment.<sup>25</sup> Clinical research by pain management specialists has established that traditional fears of patient addiction to opioids are largely unfounded.<sup>26</sup> This research also establishes that the traditional method of pain treatment on a “PRN” (as needed) basis is not the proper approach.<sup>27</sup> Instead, research has shown that optimum pain relief is obtained by providing continuous baseline dosages, which not only require smaller doses of opioids because the pain never “breaks through,” but also provide substantially greater pain relief because the patient does not have to suffer pain in order to obtain pain relief.<sup>28</sup> However, this methodology has not found its way into mainstream medical practice. The majority of physicians still prescribe opioids on a PRN basis.<sup>29</sup> In addition, the majority of physicians do not aggressively treat pain with controlled opioids out of fears of addiction and fears of criminal and professional sanctions for over prescribing opioids.<sup>30</sup>

Medical professionals are forced to choose between many competing priorities when managing a patient’s pain. The first priority is to minimize the patient’s pain. The second priority is to minimize the potential harm to the patient and to the physician. The potential harms include: patient addiction to opioid analgesics, premature patient death due to inhibition of respirations in weakened patients, compromised mental status of the patient, diversion of controlled substances from the patient to a drug abuser, abuse of controlled substances acquired fraudulently by patients,<sup>31</sup> administrative discipline, and criminal and/or civil liability for the physician for providing abused drugs.<sup>32</sup>

One factor often cited to explain why physicians have not changed their pain treatment practices is that medical schools do not provide adequate training in pain management.<sup>33</sup> In addition,

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25. Richard Penson et al., *Trust Violated: Analgesics for Addicts*, 8 THE ONCOLOGIST 199, 205 (2003).

26. See JCAHO Pain Assessment, *supra* note 18, at 17.

27. See Glajchen, *supra* note 12 at 213-14.

28. See *id.* (long-acting opioids, administered at regular intervals, reduce peak-and-trough effects found with short-acting opioids).

29. See Fleming, *supra* note 17.

30. *Id.*

31. See Glajchen, *supra* note 12, at 216-17.

32. See JCAHO Pain Assessment, *supra* note 18, at 17.

33. See Furrow, *supra* note 1, at 28; Mayer, *supra* note 1, at 320 n.64; Rich, *supra* note 1, at 5; Eippert, *supra* note 1, at 390-91; Nist, *supra* note 1, at 95; Oken, *supra* note 1, at 1933-34; Reynolds, *supra* note 1, at 88.

current standards of care do not adequately reflect advancements in pain management. This results in new doctors learning the same misinformation from prior generations.<sup>34</sup> A related factor is that “[m]edical regulators, such as state licensing boards, have not been as concerned about the care of an individual patient as they have been about protecting the public from inappropriate medical practices, such as the over prescribing of controlled substances.”<sup>35</sup> “[M]edical board members generally are aware that prescription drugs are abused with greater frequency than either heroin or marijuana. Consequently, these boards sometimes scrutinize the prescribing practices of physicians who order controlled substances to treat their patients’ pain.”<sup>36</sup> In addition to state regulators, the federal government plays a role. “[T]he DEA’s [Drug Enforcement Agency] law enforcement mindset . . . [gives] perhaps undue weight to the negative externalities associated with access to narcotics and not trusting health care professionals.”<sup>37</sup> The effect of this increased scrutiny on physicians’ prescribing practices has been to significantly discourage physicians from prescribing opioids to treat their patients’ pain.<sup>38</sup>

This is related to what may be the most significant barrier to effective pain control: the fear of addiction.

[T]here exists generally in today’s society a major concern about narcotic addiction. This understandable cultural concern is unfortunately also reflected in the medical community’s approach to treating patients suffering with pain. Many medical practitioners have justified their refusal to administer analgesics to patients in pain by adhering to their fear that the patient will become addicted to the medication.<sup>39</sup>

To some extent this is attributable to physician confusion about physical dependence versus addiction. Physical dependence is an expected side effect of long-term opioid use and is often characterized by drug “tolerance and is manifested by a drug class

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34. See sources cited *supra* note 33.

35. Frank-Stromborg, *supra* note 3, at 276.

36. *Id.*

37. Lars Noah, *Challenges in the Federal Regulation of Pain Management Technologies*, 31 J.L. MED. & ETHICS 55, 64 (2003).

38. See Furrow, *supra* note 1, at 33; Mayer, *supra* note 1, at 324-25; Rich, *supra* note 1, at 43; Eippert, *supra* note 1, at 387-88; Nist, *supra* note 1, at 87; Oken, *supra* note 1, at 1944-46; Reynolds, *supra* note 1, at 83-84.

39. Eippert, *supra* note 1, at 387 (citations omitted).

specific withdrawal syndrome that can be produced by . . . decreasing blood level of the drug.”<sup>40</sup> Addiction, on the other hand, “is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.”<sup>41</sup> Opioid addiction is a valid fear, but “[i]n general, patients in pain do not become addicted to opioids.”<sup>42</sup> For example, in the case of cancer pain, no study demonstrates that prescribing opioids for cancer pain contributes to addiction or drug-abuse problems.<sup>43</sup> Thus, physicians’ unfounded fears substantially contribute to their practice of inadequate pain management. However, although addiction rates are lower than historically believed, there is still the potential for patients to become addicted to opioids as “studies report drug abuse/dependence/addiction in 3 to 19 percent of chronic pain patients.”<sup>44</sup>

In addition, the abuse of pain-relieving drugs is a phenomenon that is growing at a staggering rate in the United States. The latest research indicates that the number of new pain-reliever abusers increased more than four fold between 1990 and 2000<sup>45</sup> to a level equivalent to that of new marijuana abusers.<sup>46</sup> To put this growth in perspective, between 1990 and 2000 only ecstasy added new users/abusers at a higher rate.<sup>47</sup> Thus, while there appears to be limited problems with pain reliever addiction by sufferers of cancer and chronic pain, there is a substantial and growing problem with the abuse of pain relieving drugs by non-medical users/abusers.

Barriers from patients and their family can also work against effective pain management. “Patients may be reluctant to report

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40. JCAHO Pain Assessment, *supra* note 18, at 17.

41. *Id.*

42. *Id.*

43. Murphy-Ende, *supra* note 3, at 846.

44. Dawn A. Marcus, *Treatment of Nonmalignant Chronic Pain*, 61 AM. FAM. PHYSICIAN 1331, 1337 (2002).

45. See Substance Abuse and Mental Health Services Administration, *Results from the 2002 National Survey on Drug Use and Health: National Findings*, Chapter 6, Figure 6.3 (Sept. 2003), available at <http://www.drugabusestatistics.samhsa.gov/nhsda/2k2nsduh/2k2SoFW.pdf> [hereinafter 2002 Drug Survey] (stating “[p]ain reliever incidence [of new non-medical users] increased from 1990, when there were 628,000 initiates, to 2000, when there were 2.7 million”).

46. *Id.* Comparing Figure 6.1 with Figure 6.3 shows there were 2.4 million new abusers of pain relievers *versus* 2.6 million new marijuana users in 2001. *Id.*

47. *Id.* Comparing Figure 6.2 with Figure 6.3 shows there were 168,000 new users in 1993 *versus* 1.9 million in 2000—an increase of over eleven fold. *Id.*

pain because they do not want to distract their physician from treating the disease, for fear of injections, or because pain signifies disease progression.”<sup>48</sup> “[M]any patients and caregivers believe that pain is an unavoidable consequence of cancer and do not attempt to alleviate it.”<sup>49</sup> “Misconceptions about addiction and tolerance and concerns about opioid-related side effects, including constipation, nausea, confusion, or drowsiness, may prevent patients from taking prescribed medications.”<sup>50</sup> Patient failure to adhere to pain management plans due to forgetfulness can also lead to poor pain control and has been identified as a major barrier to effective pain management.<sup>51</sup> A patient’s personal experience, cultural and religious beliefs, and attitudes toward pain and medication may also affect pain management and reporting.<sup>52</sup> Finally, a lack of insurance coverage for many forms of long-term pain-management treatments and drugs may prevent many patients from gaining proper access to pain management.<sup>53</sup> For example, Medicare does not cover oral-prescription pain medication for most outpatients.<sup>54</sup>

#### A. *Types of Pain*

There are three basic categories of pain that are relevant to a discussion regarding expanding tort liability for failing to adequately treat pain: acute pain, chronic pain that is nonmalignant, and pain that is associated with a terminal condition such as cancer.<sup>55</sup> Each type of pain requires varied considerations by the medical professional treating the pain. One extreme is the case of pain associated with a terminal or incurable condition, where it is appropriate for the physician to stop aggressive curative measures and to concentrate instead on palliation, which is characterized by “a singular focus on maximizing the quality of the

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48. Murphy-Ende, *supra* note 3, at 844.

49. *Id.*

50. *Id.* at 845.

51. *Id.*

52. See JCAHO Pain Assessment, *supra* note 18, at 16.

53. Diane E. Hoffmann, *Pain Management and Palliative Care in the Era of Managed Care: Issues for Health Insurers*, 26 J.L. MED. & ETHICS 267, 267 (1998).

54. Jeff Grabmeier, *Fear of Regulators Keeps Some Doctors from Good Pain Treatment* (Feb. 26, 1999), at <http://researchnews.osu.edu/archive/painman.htm>.

55. There are other categories of pain that are relevant to medical diagnosis and treatment, but are not directly relevant to a discussion of tort liability for inadequate pain management.

patient's life."<sup>56</sup> In this case, fear of addiction or abuse should not be significant considerations beyond their effect on the quality of the patient's remaining life. Another extreme is the case of acute pain where there are other significant considerations. In the case of acute pain, such as a rotator cuff injury, it is often necessary to minimize pain treatment in order to promote healing of the underlying problem because the opioids used to treat pain can "produce lethargy, apathy, physical dependence[,] and depression" that could interfere with healing.<sup>57</sup> In other cases of acute pain, such as postoperative pain, adequate pain management is essential to promote healing.<sup>58</sup> The final type of pain, chronic pain that is nonmalignant, can pose the most significant challenge to the physician because the pain treatment has to be balanced against the potential for addiction, quality of life, and the potential for diversion of opioids for illicit purposes.<sup>59</sup> These different types of pain are significant when considering a legal duty for physicians to alleviate pain because in each circumstance the justification for imposing a legal duty on the physician is different. At the same time, consideration should also be given to the idea of not imposing a legal duty on physicians to adequately control the patient's pain.

*B. Prescription Drug Abuse and the War on Drugs*

The "War on Drugs" and prescription drug abuse have had significant impacts on physicians prescribing opioids and other controlled substances.<sup>60</sup> The social "evils" of drug abuse, including prescription drug abuse, are regularly publicized in the media.<sup>61</sup> This has affected the public's perception of opioids to the point that there is a social stigma against their use. For example,

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56. Rich, *supra* note 1, at 3.

57. Carlton Miller, *Arthritis and the Role of the Physician in Nonmalignant Pain and Disability*, 16 J. HEALTH & SOC. POL'Y 33, 39 (2002).

58. See Benzion Beilin et al., *The Effects of Postoperative Pain Management on Immune Response to Surgery*, 97 ANESTHESIA & ANALGESIA 822, 826 (2003); see also Inger F. Oey et al., *Postoperative Pain Detracts from Early Health Status Improvement Seen After Video-assisted Thoracoscopic Lung Volume Reduction Surgery*, 24 EUR. J. CARDIO-THORACIC SURGERY 588, 588 (2003).

59. See generally Glajchen, *supra* note 12.

60. See Gregory E. Skipper, *The Oxycontin Dilemma*, 16 ALA. BOARD OF MED. EXAMINERS NEWSL. 1, 1 (Spring 2001), available at <http://www.albme.org/PDFs/NLSpg01.PDF>.

61. *Id.*

OxyContin has allowed many patients suffering from severe-chronic pain to carry on normal activities that were once impossible due to the severity of their pain.<sup>62</sup> However, OxyContin has received significant “bad press” because of pharmacy robberies and fatal overdoses linked to its abuse. In addition, OxyContin has a substantial street value.<sup>63</sup> As a direct result, physicians are cautious in prescribing OxyContin and some legitimate users are wary of continuing its use.<sup>64</sup> Similarly, physicians are wary of prescribing controlled substances to patients out of fear they are being deceived as to the truth of the patient’s assertion of pain.<sup>65</sup> This fear is not unwarranted as “[p]atients deceiving their physicians . . . constitute the largest percentage of controlled substance abusers.”<sup>66</sup>

Patients who deceive physicians to obtain controlled substances are considered “drug seekers.”<sup>67</sup> Behaviors commonly exhibited by drug seekers include requesting specific narcotics, inconsistencies between the patient’s reported level of pain and what the physical exam indicates to the physician, and visiting multiple physicians to obtain duplicate prescriptions.<sup>68</sup> However, in some situations it can be very difficult for a physician to distinguish between a drug seeker and a true pain sufferer because they often exhibit similar behaviors.<sup>69</sup> “[P]seudoaddiction, refers to patient behaviors that may occur when pain is undertreated, including increased focus on obtaining medications (‘drug seeking’), ‘clock watching,’ and even illicit drug use or deception.”<sup>70</sup> Pseudoaddiction can be distinguished from true addiction because such behaviors resolve with effective pain management.”<sup>71</sup>

Because some patients deceive their physician and

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62. See Carolyn Kleiner, *A Curse and a Cure*, U.S. NEWS & WORLD REP., Aug. 6, 2001, at 42.

63. See Skipper, *supra* note 60 (stating “[S]ixty 40mg tablets of OxyContin, which retail for about \$300, can bring \$2400 on the black market.”).

64. See *id.*

65. See Penson, *supra* note 25, at 199-200.

66. See Nist, *supra* note 1, at 107 (citing Bonnie B. Wilford et al., *An Overview of Prescription Drug Misuse and Abuse: Defining the Problem and Seeking Solutions*, 22 J. L. MED. & ETHICS 197, 199 (1994)).

67. “Drug seeker” is derived from one who displays “drug-seeking” behavior. See Penson, *supra* note 25, at 205.

68. See Glajchen, *supra* note 12, at 216-17.

69. See *id.* at 216.

70. *JCAHO Pain Assessment*, *supra* note 18, at 17.

71. *Id.*

fraudulently obtain controlled substances, physicians may look beyond reported pain to the physician's relationship and history with the individual patient.<sup>72</sup> Physicians' fear of prescribing controlled substances is most pronounced when the patient-physician relationship is new and the patient's pain is not substantiated by either physical indication of injury or disease that normally accompanies pain;<sup>73</sup> or in the case of reported chronic pain, where the patient does not provide adequate medical history for the physician to verify the patient's pain treatment history. In these cases, the physician might refuse to prescribe a controlled narcotic or only prescribe a limited quantity of opioids sufficient to allow the patient time to substantiate their medical history.<sup>74</sup>

## II. TRADITIONAL TORT JUSTIFICATIONS DO NOT WARRANT LIABILITY FOR INADEQUATE PAIN MANAGEMENT

There are two theoretical justifications that underlie the tort system: "utilitarianism and those based upon individual moral rights."<sup>75</sup> Utilitarian justifications focus on using tort law as a tool to implement social or public policy goals, such as deterrence by imposing the threat of liability on tortfeasors.<sup>76</sup> Justifications that focus on individual moral rights view tort law as a way of achieving justice between parties, such as compensation for harms wrongly imposed by a tortfeasor.<sup>77</sup> Some scholars believe that only one or the other justification for the tort system is correct while other scholars argue that the tort system incorporates elements of both justifications.<sup>78</sup> In the context of pain management, the scholars

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72. See Glajchen, *supra* note 12, at 216-17.

73. See Eippert, *supra* note 1, at 389 (suggesting that tort liability should only be imposed where the existence of pain can be established through objective evidence).

74. See *Watkins v. U.S.*, 589 F.2d 214 (5th Cir. 1979) (holding physician has duty to investigate history of mental illness when prescribing large amounts of a controlled substance to a patient). If there is a duty to investigate a patient's mental history, then it is likely a court could find a duty to investigate a patient's substance abuse history before prescribing large amounts of a controlled substance to such a patient. *Id.*

75. Jeffrey O'Connell & Christopher J. Robinette, *The Role of Compensation in Personal Injury Tort Law: A Response to the Opposite Concerns of Gary Schwartz and Patrick Atiyah*, 32 CONN. L. REV. 137, 138 (1999) (citing Stephen R. Perry, *The Moral Foundations of Tort Law*, 77 IOWA L. REV. 449, 449 (1992)).

76. O'Connell & Robinette, *supra* note 75 at 138.

77. *Id.* at 138-39.

78. See generally *id.*

advocating tort liability for inadequate pain management base their arguments primarily on the utilitarian justification of changing the medical practice through tort liability and secondarily on the individual's right to compensation for pain that should not have been suffered had it been properly treated by the physician.<sup>79</sup>

A. *The Utilitarian Justification*

The basic utilitarian justification offered in support of tort liability<sup>80</sup> for inadequate pain management is that tort liability will force physicians to adopt new standards of pain management and help overcome other factors that contribute to physicians' decisions that result in undertreatment of pain.

1. *Can Tort Liability Change Medical Practice Regarding Pain Management?*

The argument that tort liability will force physicians to adopt new standards of pain management is fundamentally based, although not explicitly expressed, on previous changes that tort liability has arguably generated upon medical practice.

There are many examples of tort liability, where courts have arguably effectuated changes in the practice of medicine by adopting new standards of care. In *Tarasoff v. Regents of the University of California*,<sup>81</sup> the California Supreme Court held a therapist to a duty to warn potential victims after his patient expressed a serious and credible intent to harm those persons. "According to a study . . . *Tarasoff* was effective in rendering psychiatrists and psychologists, especially in California, considerably more willing to notify potential victims and also public authorities when dealing with dangerous patients."<sup>82</sup>

*Helling v. Carey*<sup>83</sup> "found malpractice as a matter of law whenever a doctor does not include a glaucoma pressure test within a routine eye exam."<sup>84</sup> A study found that the level of routine glaucoma testing of patients under age forty by Washington ophthalmologists went up by a substantial percentage in the years

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79. See sources cited *supra* note 1.

80. See Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 379 (1994).

81. 551 P.2d 334, 340 (Cal. 1976).

82. Schwartz, *supra* note 80, at 399-400.

83. 519 P.2d 981, 983 (Wash. 1974).

84. Schwartz, *supra* note 80, at 400.

following the decision.<sup>85</sup>

Another area of medicine that tort liability has changed is the surgical precautions taken to prevent leaving a surgical tool in a patient, which frequently leads to malpractice actions.<sup>86</sup> “[T]o prevent such lawsuits and better protect patients, hospitals are prescribing a variety of new operating-room procedures, from computerizing the way they keep track of surgical tools to bearing down on doctors who seem overly eager to close up a patient before all tools have been accounted for.”<sup>87</sup>

The informed consent doctrine is often cited as a primary example of how tort liability can generate beneficial change in medicine.<sup>88</sup> Studies based on a Canadian opinion that broadened a doctor’s duty to provide informed consent found that sixty percent of the surgeons who had been made aware of the decision chose to modify their practice to spend more time discussing surgical risks with patients.<sup>89</sup> A Harvard study of New York physicians showed that “during the previous decade the threat of liability led almost seventy-eight percent of physicians to spend more time ‘explaining risks’ to patients.”<sup>90</sup>

In each of these examples, it is arguable that judicially imposed tort liability changed the medical profession by altering the physician’s standard of care. In each case, the judicially imposed duty required medical professionals to take additional action that was not previously part of the standard of care. In some respects, a court mandating a broader standard of care for pain management is similar. However, the standard of care for pain management is a significantly more complex issue than the examples cited. Each example concerned a very specific obligation that was imposed on doctors that was easily measurable, potentially as a matter of law.<sup>91</sup> A court cannot mandate how a physician should treat pain because each patient requires individual considerations. A court cannot simply mandate that a physician has an obligation to provide opioids to any patient claiming

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85. *Id.*

86. *Id.* at 399.

87. *Id.* at 399 (quoting Edward Felsenthal, *Forgotten Surgical Tools Spur Lawsuits*, WALL ST. J., Dec. 11, 1992, at B12).

88. *Id.* at 401.

89. *Id.* at 400-01.

90. *Id.* at 401.

91. *Id.*

sufficient pain, as this would be illegal.<sup>92</sup> In addition, a court cannot mandate what the standard of care for pain management should be, especially in light of the level of detail required for determining an individual case because there is not a single standard of care—it varies from case to case. “Many strategies exist to manage various types of pain.”<sup>93</sup>

There are a multitude of practice guidelines in existence, and they only provide generalities, not specific treatment protocols. As an example, JCAHO recently stated that “[s]ystem barriers to pain assessment and management include an absence of clearly articulated practice standards,”<sup>94</sup> despite documenting thirty-one separate clinical practice guidelines that had been produced by various organizations between 1992 and 2000 to specify how to treat pain in various situations.<sup>95</sup> If one of the barriers to pain management is the lack of clearly articulated practice standards, then it is clearly unreasonable to expect a court to impose an effective standard of care based on existing clinical practice guidelines that physicians follow today in avoiding tort liability. Thus, it is unlikely that a court would be able to effectuate the type of systematic change that may have been shown in previous cases by simply dictating the standard of care to the medical profession.

## 2. *Can Tort Liability Overcome Other Factors that Contribute to the Undertreatment of Pain?*

Perhaps the most unsupported proposition by the proponents of tort liability for inadequate pain treatment is the scholars’ assertion that tort liability will overcome other factors that contribute to the undertreatment of pain.<sup>96</sup> However, none of the scholars support this conclusion with direct evidence; it is only a logical assumption that is made.<sup>97</sup> Deterrence is the basic method through which tort liability can produce utilitarian changes on

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92. See *infra* Part IV.A and note 167 (Only a physician can make the determination that the use of a controlled substance is for a “legitimate medical purpose.”).

93. JCAHO Pain Assessment, *supra* note 18.

94. *Id.* at 15.

95. *Id.* at 75.

96. See Mayer, *supra* note 1, at 350 (stating that “the impact of the [Bergman v. Chin, No. H205732-1 (Cal. Super. Ct. June 13, 2001)] case will serve to improve treatment of all patients suffering needlessly from pain”); Oken, *supra* note 1, at 1968-69, 1981; Nist, *supra* note 1, at 87-88; Furrow, *supra* note 1, at 28-31.

97. See *supra* note 96.

society. "By imposing the threat of liability on tortious conduct, the law can discourage parties from engaging in that conduct."<sup>98</sup> In the case of pain management, the goal of tort liability would be to deter undertreatment in the face of preexisting substantial deterrence for overtreatment.

In the case of medical malpractice, it is questionable how much tort liability truly deters negligence due to the liability insurance that most physicians carry. Typically, physicians are not personally held financially responsible for adverse medical malpractice decisions or the litigation costs associated with a medical malpractice claims.<sup>99</sup> There is limited indirect pressure created by malpractice insurers because the insurers usually do not base malpractice premiums on past claims of individual physicians.<sup>100</sup> In the case of physicians, malpractice premiums are calculated based on broad specialty groupings.<sup>101</sup> Thus, tort liability does not directly deter physicians. However, without any doubt, tort liability has some indirect deterrent effect on physicians.

[T]he threat of tort litigation has a substantial psychological impact on physicians in excess of the diluted financial incentives created. Physicians overestimate the risk of being sued and the size of feared judgments. The sheer unpleasantness of being sued also deters, although it has been argued that the lack of clarity as to the locus of negligence in most cases does not provide useful feedback to providers.<sup>102</sup>

In order for tort liability to deter undertreatment of pain, it would have to overcome the physician's fears of disciplinary action and criminal prosecution that have contributed to the physician's decision to undertreat pain.

Doctors' fears of disciplinary action and criminal prosecution are justified. There is no evidence that large numbers of physicians are sanctioned for their treatment of patients in pain, but the impact of the process on those physicians who are only investigated, or only charged but not disciplined, or only warned or cautioned but not

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98. Schwartz, *supra* note 80, at 381.

99. This is, of course, true where insurance covers negligent behavior of any kind.

100. See Skipper, *supra* note 60; see also SCOTT BECKER, HEALTH CARE LAW: A PRACTICAL GUIDE § 12.06, 1-12 (2d ed. 2003).

101. BECKER, *supra* note 100.

102. Furrow, *supra* note 1, at 30.

penalized is severe. The prosecutorial stance stimulated by a “war on drugs” and by increasing public scrutiny of disciplinary agencies may unintentionally interfere with adequate pain relief because it has intensified and criminalized investigations and later proceedings. Descriptions of the investigation of physicians engaged in the treatment of pain patients with controlled substances present a scenario that would easily intimidate most people. Some evidence also suggests that many state medical boards have not adapted to more current approaches to the use of controlled substances in pain management and that they may rely solely or too heavily on dosage and length of treatment as indicators of inappropriate and illegitimate prescription practices . . . . State disciplinary boards are also involved, often in collaboration with criminal prosecutors, in the war against drugs, penalizing providers who prescribe controlled substances that can be diverted to street use or who themselves deal drugs using their prescriptive authority.<sup>103</sup>

There is no evidence that the deterrence effect of tort liability can overcome or even mitigate the deterrence effect of imprisonment or loss of medical license that has deterred so many physicians into playing it safe—and, in effect, undertreating pain.

An additional factor in this equation of deterrence is that physicians perceive that the medical malpractice system is not entirely fair and accurate. To some extent, there is the belief that juries do not have the education or training to fairly evaluate whether a physician’s decision was proper and that juries instead are sympathetic with injured patients and view physicians, hospitals, and their insurers as deep pockets that can afford to compensate the sympathetic patient. To the extent that physicians view the medical malpractice system as a “litigation lottery,” its potential to deter physician conduct is limited.<sup>104</sup> It is arguable that one of the main effects of medical malpractice on the practice of medicine is to encourage physicians to practice “defensive medicine.”<sup>105</sup> This practice involves ordering tests and treatments that are only minimally indicated or not cost effective in the judgment of the

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103. Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J.L. MED. & ETHICS 319, 320 (1996).

104. Theresa M. Hottenroth, *Lessons From Canada: A Prescription for Medical Liability Reform*, 13 WIS. INT’L L.J. 285, 288 (1994).

105. *Id.* at 289.

physician. Nevertheless, they are ordered either to create information predominately for future litigation purposes or alternatively because the patient threatens to sue the physician in order to have the test/procedure performed.<sup>106</sup> The main disincentive to defensive medicine is that it increases the cost of health care for everyone; whereas the physician is encouraged to practice defensively by the more personal threat of litigation.<sup>107</sup>

The phenomenon of defensive medicine to some extent reflects the disdain that physicians have for the jury as a decision maker: the physician practices defensive medicine because he or she does not trust that the jury will come to what the physician considers a proper medical judgment regarding whether a test or procedure was warranted given the information available to the physician when the decision was made.<sup>108</sup> One worry is that the jury will improperly make a post hoc determination of whether the test or procedure was warranted based on the result of the decision. This effect of limited deterrence of civil judgments could be especially pronounced in a physician's determination of how to treat pain because it likely indicates that more weight will be given to factors such as state medical boards, hospital regulations, and perceived criminal liability than to what a civil court says.

### 3. *What Side Effects Could Tort Liability Have if Imposed for Inadequate Pain Management?*

To justify expanded tort liability based on utilitarian goals, it is essential to examine the complete effect tort liability could have on pain management. A significant disadvantage to tort liability for mismanaging pain is that it may decrease the overall availability of pain management and increase the cost of pain management.

It will be expensive to litigate cases of pain mismanagement. Expensive expert testimony will be required by both parties in order to determine if the defendant's conduct complied with or deviated from the standard of care.<sup>109</sup> There are situations in which pain cannot be clinically controlled regardless of what treatment is

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106. *See id.*

107. *Id.*

108. *See id.*

109. *See* BECKER, *supra* note 100 (indicating that a court could not articulate a standard of care for pain management that precludes the need for expert testimony to establish the standard of care).

used,<sup>110</sup> requiring additional expert testimony regarding the efficacy of treating the patient's pain. In addition, complete pain elimination is not the goal of opioid use when treating chronic pain.<sup>111</sup> This will also require expert testimony to determine whether the optimum level of pain relief was achieved. Another factor is that the subjective nature of pain will require additional expert testimony to establish whether the plaintiff actually suffered pain. The subjective nature of pain will also make it difficult to dispose of trivial or frivolous claims by summary judgment motions, as the injury to the plaintiff and appropriateness of the physician's response will be factual, not legal issues. In addition, the number of people suffering from pain in the United States is substantial. "Each year, an estimated 25 million Americans experience acute pain due to injury or surgery and another 50 million suffer chronic pain."<sup>112</sup> The sheer number of people suffering some form of pain in the United States could result in a flood of litigation given the current inadequacies of pain management practices and the supposition that ten percent of chronic pain is uncontrollable.<sup>113</sup> Finally, inadequate pain management has the potential for high damage awards.<sup>114</sup> The potential for high damage awards may lead to high pretrial settlement costs because plaintiffs will have a high expectation for the value of their claims.

Physicians' medical malpractice insurance policies will most likely cover the costs of litigation and damage awards. As a result, insurance companies will have to raise insurance premiums to cover these new expenses. Insurance companies will likely raise all

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110. Rich, *supra* note 1, at 7 ("There is a strong consensus that . . . ninety percent of all pain experienced by patients can be relieved."). This implies that ten percent of all pain cannot be relieved.

111. Marcus, *supra* note 44.

112. JCAHO Pain Assessment, *supra* note 18, at 3; *see also* Rich, *supra* note 1, at 15 (citing NATIONAL INSTITUTES OF HEALTH, CHRONIC PAIN: HOPE THROUGH RESEARCH, Pub. No. 90-2406, 2-3 (1989) (noting a 1989 study found that "five million Americans suffer[ed] from back pain alone, of which two million [were] so disabled they [could not] work.")).

113. *See* Hottenroth, *supra* note 104, at 7 and accompanying text.

114. *See* Terrie Lewis, *Perspectives on Elder Law: Pain Management for the Elderly*, 29 WM. MITCHELL L. REV. 223, 235, 237 (2002) (In 1990, a North Carolina jury ordered a nursing home to pay \$7.5 million in compensatory damages and \$7.5 million in punitive damages for not providing a patient pain medication for three days. In 1998, a California jury awarded \$1.5 million for under-medicating a patient's pain for five days as he was dying from lung cancer under an elder abuse statute); *see also* Oken, *supra* note 1, at 1979 (stating "[J]urors will make physicians pay heavily for needless patient suffering").

physicians' premiums, not just those of the physicians being sued because "insurers cannot and do not vary premiums very much according to accident record. It is too complex, and too unreliable statistically."<sup>115</sup> However, insurance companies would likely respond by creating a new practice category for insurance coverage, allowing them to charge additional premiums only to physicians who practice pain management,<sup>116</sup> and these additional premiums would likely be significant.<sup>117</sup> This could result in physicians choosing not to practice pain management to avoid additional and potentially significant malpractice premiums.

Tort liability also has the potential to place the doctor in a no-win situation. The standards a court could impose on physicians would not necessarily be compatible with existing state criminal standards or federal standards. An example is the New York State Controlled Substance Act, which defines an addict as being "a person who habitually uses a narcotic drug and who by reason of such use is dependent thereon."<sup>118</sup> "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."<sup>119</sup> "[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."<sup>120</sup> However, most pain management guidelines specify that opioids should not be withheld from patients who are addicted.<sup>121</sup> A judicially imposed standard of care and duty for physicians to relieve pain would likely not take into account specific statutory restrictions on physicians such as the New York State Controlled Substance Act. Ambiguous language in the statute, combined with generalities from the standard of care, could place physicians in a situation where they

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115. O'Connell & Robinette, *supra* note 75, at 147.

116. See BECKER, *supra* note 100.

117. The high premiums would be based on the high cost of defense, large awards, large settlement value, and a very large number of pain sufferers who could file suit if an action for inadequate treatment of pain were recognized.

118. Rich, *supra* note 1, at 46-47 (quoting N.Y. PUB. HEALTH LAW § 3302(1) (McKinney 1993)).

119. *Id.* at 47.

120. *Id.*

121. See Sidney H. Schnoll & Michael F. Weaver, *Addiction and Pain*, 12 AM. J. ON ADDICTION §27, §33 (2003); see also Mitchell J. Cohen et al., *Ethical Perspectives: Opioids Treatment of Chronic Pain in the Context of Addiction*, 18 CLINICAL J. OF PAIN §99, §106 (2002).

would be unsure of whether they could treat a patient.

Higher insurance rates and a hostile tort environment could cause physicians to leave the practice of pain management.<sup>122</sup> Alternatively, a hostile climate for practicing pain management in a particular state could encourage physicians practicing pain management to move to a less hostile state.<sup>123</sup>

It is likely that only physicians who practice a significant amount of pain management would continue the practice given a significant new expense.<sup>124</sup> For example, the threat of liability and the cost of insurance have resulted in “a number of general practitioners in rural areas [refusing] to deliver babies, imposing on their patients the inconvenience of seeking obstetric care in a distant metropolitan area.”<sup>125</sup> The likely result of higher costs for medical malpractice insurance would be fewer physicians practicing pain management and higher health care costs for pain management.<sup>126</sup>

This would likely result in more patients suffering unnecessary pain due to difficulties in finding a physician to treat their pain. As of 2002, “with just over 1,000 pain management specialists practicing in the United States, patients would have difficulty getting prescriptions for needed drugs if only such specialists were permitted to prescribe them.”<sup>127</sup> In addition to a shortage of pain

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122. Physicians are not required to practice pain management. Oken, *supra* note 1, at 1989 (“Physicians have every right to say ‘I don’t do palliative care,’ and send patients elsewhere.”).

123. See Christopher Guadagnino, *Physician Shortage in Pennsylvania?*, PHYSICIANS NEW DIGEST (August 2003) (explaining surging malpractice insurance costs coupled with low private insurer reimbursements relative to other states resulted in Pennsylvania physicians leaving the state, retiring early, or dropping risky procedures); see also Scott Shepard, *Malpractice Costs Driving Doctors Away*, MEMPHIS BUS. J., available at [http://www.phg.com/articlepf\\_a021.htm](http://www.phg.com/articlepf_a021.htm) (last visited Feb. 10, 2005) (claiming “crushing costs” for medical malpractice and slow and inconvenient state medical licensing procedures are driving physicians from Mississippi and discouraging others from taking their place).

124. There is an additional factor that could lead physicians to leave the practice of pain management: the “hassle factor” of dealing with drug seekers.

125. Schwartz, *supra* note 80, at 403.

126. The counter argument to this is that it would be beneficial for pain to only be managed by experts who would provide the best standard of care for their patients. However, while it is self-evident that specialists in pain management are best suited to deal with the more difficult cases of pain, there is no evidence that other physicians, with proper training, are unable to treat the majority of simple cases. In addition, given the number of patients suffering from pain, the result of a specialist providing medical care instead of a primary care physician is an increase in the overall health care costs of pain management.

127. Noah, *supra* note 37, at 64.

management specialists, the United States is currently experiencing a general shortage of physicians.<sup>128</sup> Increased costs compounded with existing concerns regarding criminal penalties and state licensing boards will likely result in physicians choosing other areas of specialization—exacerbating the shortage of pain management specialists.

*B. Individual Moral Rights Justification*

Individual moral rights justifications—or corrective justice justifications in the case of tort liability—generally focus on achieving justice between the parties. In the context of medical malpractice, the corrective justice theory places the liability for a patient's injury on the negligent party in an attempt to make the injured patient whole.<sup>129</sup> The individual moral rights justification in medical malpractice also includes an aspect of the concept of loss spreading: the doctor/hospital/insurance company is better able to spread the expenses of an individual's loss throughout society, preventing an individual from having to bear a catastrophic loss.<sup>130</sup>

In the context of inadequate pain management, the basic individual moral rights justification for expanding tort liability is that the patient unnecessarily suffered pain that could have been prevented but for the physician's improper pain management. On an individual basis there is an intuitive appeal to this theory because if a physician is under an affirmative duty to relieve the patient's pain and this does not occur due to the physician's negligence, then holding the physician liable for the pain that occurred is the only civilized way to achieve justice between the parties. Thus, strictly in terms of a corrective justice theory, inadequate pain management is a basis for tort liability.

However, in terms of compensation, “[m]ost analysts agree that the medical liability system in the U.S., as a whole, ‘fail[s] miserably’ as a method of compensating injured patients.”<sup>131</sup> The

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128. See Jennifer Moody, *The Physician Shortage is Official: Now What?*, HEALTH LEADERS NEWS (Jan. 12, 2004) (noting the Council of Graduate Medical Education and the AMA reversed their longstanding positions on a physician surplus, both now indicating physician shortages); see also Victoria Stagg Elliott, *Physician Shortage Predicted to Spread*, AM. MED. NEWS 1 (Jan. 5, 2004).

129. Hottenroth, *supra* note 104, at 286.

130. See 2 FOWLER V. HARPER & FLEMING JAMES, JR., THE LAW OF TORTS 759-64 (1956).

131. Hottenroth, *supra* note 104, at 286 (quoting Randall R. Bovberg, *Medical*

majority of patients injured because of medical negligence never file a claim or receive any compensation for their injury.<sup>132</sup> In addition, the tort liability system is an expensive means of performing the compensation function as the cost of investigation, trial, and attorney's fees substantially reduce the recovery of the injured patient. When including the cost of the defense in the equation, significantly more money is spent on administering the medical malpractice tort and insurance system than is spent on compensating injured patients.<sup>133</sup>

One difficulty in applying the compensation theory to justify tort liability for inadequate pain management is that pain is an intangible loss; there is no way to accurately value suffering from inadequately managed pain. This uncertainty in how to value pain has led to large and dramatically inconsistent verdicts for pain and suffering damages that are a part of other tort awards.<sup>134</sup> This has also led some critics to question whether awards for pain and suffering accomplish the stated goals of compensation.<sup>135</sup> However, if there is liability for inadequate pain management, then there is no other form of damages that would compensate the patient.<sup>136</sup> Because money is the currency of our society, awarding money to the injured party is a way for society to recognize the importance of the injured party's losses.<sup>137</sup> Accordingly, the purpose of tort compensation for pain and suffering is not to compensate for the injury so much as to acknowledge its value by "recognizing the wrong and signifying its weightiness."<sup>138</sup> Although it is difficult to establish the value of suffering from pain, if a cause of action for inadequate pain treatment were recognized, this factor would likely be treated as an issue of fact for jury determination—as pain and

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*Malpractice on Trial: Quality of Care is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 326-28 (Spring 1986)).

132. See *id.* (stating "[A]s many as nine out of ten victims of medical negligence never file a claim.").

133. See *id.* at 287 (stating "[A]s little as twenty-eight cents of each insurance premium dollar actually goes to compensate injured patients.").

134. Jeffery C. Dobbins, *The Pain and Suffering of Environmental Loss: Using Contingent Valuation to Estimate Nonuse Damages*, 43 DUKE L.J. 879, 892 (1994).

135. DAN B. DOBBS, LAW OF REMEDIES: DAMAGES-EQUITY-RESTITUTION 658-60 (2d ed. 1993).

136. Damages based upon an inadequate pain management theory would take the place of pain and suffering damages in order to avoid a double recovery.

137. Dobbins, *supra* note 134, at 895.

138. Margaret Jane Radin, *Compensation and Commensurability*, 43 DUKE L.J. 56, 74 (1993).

suffering damages currently are treated where pain and suffering is only a component of the claim.<sup>139</sup>

Although there is a valid corrective justice justification for allowing the patient who unnecessarily suffered pain due to a physician's negligence to sue, the issue of whether there is an individual moral rights justification for tort liability should focus instead on the issue of compensation and whether suffering pain is a loss that should be spread throughout society. Loss spreading is the second major individual moral rights justification for tort liability and it focuses on the inability of an individual to effectively bear the full burden of another's negligent action.<sup>140</sup> In effect, tort liability can operate as a form of insurance against loss, albeit an expensive form of insurance. This justification is clearest when the plaintiff is negligently injured resulting in additional losses: medical expenses, lost income, lost property, etc. In the case of inadequate pain management, it is not clear that pain alone qualifies as a loss. In this situation, it is assumed that the patient's pain was preexisting and the physician's negligent care did not adequately alleviate the pain. At worst, the patient is in the same position they were in before the physician treated them. In addition, there is no loss of property, income, or additional expenses involved with inadequate pain treatment.<sup>141</sup> The reality of medical malpractice insurance is that it is an expense that is ultimately born by the consuming public at large. Physicians and hospitals cover the additional expenses eventually through higher reimbursement from patients' insurance companies which results in higher insurance premiums for patients. In the current era of skyrocketing medical costs, it is questionable whether there is adequate justification for society reimbursing patients for pain they were already suffering. However, modern American society places great value on quality of life, and pain is certainly an important determinant of quality of life. Therefore, society may value a pain-

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139. See 2 DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* ¶ 18.02 (Matthew Bender & Co., Inc., 2003) (stating that the jury typically has "broad discretion" in awarding damages for pain and suffering).

140. HARPER & JAMES, *supra* note 130, at 762-63.

141. However, it can be argued that the failure to treat pain could result in lost wages if the patient was unable to work but would have been able to work with adequate treatment. It could also be argued that failed pain treatment could result in additional medical expenses as the patient attempts to have their pain treated. However, both of these situations likely would not amount to damages sufficient to warrant the expense of trial in order to recover. This leaves the real issue to be valuing the pain that was unnecessarily suffered.

free life highly enough to warrant reimbursing an individual who unnecessarily suffered pain due to negligent pain management.

### III. MISMANAGEMENT OF PAIN DOES NOT FIT WITHIN TRADITIONAL CONCEPTS OF MEDICAL MALPRACTICE

It is generally recognized that the elements of an action for medical malpractice are: (1) the existence of a physician-patient relationship giving rise to a duty; (2) a violation of the applicable standard of care; (3) proof of injury or damage; and (4) development of a causal relationship between the violation of the standard of care and the harm.<sup>142</sup> The first element is typically not at issue as courts generally hold that a physician owes a legal duty of care to his or her patients.<sup>143</sup> However, the remaining elements could prove difficult to establish in a case of inadequate pain management.

#### A. *Standard of Care for Pain Management*

The duty of a physician to exercise reasonable care is measured against the “knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field.”<sup>144</sup> This is commonly referred to as the “standard of care” that a physician’s conduct must conform to in order to avoid being held negligent in a court of law.<sup>145</sup> This “standard, recognizing that ‘medicine is not an exact science,’ holds physicians responsible for their negligence without making them guarantors of the health of their patients.”<sup>146</sup> To satisfy this standard a physician’s practice need only comply with the customary practice of the average member of the profession.<sup>147</sup> It is significant to note that a physician usually is only liable for a departure from the applicable standard of care, not for a mistake in judgment of one appropriate alternative medical treatment over another.<sup>148</sup>

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142. 3 J. D. LEE & BARRY A. LINDAHL, MODERN TORT LAW: LIABILITY AND LITIGATION § 25:1 (2d ed. 2002).

143. Reynolds, *supra* note 1, at 90.

144. Aiello v. Muhlenberg Reg’l Med. Ctr., 733 A.2d 433, 437 (N.J. 1999).

145. *Id.*

146. *Id.* (quoting Schueler v. Strelinger, 204 A.2d 577 (N.J. 1964)).

147. Reynolds, *supra* note 1, at 91.

148. 3 LEE & LINDAHL, *supra* note 142, § 25:16. However, it is interesting to note that many courts have begun to re-examine and reject the “good judgment

Because the “standard of care” that a physician’s conduct generally must conform to is determined by the customary practice of the average physician, the standard of care for pain management is currently very low because the average physician is still practicing outdated pain management.<sup>149</sup> This is the source of the call for courts to adopt medical practice guidelines for pain management as the standard of care instead of relying upon the customary practice of the average member of the profession.<sup>150</sup> However, as discussed in Part II.A.1, the medical practice guidelines only provide general guidance, not specific information of how an individual situation should be treated. Thus, it is not reasonable to base the standard of care solely on practice guidelines. The practice guidelines could be useful in rebutting a physician’s claim that they were worried about addiction. Additionally, guidelines could be used in conjunction with expert testimony to illustrate the inadequacies of a particular pain treatment plan. However, this would require the court to disregard how average physicians deal with pain.

*B. Proving Pain as Damages*

Proving pain with sufficient certainty to allow tort recovery could be difficult for some suffers of pain that is medically unexplainable or unquantifiable. “Damages for pain and suffering . . . are recoverable where there is evidence of actual pain.”<sup>151</sup> The most common method of proving pain is through the plaintiff’s own testimony and the testimony of other witnesses who relate their observations of the plaintiff’s pain.<sup>152</sup> However, “[j]urors are not compelled to find pain where there was no objective injury.”<sup>153</sup> In addition, jurors “are not obliged to believe that every injury causes pain or the pain alleged.”<sup>154</sup> Thus, in situations where a medical cause for the pain suffered can be clearly established, a patient would likely be successful in proving pain with sufficient

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rule.” *See id.* n.5 (citing various recent cases in which courts have rejected this rule).

149. Rich, *supra* note 1, at 80.

150. *See* Reynolds, *supra* note 1, at 95; Rich, *supra* note 1, at 81; Oken, *supra* note 1, at 1975-77; Furrow, *supra* note 1, at 30.

151. 2 DAVID W. LOUISELL & HAROLD WILLIAMS, MEDICAL MALPRACTICE ¶ 18.02 (Matthew Bender & Co., Inc., 2003).

152. Furrow, *supra* note 1, at 36.

153. Boggavarapu v. Ponist, 542 A.2d 516, 519 (Pa. 1988).

154. *Id.* at 518.

certainty to meet this requirement. However, in situations where a patient claims medically unexplainable pain or claims pain in excess of what would medically be expected from a particular injury or disease, a jury would have to make the same determination as the treating physician regarding the veracity of the patient's claims of pain. It is questionable whether a patient with medically unexplainable pain could prove the suffered pain with sufficient certainty to allow tort recovery.

*C. Causal Relationship Between Inadequate Treatment and Suffered Pain*

"In medical malpractice cases, the general rule is that the plaintiff must prove causation through medical expert testimony in terms of probability to establish that the injury was, more likely than not, caused by the defendant's negligence."<sup>155</sup> However, there are situations where traditional notions of proximate causation are relaxed to permit recovery, such as where a patient is deprived of a chance of recovery despite testimony establishing that the result was inevitable regardless of the negligence of the physician (this is known as the loss-of-chance theory).<sup>156</sup>

In the typical tort case, pain and suffering is the result of a physical injury to the plaintiff caused by the defendant.<sup>157</sup> Courts are generally willing to instruct the jury on pain and suffering only when the plaintiff has suffered a tangible injury due to the defendant and a causal relationship is established between the defendant's negligence and the tangible injury.<sup>158</sup> In the medical malpractice setting, pain due to a missed diagnosis resulting in a lost opportunity to treat the problem can be a part of the damages.<sup>159</sup> But failure to adequately treat pain is more complicated: the physician is not responsible for the patient's condition or for a worsening of the patient's condition, but instead for pain mismanagement, which is the by-product of an underlying disease.<sup>160</sup> Under traditional notions of causation, a physician cannot be said to have caused the pain suffered by the patient

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155. *Roberts v. Ohio Permanente Med. Group*, 668 N.E.2d 480, 482 (Ohio 1996).

156. *Id.*

157. *Furrow*, *supra* note 1, at 36.

158. *LEE & LINDAHL*, *supra* note 142, § 3:2.

159. *Id.* § 25:85; *see also Helling v. Carey*, 519 P.2d 981 (Wash. 1974) (finding ophthalmologist defendants liable when they failed to order a glaucoma test for plaintiff leading to plaintiff losing part of her vision).

160. *Furrow*, *supra* note 1, at 36.

simply because the physician negligently failed to treat the patient's pain. However, it is possible that a court would extend the reasoning behind the loss-of-chance theory and relax the causation requirement when it is clearly established that the plaintiff suffered pain that was treatable and was only inadequately treated due to the treating physician's negligence.

#### IV. TORT LIABILITY WOULD COMPROMISE THE PHYSICIAN'S ROLE AS GATEKEEPER FOR CONTROLLED SUBSTANCES

##### A. *Physicians Are the Gatekeepers of Controlled Substances*

Physicians have been legislatively placed in the role of the gatekeeper for controlled substances through acts of Congress and the Drug Enforcement Administration (DEA).<sup>161</sup> In 1970, Congress passed the Controlled Substance Act (CSA) that created a uniform national standard for the control of potentially dangerous drugs that have the potential for abuse.<sup>162</sup> Under the CSA, in order for a physician to prescribe and administer controlled substances, the physician must apply to the DEA for a federal license for such prescription and administration.<sup>163</sup> This license is separate from the state license to practice medicine that physicians receive from various state medical boards.<sup>164</sup> Prescriptions for controlled substances are written by DEA licensees on special prescription forms and require inclusion of the practitioner's registration number and signature with each controlled substance prescription;<sup>165</sup> refills are prohibited.<sup>166</sup> The DEA requires that for a controlled substance prescription to be effective, it "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."<sup>167</sup> "The responsibility for the proper prescribing . . . of controlled

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161. 21 C.F.R. § 1306.04(a) (2004).

162. Noah, *supra* note 37, at 58.

163. See Steven E. Stark, *Bio-ethics and Physician Liability: The Liability Effects of Developing Pain Management Standards*, 14 ST. THOMAS L. REV. 601, 623 (2002).

164. See *id.*

165. 21 C.F.R. § 1306.05(a) (2004). On January 4, 2005, the DEA amended 21 C.F.R. § 1306.05 and strengthened the restrictions and controls on controlled substance prescriptions, requiring that the medical need be written on the prescription. 70 Fed. Reg. 291, 292 (Jan. 4, 2005).

166. 21 C.F.R. § 1306.12 (2004).

167. 21 C.F.R. § 1306.04(a) (2004).

substances is upon the prescribing practitioner . . . .”<sup>168</sup>

“The primary role of the DEA with respect to pharmaceutical controlled substances is to prevent, detect, and investigate the diversion from legitimate users, while ensuring their availability for legitimate medical use.”<sup>169</sup> The DEA has authority to suspend or revoke the license of practitioners who dispensed drugs in a manner that threatens the public health and safety. “[A]ll of the DEA’s policies, procedures, and investigation programs . . . are guided by the underlying principles . . . that link the validity of prescriptions for controlled substances to the requirement that it be ‘issued for a legitimate medical purpose . . . .’”<sup>170</sup>

The CSA divides drugs into five different schedules. Schedule I drugs are defined as having a high abuse potential, having no currently accepted medical use in the United States, and having a lack of accepted safety for use under medical supervision.<sup>171</sup> Examples of Schedule I substances are heroin and marijuana.<sup>172</sup> Schedule II drugs are considered to have an accepted medical use and to have a high abuse potential that may lead to severe psychological or physical dependence.<sup>173</sup> Schedule II substances are some of the most frequently used for pain management: morphine, Demerol, Percodan, and fentanyl.<sup>174</sup> Schedule III-V substances are similar to Schedule II substances but are characterized by progressively decreasing abuse potential in comparison with the prior schedule.<sup>175</sup>

*B. Tort Liability for Pain Management Could Compromise Congressional Intent*

Congressional intent is clear that physicians should be responsible for determining whether an individual’s condition presents a legitimate medical purpose for prescribing a controlled substance.<sup>176</sup> Such a determination requires the physician to assess

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168. *Id.*

169. H.R. REP. NO. 106-378, at 2-3 (Oct. 13, 1999); Stark, *supra* note 163, at 623.

170. Stark, *supra* note 163, at 623-24 (citing 21 C.F.R. § 1306.04(a) (2004)).

171. 21 U.S.C. § 812(b)(1) (2000).

172. *Id.*

173. *Id.* § 812(b)(2).

174. Rich, *supra* note 1, at 44-45.

175. 21 U.S.C.S. § 812(b)(3)-(5) (Law. Co-op. 2004).

176. In the CSA, Congress specified factors to consider that were primarily related to the potential for abuse, rather than accepted medical use. *See* Noah,

the severity and cause of the pain based on the patient's reported pain, medical history, and physical examination. The CSA, arguably, would pre-empt state tort causes of action for inadequate pain management that based liability on a physician's decision to prescribe or withhold controlled substances.

In *Grier v. American Honda Motor Co.*,<sup>177</sup> the Supreme Court, in a 5-4 decision, held that a state common-law tort action based on an auto manufacturer's failure to provide airbags was preempted by the 1984 version of a Federal Motor Vehicle Safety Standard,<sup>178</sup> with which the manufacturer had complied. The Court held the tort action was pre-empted because of conflict with the "means-related federal objective"<sup>179</sup> of the standard. The standard "deliberately sought variety . . . allowing manufactures to choose among different passive restraint mechanisms, such as airbags, automatic belts, or other passive restraint technologies."<sup>180</sup> The tort action, the Court held, precluded choice by imposing a duty on the manufacture to install airbags.<sup>181</sup>

A state tort action for inadequate pain management might arguably conflict with the congressional objective that CSA regulated controlled substances be administered only after a physician makes the determination that there is a legitimate medical purpose to do so.<sup>182</sup> Allowing a jury to make the same determination post-hoc creates a conflict because it will create an outside influence on the physician's medical judgment. The defensive medicine phenomenon<sup>183</sup> illustrates how the threat of tort liability encourages physicians to make decisions that are influenced by non-medical factors. Thus, the CSA would likely pre-empt state tort actions for inadequate pain management that include a duty to prescribe controlled substances.

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*supra* note 37, at 58 n.63.

177. 529 U.S. 861 (2000).

178. 49 C.F.R. 571.208 (2004).

179. *Grier*, 529 U.S. at 881.

180. *Id.* at 878.

181. *Id.* at 881.

182. *See* 21 C.F.R. 1306.04(a) (2004).

183. *See infra* Part II.A.2.

*C. Physicians Should Have Qualified Immunity from Tort Liability for the Decisions They Make in the Congressionally Imposed Role of Gatekeeper of Controlled Substances*

Physicians are often put in the position of having to judge the honesty of patients' claims of pain in order to prescribe narcotics. This is not unlike the position government officials and judges are in when they make decisions. "[G]overnment officials are entitled to some form of immunity from suits for damages. . . . [P]ublic officers require this protection to shield them from undue interference with their duties and from potentially disabling threats of liability."<sup>184</sup> Federal "qualified immunity shields government officials performing discretionary functions 'from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.'"<sup>185</sup>

In *Wilkinson v. Russell*,<sup>186</sup> state social workers were granted qualified immunity from suit for an allegedly inadequate child abuse investigation that violated settled standards of the profession and wrongfully substantiated the mother's allegations that the father had sexually abused the child.<sup>187</sup> State social workers did not seek corroboration,<sup>188</sup> relied on the opinion of a child psychiatrist who had met the children only two or three times,<sup>189</sup> and ignored evidence that the mother coached the child.<sup>190</sup> Despite these problems, the court concluded that the social workers had a reasonable basis for their determination and therefore the plaintiffs' constitutional rights were not violated.<sup>191</sup> This decision was "in keeping with the basic precept that a *mere failure to meet local or professional standards*, without more, should not generally be elevated to the status of constitutional violation."<sup>192</sup>

There is a contractual relationship between the patient and the physician: the physician is offering services to the public for pay, not to the state for the public good; and the state has no

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184. *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982).

185. *Zahra v. Town of Southold*, 48 F.3d 674, 686 (2d Cir. 1995) (quoting *Harlow*, 457 U.S. at 818).

186. 182 F.3d 89 (2d Cir. 1999).

187. *Id.* at 92.

188. *Id.* at 100.

189. *Id.* at 105.

190. *Id.* at 101.

191. *Id.* at 106.

192. *Id.* (emphasis added).

liability for the physician's actions.<sup>193</sup> Nevertheless, physicians perform what would otherwise be the role of a government official by acting as gatekeepers for controlled substances.<sup>194</sup> The physician must determine the medical necessity of the prescription. To do this, the physician may have to judge the honesty and truthfulness of his or her patient: if the patient is deceiving the physician, the prescription may not be medically necessary. In these situations, there is potential for a difficult determination analogous to the types of decisions for which government officials are regularly granted qualified immunity. Likewise, it is important that physicians be shielded from "undue interference" in their decision making regarding whether a patient should receive a controlled substance. Such "undue interference" could interfere with a physician making the congressionally-imposed legal decision that a prescription for a controlled substance is medically necessary.

#### V. PAIN MANAGEMENT IN END-OF-LIFE CARE SITUATIONS

Tort liability for inadequate pain management may have the most appeal in end-of-life situations in which the patient is expected to live a short time and is suffering from severe pain. Under such circumstances, physicians have less fear that opioids will be diverted or abused.<sup>195</sup> However, administering opioids to patients already weakened by terminal disease has the potential to hasten death, typically through respiratory depression.<sup>196</sup> When a physician prescribes opioids for a patient who has prohibited life saving measures,<sup>197</sup> that physician knows the opioids may hasten the patient's death. This decision may go against the moral and ethical beliefs of the physician. Although the Supreme Court has held that a patient has a right to palliative care, even if that care hastens

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193. See LEE & LINDAHL, *supra* note 142, § 16:3 (government liability for the actions or omissions of government employees limited to actions within the scope of employment).

194. One alternative would be a system where the physician's prescription would have to be individually reviewed by a DEA employee to ensure that the controlled substance would not be diverted or used for improper purpose. This system of review would be similar to what some health insurance companies do when they assign a caseworker to authorize physician decisions regarding health care expenditures.

195. JCAHO Pain Assessment, *supra* note 18, at 17.

196. *Id.* at 38, 41.

197. Such as a ventilator, if the patient stops breathing due to respiratory depression.

death,<sup>198</sup> the Court did not hold an individual physician has an affirmative duty to provide such care. Tort liability for inadequate pain management has the potential to penalize a physician for choosing, based on his or her own moral and ethical beliefs, not to hasten patients' deaths.

The case of *Bergman v. Chin*<sup>199</sup> provides a good example of the conflicting positions. At age eighty-five, Bergman was informed he likely had terminal lung cancer. He refused further testing and requested hospice care.<sup>200</sup> Bergman's complaint charged Dr. Chin with elder abuse for not adequately treating his pain while in the hospital and for sending him home without adequate pain medication.<sup>201</sup> Dr. Chin defended his decision to not use stronger opioids, pointing out that Bergman "went into respiratory distress and didn't breathe for about 15 seconds"<sup>202</sup> when he was given two injections of morphine in the emergency room. Bergman also complained that Dr. Chin's ordered PRN use of opioids required Bergman to suffer pain before receiving relief, and that Bergman's pain was never controlled while in Dr. Chin's care.<sup>203</sup> Once Bergman left the hospital and returned to the care of his family physician, he was given the morphine that he requested and died the next day.<sup>204</sup> Dr. Chin was found liable for elder abuse, and the jury awarded \$1.5 million in damages.<sup>205</sup>

The standard of proof in elder abuse cases is higher than in medical malpractice cases. The physician's conduct must be reckless, rather than negligent, in order for him or her to be held liable.<sup>206</sup> The jury did not indicate upon what basis Dr. Chin was held liable, but the case provides an example of the conflict between a physician's duty to not harm the patient and the

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198. See *supra* note 15 and accompanying text.

199. No. H205732-1 (Cal. Super. Ct. June 13, 2001) (jury form can be viewed at <http://www.compassionindying.org/bergman/verdict.pdf>).

200. Susan Okie, *Doctor's Duty to Ease Pain at Issue in Calif. Lawsuit*, WASH. POST, May 7, 2001, at A03 (providing a thorough recount of Bergman's situation), available at <http://www.washingtonpost.com>; see also Mayer, *supra* note 1, at 327-41.

201. Mayer, *supra* note 1, at 327-41.

202. Mark Crane, *Now you may be liable for undertreating pain*, MED. ECON. 1, 3 (2001), at <http://www.compassionindying.org/bergman/medicalecon.pdf>.

203. Mayer, *supra* note 1, at 330-32.

204. Okie, *supra* note 200.

205. Mayer, *supra* note 1, at 341.

206. *Doctor Liable for not Giving Enough Pain Medication*, at <http://www.cnn.com/2001/LAW/06/13/elderabuse.lawsuit> (last visited Jan. 23, 2005).

patient's right to be free from pain. In this case, Dr. Chin had sound medical reasons for not providing stronger opioid treatment, yet a jury found his behavior not merely negligent, but reckless.<sup>207</sup>

## VI. CURRENT CHANGES WILL ADEQUATELY ADDRESS THE PROBLEM OF INADEQUATE PAIN MANAGEMENT

Inadequacy of the changes in pain management practices and the need for discussions of ethical issues, are often cited as reasons why tort liability for inadequate pain treatment is necessary to force changes in pain management techniques and beliefs. However, significant changes have occurred that will likely effectuate the changes in pain management habits that are sought by tort liability proponents without resorting to tort liability and the potential problems tort liability presents for inadequate pain management.

### A. *Changes in Hospital Accreditation*

Effective January 2, 2001, "the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) . . . require[d] hospitals, homecare agencies, nursing homes, behavioral health facilities, outpatient clinics, and health plans to implement specific strategies to assess and manage pain."<sup>208</sup> These standards require healthcare providers to:

- [1] Recognize the rights of patients to appropriate assessment and management of pain . . .
- [2] Assess the existence and . . . the intensity of pain in all patients . . .
- [3] Record the results of the assessment in a way that facilitates reassessment and follow-up . . .
- [4] Determine and ensure staff competency in pain assessment and management and address pain assessment that supports the appropriate prescription or ordering of effective pain management . . .
- [5] Establish policies and procedures that support appropriate prescription or ordering of pain medication . . .
- [6] Educate patients and their families about effective pain management . . .
- [7] Include patients' needs for symptom management in the discharge

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207. This case also illustrates the dangers of putting a sympathetic plaintiff who suffers pain in front of a jury and expecting a jury to evaluate a physician's pain treatment decision-making objectively. *Bergman v. Chin*, No. H205732-1 (Cal. Super. Ct. June 13, 2001).

208. Frank-Stromborg & Christensen, *supra* note 3, at 276-78.

planning process . . . [8] Collect data to monitor the appropriateness and effectiveness of pain management.<sup>209</sup>

The JCAHO standards for pain management have the potential to radically improve and change the treatment of pain at the locations where severe pain is most likely to be suffered—in hospitals and nursing homes. A common result of the new JCAHO standard is that hospitals will take a multidisciplinary approach to pain treatment that gives a voice to other groups in the hospital—such as nursing and pharmacy—in creating a patient’s pain treatment plan.<sup>210</sup> Giving these other parties a say in a patient’s pain management plan prevents the opinion of an individual physician from preventing a patient from receiving adequate pain relief.<sup>211</sup> This also helps to ensure that the hospital’s policies that have met the JCAHO accreditation standards are uniformly applied to every patient in the institution.<sup>212</sup>

While accreditation is voluntary, JCAHO accreditation can be substituted for federal certification surveys that are required before Medicare and Medicaid reimbursement can be received; additionally, JCAHO accreditation fulfills licensure requirements in many states.<sup>213</sup> Thus, the majority of hospitals will implement the JCAHO standards.<sup>214</sup> However, currently these standards will not directly affect all cases of pain management that occur, because physicians who do not work at regulated organizations are not covered. Looking to the future though, all physicians will eventually be affected by the new standards because physicians are only trained in accredited hospitals—hospitals that are required to implement the new standards. Unfortunately, the new standards have not been in place long enough to evaluate their direct effect on pain management.

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209. *Id.* at 276-77 (citing JCAHO Standards, 2001).

210. Joint Commission on Accreditation of Healthcare Organizations, *Improving the Quality of Pain Management Through Measurement and Action*, at [http://www.jcaho.org/news+room/health+care+issues/pain+mono\\_jc.pdf](http://www.jcaho.org/news+room/health+care+issues/pain+mono_jc.pdf) (Mar. 2003).

211. *Id.*

212. *Id.*

213. See *Facts about the Joint Commission on Accreditation of Healthcare Organization*, at <http://www.jcaho.org/about+us/index.htm> [hereinafter *Facts about JCAHO*] (last modified July 2004).

214. See Dennis S. O’Leary, *President’s Message*, at <http://www.jcaho.org/about+us/president+message.htm> (indicating that JCAHO accredits more than 15,000 health organizations in the United States) (last visited March 11, 2005).

The JCAHO accreditation standards related to pain management address the majority of the concerns cited by scholars supporting the need for tort liability. One concern frequently cited in support of tort liability for inadequate pain management is that current medical school curriculums do not include any content regarding pain management.<sup>215</sup> Critics contend that tort liability is necessary to force physicians to obtain training in current pain management techniques.<sup>216</sup> The focus on medical school curriculum may be misplaced however, because generally, physicians learn their clinical practice methods through clinical training obtained in hospitals and medical clinics during the last two years of medical school and the three or more years of residency training—not in a formal classroom style setting.<sup>217</sup> This may be a significant factor in why advances in pain management were not generally learned by new physicians: the physicians training these new physicians did not practice using the advances in pain management, so new physicians were not exposed to the advances. However, subject to the new JCAHO requirements, institutions that train new physicians will require all physicians practicing there to follow guidelines that utilize the advances in pain management—resulting in future generations of physicians that do not perpetuate misconceptions regarding pain treatment and opioid prescription.

The JCAHO accreditation standards for pain management also address the often-cited concern that there needs to be a counter-pressure to the factors that discourage physicians from prescribing adequate opioids to relieve pain.<sup>218</sup> The JCAHO standards address this concern because for most physicians to practice medicine in a hospital or other healthcare institution, they will be required to meet these standards.<sup>219</sup> While not all physicians have admitting privileges in a hospital or other healthcare facility are covered by the JCAHO standards, the majority of physicians who deal with significant pain will be, especially in the case of terminal pain as

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215. See Furrow, *supra* note 1, at 28, 33-34; Rich, *supra* note 1, at 10; Oken, *supra* note 1, at 1933; Reynolds, *supra* note 1, at 88.

216. *Id.*

217. See generally *Physician Education for a Changing Health Care Environment*, Council on Graduate Medical Education, Thirteenth Report (Mar. 1999), at <http://www.cogme.gov/13.pdf>.

218. See Furrow, *supra* note 1, at 28-29; Reynolds, *supra* note 1, at 89.

219. See *Facts about JCAHO*, *supra* note 213 (indicating that the majority of hospitals will implement the JCAHO standards).

these patients usually end up in the hospital. Because many physicians do practice in hospitals and other healthcare institutions that are accredited under JCAHO, the requirements that the physicians comply with the institution's pain management standards will effectively force these physicians to bring their practice into compliance with the standards. In addition, as hospitals and other large healthcare institutions are required to implement these changes, they in turn have the potential to be powerful political voices to effectuate necessary changes in state medical boards and federal agency standards and policies which unreasonably inhibit pain relief.

This form of change has a high success probability because the medical profession is driving it internally. The determination of whether an individual should receive opioids for pain relief is, legally speaking, strictly a medical decision.<sup>220</sup> In addition, institutional review of an individual's action in regard to individual cases of pain mismanagement should result in efficient correction of problems, preventing repeated problems and giving an effective medium for aggrieved patients to voice their concerns regarding an individual physician. This may not be as vindicating for the individual's rights as winning a judgment in court, but it has greater potential to effectuate meaningful change rapidly and with less confrontation than recovering damages in a civil trial.

A final issue that will be effectively addressed by the JCAHO accreditation standards is the concern that the courts need to set the standard of care based on recommended practice guidelines instead of current national physician practices.<sup>221</sup> The JCAHO accreditation standards regarding pain management effectively force most hospitals and healthcare facilities to implement current practices in pain management in the care their patients receive.<sup>222</sup> This will inevitably change the clinical pain management practices of the majority of physicians in the country. Once this has

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220. 21 C.F.R. § 1306.04(a) (2004) (physician is responsible for determining the medical necessity for controlled substance to be prescribed).

221. See Furrow, *supra* note 1, at 32-33; Rich, *supra* note 1, at 81-83.

222. See *Facts about JCAHO*, *supra* note 213; *Joint Commission Focuses on Pain Management*, at <http://www.hcaho.org/news+room/health+care+issues/jcaho+focuses+on+pain+management.htm> (Aug. 3, 1999). JCAHO's current accreditation standards include current practice in pain management. JCAHO accredits most hospitals and health care facilities. For these hospitals to remain accredited, they have to meet JCAHO's requirements regarding pain management, resulting in the adoption of JCAHO's pain management standards in most hospitals and health care facilities. See *Facts about JCAHO*, *supra* note 213.

occurred, courts will only have to look to the national standard of care to determine if a physician has been negligent in relieving pain. Thus, there is no need for a legislature or judge to take the determination of an appropriate standard of care of pain management away from the nation's practicing physicians.

*B. Changes in State Regulation of Medicine*

"Many states are attempting to address pain management concerns through their legislatures by enacting new laws or by making changes to current laws."<sup>223</sup> In addition, "the undertreatment of pain is being addressed [in some states] by enacting administrative rules and guidelines or by enforcing these rules more diligently."<sup>224</sup> For example, California has passed a bill "requiring all California doctors to take a pain management course."<sup>225</sup> The law "also requires that the state medical board track complaints of doctors mishandling pain care and ensure that those complaints are reviewed by a pain specialist."<sup>226</sup> In addition, the Supreme Court's rulings on physician-assisted suicide in *Washington v. Glucksberg*<sup>227</sup> and *Vacco v. Quill*<sup>228</sup> have "prompted state legislatures to enact new and revise existing intractable pain statutes, which are designed to encourage the administration of opioid analgesics and other controlled substances in appropriate circumstances."<sup>229</sup> "At present, a majority of states have in place laws that directly address pain management issues and many have enacted more than one."<sup>230</sup>

As an example, Minnesota has directly addressed the issue of pain management in several statutes. Minnesota's Intractable Pain Treatment Act<sup>231</sup> addresses physicians fears of regulatory scrutiny for the prescription of controlled substances by stating that "[n]o physician shall be subject to disciplinary action by the Board of Medical Practice for appropriately prescribing or administering a controlled substance . . . in the course of treatment of an individual for intractable pain. . . ."<sup>232</sup> Furthermore, Minnesota's Criminal

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223. Frank-Stromborg & Christensen, *supra* note 3, at 277.

224. *Id.*

225. Mayer, *supra* note 1, at 348.

226. *Id.* at 349.

227. 521 U.S. 702 (1997).

228. 521 U.S. 793 (1997).

229. Oken, *supra* note 1, at 1964.

230. *Id.*

231. MINN. STAT. § 152.125 (2003).

232. *Id.* § 152.125, subd. 2.

Code shields healthcare providers from a charge of aiding suicide or aiding attempted suicide for prescribing opioids to treat a patient's pain "unless the medications . . . are knowingly administered . . . to cause death."<sup>233</sup>

Thus, significant changes have occurred and continue to occur. These changes are improving pain management without resorting to tort liability.

## VII. CONCLUSION

It is obvious that many physicians' pain management practices are out-of-date and largely ineffective. However, the myopic view that tort liability for inadequate pain management is necessary to improve the treatment of pain in the United States fails to consider all of the implications of such liability. This limited view also fails to consider how other changes in the healthcare system might accomplish effective pain management strategies. In addition, although there are studies that indicate that opioids are not as addictive as many physicians fear,<sup>234</sup> these studies are generally limited to patients suffering from cancer pain.<sup>235</sup>

The rapid growth in the abuse of painkillers<sup>236</sup> substantiates physicians' fears of over-prescribing opioids. Pain management is too complex of an issue to be guided by a simple declaration that a physician has a duty to relieve a patient's pain. Such a duty has the potential to drastically reduce the availability of physicians providing pain relief for their patients by creating a professionally untenable situation. An attempt to use clinical practice guidelines to impose a standard of care that does not reflect the practices of the average physician could result in a flood of litigation given the sheer number of people in the United States who suffer from inadequately controlled pain. In contrast, by using existing changes in the accreditation of hospitals, the goal of improving pain relief can be achieved without implicating the problems associated with tort liability. Before imposing a new form of tort liability, a court or legislature should look beyond the interests of the parties directly impacted by the new tort and examine the overall impact on society. In the case of inadequate pain

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233. MINN. STAT. § 609.215, subd. 3 (2003).

234. See JCAHO Pain Assessment, *supra* note 18, at 17.

235. See *id.*

236. See 2002 Drug Survey, *supra* note 45 and accompanying text.

management, the balance is tipped to a finding that tort liability is unnecessary and restrictive—society does not gain enough benefit to outweigh the cost such liability would impose.

However, this balance could change in the future. Once the average physician's pain management practices are in line with recommended guidelines, it is possible that tort liability for inadequate pain management could be socially useful in some situations. For example, in end-of-life care, there is not a justifiable concern about diversion of opioids, especially if a professional caregiver administers the opioids. The only valid concern would be the moral and ethical dilemma created by the potential for hastening a patient's death. As long as the laws governing tort liability expressly recognize that a physician is not required to provide pain relief that could be potentially harmful, it is possible that tort liability could serve a socially useful function by helping to ensure that physician negligence does not result in unnecessarily painful, avoidable deaths.

In the situation of acute or non-terminal chronic pain, it is unlikely that tort liability for inadequate pain management could exist without compromising the impartiality required by Congress to ensure that controlled substances are not diverted for improper use. Any type of liability could be used by a "drug seeker" to exert pressure on a physician to prescribe controlled substances and would likely be pre-empted by federal drug control laws.

Today, there is insufficient justification for tort liability for inadequate pain management. Thus, inadequate pain management should continue as is—a form of damage that the tort system does not recognize.