The Role of State Attorneys General in Improving End-of-Life Healthcare: Holding Hospitals and Nursing Homes Accountable for Undertreatment of Pain

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There is significant evidence of widespread undertreatment of pain among terminally and chronically ill patients in the United States. “During the last twenty-five years, the literature of the health care profession has documented a serious and persistent problem—the undertreatment of pain and the failure to effectively address suffering in the clinical setting.”¹ The two most serious barriers to solving this problem are a lack of education among healthcare providers about palliative care and a fear that prescribing controlled substances, even when they are the only way to relieve a patient’s pain, will result in regulatory and legal consequences. In the past several years, state attorneys general have become increasingly aware of the problem and willing to use their offices to improve the quality of end-of-life care in their states. This paper will argue that the most effective way for attorneys general to use their consumer protection power in this area is to focus on the rights of patients in nursing homes and hospitals.

Part I will discuss the problem in detail. Part II will provide an overview of palliative care policy, including education of medical professionals, federal drug enforcement policy, and the importance of a balanced approach. It will also address current efforts to improve the situation, including the National Association of Attorneys General End-of-Life Healthcare Project, as well as state legislative efforts. Finally, Part III will make the case that attorneys general should use their consumer protection power to hold hospitals and nursing homes legally accountable for the undertreatment of pain.

Pursuing cases against facilities where patients’ pain is undertreated will address both major obstacles to improving end-of-life care: lack of education among providers and fear of consequences for prescribing pain medication.

**Part I: The Undertreatment Problem**

The undertreatment of pain has become a chronic problem in American healthcare. In a 1995 study of 9,105 patients at five teaching hospitals, the results showed that 50% of patients were in moderate to severe pain before their deaths. In nursing homes, up to 40% of cancer patients do not receive adequate pain treatment; 26% receive no pain medication at all. The extent of the problem is considerable, both in the number of people affected and the costs:

The prevalence of undertreated moderate to severe pain is a persistent problem that affects more than fifty million Americans, including individuals with chronic non-malignant conditions and terminal illnesses. The inadequate management of pain costs the United States as much as $100 billion per year in health care expenditures, disability payments, and lost productivity.

The most common response of physicians asked why they are averse to prescribing opioids, which are the most effective pain drugs available, is that they fear administrative or criminal consequences. “A 2001 California survey showed that 40% of primary care physicians reported that fear of investigation tempered their use of opioids for patients

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2 SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 J.A.M.A. 1591 (1995).
4 Amy Dilcher, Damned if They Do, Damned if They Don’t: The Need for a Comprehensive Public Policy to Address the Inadequate Management of Pain, 13 ANNALS HEALTH L. 81 (2004).
5 See Rich, supra note 2, at 54-58.
with chronic non-malignant pain out of fear of investigation.” The recent convictions of Drs. Ronald McIver and William Hurwitz on federal drug trafficking charges have certainly not allayed these concerns. As medical boards, state legislatures, and state attorneys general have become more aware of the undertreatment problem, they have struggled to find a way to improve access to pain management while addressing doctors’ concerns about legal consequences on the federal level.

There are several other major factors that have contributed to the undertreatment problem. First, patients and medical providers alike have been affected by “opiophobia,” a fear that the use of prescription opioids causes drug abuse. “Recent studies confirm that health care providers are reluctant to prescribe, dispense, or administer opioids because they fear causing addiction or contributing to the drug abuse problem.” This is partially due to a lack of training in palliative care in medical schools, a problem that both the medical profession and state legislatures are currently trying to remedy (for instance, New York recently passed the Palliative Care Education and Training Act, which provides significant funding for training physicians in pain management). Second, providers and patients both fear that the use of narcotic pain medication in terminally ill patients may hasten death, and therefore amount to assisted suicide or euthanasia.

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6 See Dilcher, supra.
9 See Dilcher, supra.
10 Id.
12 See Dilcher, supra.
However, the appropriate use of narcotics does not correlate with faster death.\textsuperscript{13} Opioid dosing is based on titration, which is a gradual increase of medication which stops at the point where the negative side effects (such as sedation and depressed breathing) outweigh the benefits, and a physician using the medication correctly would not titrate to the point where it would accelerate the patient’s death. Additionally, the medical profession’s focus on objective diagnosis and treatment makes pain management more difficult, because pain is inherently subjective.\textsuperscript{14} Medicare and Medicaid reimbursement problems are another serious obstacle.\textsuperscript{15} There are also racial disparities in pain treatment, and white patients who go to hospitals in pain are more likely to receive opioids than black or Hispanic patients.\textsuperscript{16} While payment issues and racial disparities fall outside the scope of this paper, they are significant barriers to competent end-of-life care that would have to be addressed in a comprehensive policy.

While inadequate pain management is a serious problem with both chronic and terminal illnesses, this paper will focus on palliative care at the end of life. Hospice is a form of medical care that specializes in pain management and most patients in hospice die without pain. However, less than 20\% of patients at the end of their lives receive hospice care.\textsuperscript{17} Depending on where they live, 20\% to more than 50\% of Americans die

\textsuperscript{14} See Dilcher, \textit{supra}.
\textsuperscript{15} \textit{Id}.
\textsuperscript{16} Press Release, U.S. Department of Health and Human Services, Blacks, Hispanics and Other Groups Less Likely to Get Strong Pain Medications in Hospital Emergency Departments (January 1, 2007), available at http://news.yahoo.com/s/usnw/20080101/pl_usnw/blacks__hispanics_and_other_groups_less_likely_to_get_strong_pain_medications_in_hospital_emergency_departments__;_ylt=Aj6g8Y6vTJPLwLkoY8C0VEEKeK.
in hospitals.\textsuperscript{18} 50\% of those patients experience moderate to severe pain in the last three days of their lives.\textsuperscript{19} In nursing homes, a recent study found that up to 40\% of cancer patients did not receive sufficient pain treatment.\textsuperscript{20} Consequently, a successful policy by a state attorney general to improve palliative healthcare would target hospitals and nursing homes. There is a strong argument for treating inadequate pain management as an issue of consumer rights. A careful reading of the various concurring opinions in \textit{Washington v. Glucksberg} and \textit{Vacco v. Quill} shows that the Supreme Court comes close to recognizing the right to pain medication as a fundamental constitutional right.\textsuperscript{21} Further, there have been several recent successful tort suits for undertreatment of pain, which resulted in financial awards\textsuperscript{22} as well as a settlement that required the defendant hospital to educate its staff in pain management.\textsuperscript{23} Health care bureaus are a standard part of state attorneys general’s offices, and the attorneys general regularly address issues of improper billing, language assistance, and antitrust cases with the pharmaceutical industry (among others) in hospitals. Attorneys general can take a lead in enforcing patients’ rights to pain management – as a fundamental right as well as a right as a consumer of medical services – by pursuing cases of undertreatment in hospitals and nursing homes, and insisting on settlements that include palliative care education for staff as well as punitive measures against facilities that do not take adequate care of dying patients. This strong state-level legal incentive to provide competent pain

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\footnote{19}{See SUPPORT Study, \textit{supra}.}
\footnote{20}{See Tucker, \textit{supra} at 52.}
\footnote{21}{Beth P. Weinman, \textit{Freedom From Pain, Establishing a Constitutional Right to Pain Relief}, 24 \textit{J Legal Medicine} 495 (Dec. 2003). This article examines the concurrences of Justices Souter, O’Connor, Breyer, and Stevens. It argues that balance policies that unduly burden patients could be successfully challenged as unconstitutional.}
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management would mitigate the disincentive of the DEA’s involvement in this area, which creates the fear of legal consequences for prescribing medication. Additionally, a focus on including training programs in settlement agreements would improve the lack of education about palliative care among healthcare providers.

**Part II: An Introduction to Palliative Care Policy**

Palliative care is a medical service that “uses the advances of modern medicine and applies them not to cure or treatment but to the relief of physical and emotional suffering.”24 Palliative care for patients nearing the end of their lives is different from hospice in that it is not necessarily geared towards those expected to die within six months, and patients are not required to give up their insurance coverage for curative treatments in order to have access to it.25 Today, many terminal diseases are also long-term conditions, and patients with conditions such as cancer or congestive heart disease need palliative care for potentially extended periods of time.

Uncontrolled pain and other distressing symptoms are the primary concerns and greatest fears of patients facing serious illness. More than 90 percent of the pain associated with severe illness can be relieved if physicians adhere to well-established guidelines and seek help, when necessary, from experts in pain management or palliative care.26

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25 Id.

Traditionally, the practice of medicine has always focused on curing and treating diseases, and without education and training in palliative care, it is easy for patients dealing with a longer-term terminal illness such as cancer to be labeled drug-seekers when they ask for additional pain medication.

In recent years, the medical profession has made significant progress towards educating doctors about palliative care. In 2003, 87% of medical schools required palliative care training. However, out of over 6,000 hospitals in the United States, only 1,500 – less than 25% – had palliative care teams. Without specialized teams to consult on cases (especially since most of the physicians at those hospitals would have graduated medical school before 2003), many doctors simply do not have the knowledge, time, or communication skills to provide first-rate palliative care. Consequently, one of the most important aspects of palliative care policy is education.

Both state attorneys general and legislatures have taken a lead in this area. After successfully arguing that a state could ban physician-assisted suicide in *Vacco v. Quill*, former New York Attorney General Dennis Vacco launched a Commission on Quality Care at the End of Life in order to improve palliative care in the state. Attorney General Vacco maintained that:

> In a world in which we have made so many dramatic advances in medicine, terminally ill patients should not be forced to choose between a painful death and assisted suicide because quality palliative care is not available or accessible. State legislators have the important task of evaluating the options and making policy decisions to ensure that appropriate care is available to all.

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27 *See Brody, supra.*
The Commission’s final report found that inadequate training of healthcare providers was one of the greatest barriers to providing effective palliative care. In response, the New York Academy of Medicine, the Associated Medical Schools of New York, and Weill Cornell Medical College developed the Palliative Education Assessment Tool (PEAT), which medical schools could use to evaluate their curricula on end-of-life care. PEAT was designed to improve care in seven areas: palliative medicine, pain, neuropsychologic symptoms, other symptoms, ethics and the law, patient/family/caregiver/non-clinical perspectives on end-of-life care, and clinical communication skills. PEAT has had a significant affect on medical school education. As previously mentioned, 87% of medical schools required palliative care training in 2003. In 1997, one year before the Vacco Commission’s report, that number was only 25%.

In September 2007, the New York State Assembly enacted the Palliative Care Education and Treatment Act, the first law of its kind in the United States. The Act provides $4.6 million for undergraduate and graduate medical education in palliative care, the development of a New York State Palliative Care and Education Council, the establishment of Department of Health-designed Centers for Palliative Care Excellence, and the formation of Department of Health-certified palliative care practitioner resource centers. The funding will be distributed through a competitive grant process, using

33 See Brody, supra.
35 Id.
PEAT as a standard to evaluate potential recipients.\textsuperscript{36} This is an extremely important step forward in improving end-of-life care. It provides legislative back-up for the recommendations of the Vacco Commission ten years earlier, and addresses one of the most serious obstacles to access to palliative healthcare. It also tackles the education problem beyond medical schools, which have already seen a great deal of improvement in the past ten years. By establishing palliative care resource centers and hospital-based centers of excellence, the Act extends education to practicing professionals and will hopefully encourage the creation of specialized palliative care teams at more hospitals. Advocacy groups such as Compassion & Choices, which initiated the work on the bill, hope that the New York Act will serve as a model for other states.\textsuperscript{37}

While lack of education is a very serious barrier to quality end-of-life healthcare, arguably the most difficult obstacle to overcome is physicians’ fear that prescribing opioids will result in legal consequences. Palliative care policy has long been fraught with conflicts between pain management and drug abuse enforcement. On the federal level, narcotics are regulated under the Controlled Substances Act (CSA), which is enforced by the Drug Enforcement Administration (DEA).\textsuperscript{38} Prescription medications, including many controlled substances, are also regulated under the Federal Food, Drug, and Cosmetic Act (FDCA).\textsuperscript{39} Most of the pain medications discussed in this paper would be classified as Schedule II drugs under the CSA; Schedule II drugs have both a valid medical purpose and strong potential for abuse.\textsuperscript{40}

\textsuperscript{37} Press Release, Compassion & Choices of NY, Palliative Care Education and Training Act Enacted (September 24, 2007), \textit{available at} http://www.compassionandchoicesofny.org/Newsletter/0/News.html#1.
The CSA does attempt to find a balance between drug enforcement policy and availability of narcotics to patients who need them: “Section 801 of the CSA recognizes that controlled substances “have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” In 2001, the DEA released a joint statement with 21 health organizations, including the American Medical Association, the American Academy of Pain Medicine, and the American Academy of Hospice and Palliative Care that stated that “there is consensus, by law enforcement agencies, health care practitioners, and patients advocates alike, that [preventing drug abuse] should not hinder patients’ ability to receive the care they need and deserve.” However, the text of the CSA is confusing. Section 1306.7 seem to imply that narcotic medications should be used only when other treatments have failed, which may suggest to providers that they must go through a possibly unnecessary and time-consuming process of elimination before finally prescribing the appropriate medication: “While there is little debate that both non-pharmacologic alternatives and non-opioid medications are valuable, the decision to use a particular treatment for pain should be based on medical judgment, not governmental scrutiny.” This is despite the fact that even the DEA has acknowledged that “for many patients, opioid analgesics…are the most effective way to treat their pain, and often the only treatment option that provides significant relief.” Additionally, all of the states have their own drug enforcement laws,

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43 See Dilcher, supra.
44 Id.
which can create further confusion for prescribers. Consequently, many healthcare providers are understandably concerned about the legal ramifications of prescribing narcotics. “For better or for worse, the DEA sets the tone and drives physicians' perceptions about the legal risk associated with prescribing Schedule 2 drugs (potentially addictive drugs with critical medical uses) for seriously ill and dying patients.” Despite their possible civil liability for undertreating pain, many doctors are far more concerned about being labeled drug pushers or accused of using pain medication to hasten their patients’ deaths.

Their fears are not unfounded. In the past several years, there have been two high-profile prosecutions and convictions of doctors under the CSA. Dr. Ronald McIver ran a pain management clinic in Greenwood, South Carolina, where he prescribed high doses of opioid drugs. Some of his patients sold or abused the medication he provided, and one man died with OxyContin he had prescribed in his system. Dr. McIver was convicted of various counts of unlawful distribution of a controlled substance, conspiracy to unlawfully distribute a controlled substance, and unlawful distribution of a controlled substance resulting in death and sentenced to 30 years in prison. However, his patients all testified that they obtained their prescriptions by lying to him, and prosecutors presented no evidence that he intended to write prescriptions that would be sold or abused. The problem with inferring intent from not seeing a lie where someone else might have is that doctors “have a truth bias: they are trained to treat patients by trusting what they say. Doctors are not good at detecting liars even when they have been warned, during experiments, that they will be visited at some point by an actor faking

46 See Dilcher, supra.
47 See Quill and Meier, supra.
48 See Rosenberg, supra.
In a sense, Dr. McIver’s conviction was the criminalization of questionable medical judgment, which is a civil issue, not a criminal one.

Dr. William Hurwitz was a pain management specialist in Virginia, some of whose patients abused the drugs he prescribed and sold them on the black market. He was initially convicted in 2004 of over 50 counts of drug trafficking charges and sentenced to 25 years in prison. His conviction was overturned on appeal due to errors by the trial judge that prevented the jury from considering his defense, which was that he prescribed the drugs in good faith. Again, the prosecution presented no evidence that Dr. Hurwitz intended to illegally distribute drugs – simply that he should have known better, which is normally a civil malpractice issue. On retrial, Dr. Hurwitz was convicted of 16 counts of drug trafficking and sentenced to four years and nine months in prison, which prosecutors considered a disappointing outcome. However, in the sentencing portion of the second trial, Judge Leonie Brinkema ruled that while she agreed that he had crossed the line to providing drugs for illegal purposes, “the ‘overwhelming majority’ of his patients were legitimate…’an increasing body of respectable medical literature and expertise supports those types of high-dosage, opioid medication.”

These are not isolated cases.

The DEA’s investigatory and prosecutorial powers are broad, far-reaching, and fearsome; the mere fact of being investigated by the DEA, even without a subsequent finding of culpability, can taint a practitioner's reputation and affect his practice. For example, in 1987 the DEA investigated Dr. Albert Brady, an oncologist from Portland, Oregon, for prescribing high doses of the painkiller Dilaudid to a cancer patient in a nursing home. The DEA suspected that Dr. Brady was supplying Dilaudid to the black market rather than to his patient. Although the DEA ultimately concluded that Dr. Brady was not illicitly

49 See Tierney, Trafficker or Healer?, supra.
prescribing Dilaudid, it nevertheless notified the State Board of Medical Examiners, which fined Dr. Brady $5000 and suspended his license for a month for overprescribing controlled substances. Dr. Brady told the Journal of NIH Research that, as a result of this experience, his two partners “changed their practice overnight and became reluctant to prescribe sufficient doses of painkillers.”\footnote{See Dilcher, \textit{supra}.}

Drs. Timothy Quill (who challenged New York’s ban on assisted suicide in \textit{Vacco v. Quill}) and Diane Meier (the director of the Hertzberg Palliative Care Institute and a top specialized in palliative care) describe the DEA’s presence in end-of-life care as a “big chill.”\footnote{See Quill and Meier, \textit{supra}.} There are certainly genuine cases of doctors who use their prescription authority to break the law, and they should be prosecuted to the full extent of the law. However, the misconceptions that cloud to CSA – from the implication that all other methods of pain must be exhausted before a doctor can prescribe narcotics to the misconception, which seems to live in several provisions, that the use of opioids correlates with faster death\footnote{See Dilcher, \textit{supra}.} – create a dangerous confusion for medical professionals who are neither lawyers nor, often, experts in palliative care. As a result, doctors often hesitate to prescribe appropriate pain medication, and patients suffer needlessly.

In 2002, more state attorneys general became further involved in palliative care policy when the National Association of Attorneys General (NAAG) launched the End-of-Life Healthcare Project. The NAAG End-of-Life Healthcare Project has provided an invaluable resource for attorneys general working to improve palliative care for their constituents. In addition to educating attorney general staff on the issue, it has brought the pervasiveness and impact of the problem to their attention. The project was initiated by Oklahoma Attorney General Drew Edmondson, who chaired NAAG that year. The

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\item \footnote{See Dilcher, \textit{supra}.}
\item \footnote{See Quill and Meier, \textit{supra}.}
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\end{itemize}
project identified three areas in which attorneys general could make a difference in their states: pain management, recognition of the wishes of people at the end of their lives, and ensuring quality end-of-life healthcare.\(^54\) NAAG held three regional listening conferences to learn about how attorneys general could best use their powers and resources to improve palliative care for the citizens of their states, soliciting testimony from experts in the field. A 2003 report on the project outlined the following ways for an attorney general to become involved in improving end-of-life care:

- Becoming a visible ally of consumers concerned about their or their family members’ end-of-life healthcare.
- Issuing formal opinions and letters of advice about issues in the field.
- Disseminating easy-to-understand information about advance care directives.
- Encouraging state medical boards to ensure that their policies do not deter doctors from prescribing adequate pain medication.
- Working with state licensing boards to possibly include severe undertreatment of pain as a cause of disciplinary action.
- Promoting an appropriate balance between drug abuse enforcement and pain management in criminal law enforcement.
- Advising legislators on the end-of-life issues.\(^55\)


The project was also designed to act as a resource for attorney general staff to learn about the issue and find out what kind of strategies their counterparts in other states had used to successfully remove barriers to palliative care.

The attorneys general also concentrated strongly on the balance between drug enforcement and availability of pain medication. At its spring meeting in 2003, NAAG adopted a resolution calling for a balanced approach to promoting pain relief and preventing drug abuse. Within the resolution, NAAG endorsed the joint statement from the DEA and 21 health organizations discussed above. It also resolved to encourage states to carefully consider and try to minimize impact of their prescription drug abuse enforcement programs on the legitimate use of pain medication and called on Congress to refrain from preempting state policy on the issue. The latter part of the resolution reflects the growing gap between state government officials’ concern with end-of-life healthcare and the DEA’s perceived aggressiveness in prosecuting doctors. Attorneys general became concerned about that gap due to an alarming series of events in 2004 and 2005.

In 2004, the DEA issued the *Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel*, which reflected a balanced approach. The FAQ was based on the 2001 Joint Statement by the DEA and 21 health organizations, and went into detail about pain treatment, dosing, risks, and legal questions. However, the FAQ was suddenly withdrawn in October. One month later, it was replaced with an Interim Policy Statement, “Dispensing of Controlled Substances

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for the Treatment of Pain.” The interim statement more strongly emphasized enforcement, and added to the confusion that many doctors already feel about the laws surrounding opioids. “The Interim Policy Statement addressed ‘a few of the significant misstatements’ contained in the FAQ, leaving the interested community wondering what other aspects of the FAQ were likely to be considered ‘misstatements’ later.” On January 19, 2005, 32 attorneys general signed a letter to Karen Tandy, the administrator of the DEA, asking for an explanation. The letter expressed concern that the added emphasis on enforcement “seems likely to have a chilling effect on physicians engaged in the legitimate practice of medicine.” The participating attorneys general followed up on March 21, 2005, with an official comment (a solicitation of comments had been posted in the Federal Register when the new policy was published). The comment emphasized again that “recent DEA actions send mixed messages to the medical community and are likely to discourage appropriate prescribing for the management of pain.” The comment pointed out that this change in balance was directly opposite from state efforts to increase access to pain medication, and made several recommendations. The attorneys general asked the DEA to reaffirm its commitment to the balance policy in the 2001 Joint Statement, create an Advisory Committee to reassure all the stakeholders and assist in developing a balanced, common-sense policy, and generally, consider the real-world consequences as it develops policy. It also requested that the DEA specifically

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61 See Comment on Dispensing of Controlled Substances for the Treatment of Pain, supra at 1.
state that it is acceptable for medical practitioners to provide several prescriptions on the same day, with instructions that they be filled on different days. The comment further asked the DEA to focus on factors that differentiate criminal drug activity from legitimate medical practice in its investigations.62

The comment emphasized how significantly the added confusion in the Interim Policy Statement could affect patients, given that “physicians tend to practice conservatively to avoid even the possibility of legal involvement.”63 A doctor would be even more likely to avoid prescribing opioids, even when they would be the best option for the patient’s health, based on the policy’s statement that “it is a longstanding legal principle that the Government ‘can investigate merely on suspicion that the law is being violated, or even just because it wants assurances that it is not.’”64 The knowledge that their prescription practices are legitimate would offer cold comfort to a doctor who had heard (for instance) of the case of Dr. Albert Brady, discussed earlier in this paper, who suffered serious professional consequences after being investigated despite the DEA’s conclusion that he was not, in fact, prescribing drugs for illegal purposes. Most doctors understand that a DEA investigation, even if it uncovers no evidence of any wrongdoing, will cost them a great deal to defend, at a significant cost to their livelihood and professional reputation. The DEA’s statement amounts to what many providers would consider a very serious threat.

The attorneys general also questioned the Interim Policy Statement’s “correction” of a statement in the FAQ that the number of patients in a practice who receive opioids, number of pills prescribed, and length of time that the prescription lasts do not indicate

62 Id. at 2.
63 Id at 4.
64 See Interim Policy Statement, supra.
any illegal activity, and should not be used as the basis of an investigation without other evidence. The new policy states that those factors “can indeed by indicative of diversion.”65 The comment pointed out that by naming these factors as potential bases of investigation, the DEA would directly discourage doctors from prescribing medication they legitimately feel their patients need. The attorneys general argued that the most effective way to investigate drug crimes is to start with “drugs that are illegally on the streets and work back to see how they got there. An undue focus on potentially misleading factors like the number of prescriptions written or number of patients seen in a practice would serve neither the goals of law enforcement nor the needs of suffering patients.”66 They also objected to the DEA’s new prohibition on pre-dated prescriptions. State medical boards have allowed doctors to provide several prescriptions with instructions to fill them on different dates in order to allow chronically ill patients to maintain their medical routine without the time and expense of multiple trips to the doctor simply to get new prescriptions. The new policy especially burdens patients who are very ill and nearing the end of their lives, for whom travel can be very difficult.67 The comment concluded by emphasizing that “improvements in health sciences and health care have not only allowed people to live longer, but have also prolonged the process of dying for most people in the United States.”68 The attorneys general urged the DEA to consider the effects on the growing population of people in legitimate need of pain medication when shaping drug enforcement policy.

65 Id.
66 See Comment on Dispensing of Controlled Substances for the Treatment of Pain, supra at 6.
67 Id. at 7.
68 Id. at 9.
The DEA responded to NAAG (as well as many other organizations that expressed concerns) with its final Policy Statement, “Dispensing Controlled Substances for the Treatment of Pain,” on September 6, 2006. The DEA attempted to reassure the concerned medical and legal communities by stating that it understands that the number of physicians who violate that CSA is extremely small, and that there is no “crackdown” on doctors. However, it stood by the language stating that the government “can investigate merely on suspicion that the law is being violated, or even just because it wants assurance that it is not.”

The policy statement states:

The foregoing is a correct statement of the law, and the DEA is not unique in this regard. All law enforcement agencies – Federal and States – have long been governed by this same principle...While those who commented on the subject of investigations generally acknowledged that DEA had properly stated the law, some asserted that, by doing so, the agency might have caused some physicians to fear the prospect of being investigated and thereby discouraged them from providing proper pain treatment. DEA believes, however, physicians will understand that correctly stating the legal standard which has historically applied to regulatory agencies is no cause for alarm. DEA does not use its investigatory authority in an arbitrary manner. Further, as DEA has repeatedly stated in this document and elsewhere, there is no "crackdown" or increased emphasis on investigating physicians, and the statistics bear that out. In 2005, as in prior years, only a tiny fraction of physicians (less than one in ten thousand) lost their registration based on a DEA investigation of improper prescribing of controlled substances.

The DEA also refused to provide a set of clear guidelines on the use of controlled pain medications, arguing that the courts have never identified specific criteria of what prescribing is and is not legally allowable, and that providing the guidelines would undercut the authority of state medical boards to regulate the practice of medicine. It also declined to create an Advisory Committee as the comment requested. Because of the


70 Id.
recency of these policy changes, their effects on physicians’ prescribing patterns remains
to be seen.

**Part III: Using the Attorney General’s Power to Protect Consumers at the End of
their Lives**

There are both cases and strong arguments from the interested community for
using the legal system to protect patients seeking pain relief. Two important recent cases
held the undertreatment of pain to be elder abuse. In *Bergman v. Eden Medical Center*, a
jury found that by failing to relieve the pain of a patient dying of lung cancer, a doctor
committed reckless negligence and elder abuse.\(^{71}\) In *Tomlinson v. Bayberry Care Center*,
the attorney general’s office actually played a role. After Lester Tomlinson died of lung
cancer following twenty days of extreme, severely undertreated pain, his family filed a
civil suit as well as complaints with the Medical Board of California, the California
Department of Health, and the Center for Medicaid and Medical Services. The Medical
Board filed charges against Mr. Tomlinson’s physician through the state attorney
general’s office, and the Department of Health sanctioned the facility where he died.
When the civil suit was settled, the hospital agreed to implement a palliative care
education program for its staff.\(^{72}\) Advocates and scholars have argued powerfully in
support of implementing consequences for undertreatment of pain. Kathryn Tucker, the
legal director of Compassion & Choices, argues that Intractable Pain Treatment Acts,
which provide a “safe harbor” from board discipline (but not law enforcement) for

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physicians who follow a set of guidelines in their prescription practices, have been ineffective in resolving the undertreatment problem. She writes:

IPTAs [(Intractable Pain Treatment Acts)] that currently provide a safe harbor for physicians who follow guidelines in prescribing medications to relieve pain should be revised to explicitly create rough waters for physicians who fail to do so. Such amendments would require disciplinary action, or provide an explicit tort cause of action, when there is failure to adequately prescribe, order, administer, or dispense controlled substances, including opioid analgesics, for pain relief or modulation in accordance with prevailing clinical practice guidelines…This is essential because a safe harbor is not enough; the seas outside must be rough. Physicians who presently fail to adequately treat pain believe that they are already in a safe harbor because there has not historically been professional accountability for such conduct. There must be a reason to seek the safe harbor. Until physicians are aware that professional consequences and accountability attach if they fail to treat pain adequately, necessary improvement in provision of pain care will not occur.73

While attorneys general cannot tell licensing boards when to impose discipline, they do have the ability to create rough seas of their own. All state attorneys general are charged with enforcing laws protecting consumers, including consumers of medical care who are at the end of their lives. There are a number of examples of attorneys general using their consumer protection power in the healthcare field. For instance, in November 2007, Massachusetts Attorney General Martha Coakley announced a settlement for $75,000 with a nursing home that was not properly caring for one of its residents.74 In April 2007, Michigan Attorney General Mike Cox announced that a penalty had been imposed against a corporation for inadequate quality of care at its nursing home.75 In addition to financial penalties, attorneys general regularly pursue settlements that require facilities to take specific actions to improve their quality of care. For example, in 2003, New York

73 See Tucker, supra at 54.
75 Id.
Attorney General Eliot Spitzer reached an agreement with two hospitals in a town with a high population of refugees that required the hospitals to provide language assistance to patients.\textsuperscript{76}

State attorneys general should add their offices as a means of legal recourse for patients with undertreated pain and their families. Their offices already have experience protecting the rights of consumers undergoing medical care, and courts have already found that patients have a right to have their pain relieved when possible. However, an investigation by the attorney general would have far broader effects on a hospital or nursing home’s practice than a malpractice suit by a patient or family. By imposing a financial penalty paid to the state, the attorney general would send a powerful message that providers are accountable not only to individual patients, but to society at large – and that their patients’ rights will be enforced and protected by the government. That message would create a strong incentive to competently and fully treat pain, which would at least to some extent moderate the disincentives many doctors see in the DEA’s policy and actions. Further, by targeting hospitals and nursing homes, the attorney general’s office could reach far more providers than if it tried to monitor individual doctors (a task that for a number of reasons is far better left to medical boards). Organizations that employ healthcare providers have a duty to monitor them, and are responsible for their misconduct, and the doctors who work there have obvious incentives for not putting their employers in legal and financial jeopardy.

An effective program by an attorney general’s office would include the following components:

• Informing citizens of their right to pain management and the attorney general’s intention to enforce that right.

• If they do not already exist in the particular state, advocating that the legislature pass specific laws protecting a patient’s right to have his or her pain competently treated.

• Participating in cases brought by patients whose pain was undertreated and their families by conducting independent investigations.

• Pursuing financial settlements on behalf of the state for violations of consumer protection statutes.

• Insisting that settlements include an education program in palliative care for the hospital or nursing home staff. As discussed earlier in this paper, lack of education is a major obstacle to adequate palliative care, and any effective policy in this area must address it.

• Requiring that settlements include a demonstration by the hospital or nursing home of a process that ensures that patients have access to pain management. The details of the process would depend on the facility and its resources, but it could include an ombudsman for patients at the facility, pain reports that healthcare providers would have to file on their patients, or consultation for each patient by a pain management specialist.

• Encouraging state licensing boards to pursue disciplinary action against doctors who fail to adequately treat pain.
• Acting as an informational resource for healthcare providers concerned about possible legal consequences for prescribing pain medication under the CSA.

A policy incorporating these elements would address both major barriers to quality pain management: lack of education and fear of legal and regulatory consequences for prescribing controlled substances. The attorney general’s office cannot solve those problems on its own. State legislatures have an important role to play in improving palliative care education, and New York’s recent passage of the Palliative Care Education and Training Act is an important first step. Unfortunately, completely overcoming physicians’ fear of legal repercussions is impossible: state attorneys general do not have the power to protect doctors from the DEA. However, they can counteract the effect of the DEA’s policy on doctors’ prescribing practices by creating a legal climate in which there are consequences for failing to provide adequate pain relief. While doctors’ fears are understandable, they cannot be allowed to prevent patients from accessing the care they need.

**Conclusion**

In order to effectively improve end-of-life care for their constituents, state attorneys general should investigate and pursue legal cases against nursing homes and hospitals where patients are denied pain relief. The NAAG End-of-Life Healthcare Project has provided attorneys general with information and resources for developing a compassionate, balanced policy. In order to be effective, that policy has to include
enforcement. By insisting on agreements that require healthcare facilities to educate their employees about palliative care in addition to financial settlements, attorneys general can play an important role in tackling the two most challenging obstacles to quality end-of-life care: lack of education among healthcare providers and a legal climate that currently discourages doctors from providing competent pain management.