



---

## THE NEW YORK ACADEMY OF MEDICINE

---

**TESTIMONY OF  
DAVID KEEPNEWS, PhD, JD, RN  
DIRECTOR, OFFICE OF POLICY DEVELOPMENT  
THE NEW YORK ACADEMY OF MEDICINE  
TO THE  
NEW YORK STATE ASSEMBLY COMMITTEE ON HEALTH  
HEARING ON A.10407—PAIN MANAGEMENT LEGISLATION  
November 5, 2004  
New York, NY**

Good morning, Chairman Gottfried and Members of the Health Committee. I am David Keepnews, Director of the Office of Policy Development at the New York Academy of Medicine. The Academy is an independent, non-profit organization dedicated to enhancing the health of the public through research, education and advocacy, with a particular emphasis on underserved urban populations.

We appreciate the opportunity to speak to you today regarding barriers to good pain management, including the proposals contained in A.10407 to reduce those barriers. Ensuring management of pain is a critical component of providing good, quality health care services to patients at the end of life, those experiencing chronic pain, and those experiencing shorter-term pain resulting from acute medical conditions or during recovery from surgery. Unfortunately, even though relief from pain is increasingly recognized as an essential component of quality health care, inadequate pain management remains a significant problem.

We are encouraged that the Health Committee is focusing attention on ongoing barriers to pain management. We applaud the efforts of Chairman Gottfried, the co-sponsors of A.10407 and the bill's proponents to bring this issue to the public's attention.

We strongly agree with the bill's overall goal to establish clear and effective public policy promoting good pain management. However, we have serious concerns regarding the bill as it is now written. In particular, the bill fails to take into account significant progress that has been made in New York State over the past several years. Further improvement in reducing barriers to pain management is needed but, by failing to address problems as they exist today, the bill's likely effectiveness is greatly compromised.

## **SIGNIFICANT PROGRESS IN MEDICAL EDUCATION**

An important example of significant progress in our state is in the area of medical education. A.10407 would require medical schools to include education and training in pain management and end-of-life care. But over the past six years, New York's medical schools have engaged in concerted, voluntary efforts to develop and to strengthen curriculum content in precisely the areas outlined in the bill.

These efforts began following the work of the Commission on Quality of Care at the End of Life, convened by then-Attorney General Vacco, which released its final report in 1998. That report outlined a series of recommendations for reducing barriers to high quality care for patients at the end of life. Of course, a major component of providing quality end-of-life care is managing pain. The report found that "inadequate education of health care professionals in end-of-life care is viewed as one of the greatest obstacles to the effective delivery of palliative care today."<sup>1</sup> It noted that no medical schools in New York State at that time required palliative care education. The report called for including appropriate curriculum and training experience in palliative care in educating physicians, nurses, physician assistants, pharmacists, social workers and psychologists.<sup>2</sup>

In response to this call, the New York Academy of Medicine led a collaborative initiative with the state's medical schools. Funded by a grant from the Robert Wood Johnson Foundation, this initiative developed the Palliative Education Assessment Tool (PEAT), an instrument by which medical schools could assess their curricula with regard to content on end-of-life care in order to plan and implement measures to improve medical education across seven domains:

- Palliative medicine
- Pain
- Neuropsychologic symptoms
- Other symptoms
- Ethics and the law
- Patient/family/caregiver/nonclinical perspectives on end-of-life care
- Clinical communications skills<sup>3</sup>

Thus, PEAT includes pain as a specific domain, as well as other domains relevant to pain management. This initiative has led to significant enhancement of medical schools' palliative care content in basic science courses, ethics and humanities courses, clerkship rotations and faculty development<sup>4</sup>. These efforts have established New York as a national leader in ensuring that course content and clinical experience in palliative care, including pain management, are integral to undergraduate medical education.

Ongoing evaluation of current educational content and outcomes could help to identify remaining gaps and to develop strategies to remedy them. The state's medical schools have already demonstrated their capacity to embrace efforts to improve education in these areas and to engage in voluntary change through their existing curricular structures.

## CHANGES IN DISCIPLINARY POLICIES AND PRACTICES

Health care providers' concerns regarding professional discipline for prescribing, dispensing or administering opioid pain medication is widely recognized as a barrier to providing needed pain management<sup>5</sup>. Policies and actions by some state regulatory boards have often lagged behind current understanding of and approaches to pain management, particularly use of opioids for chronic pain<sup>6</sup>. Studies of physician prescribing practices have pointed to the "chilling effect" that may result from even a small number of disciplinary or criminal cases<sup>7</sup>.

Over the past several years, efforts spearheaded by groups including the Mayday Project of the American Society of Law, Medicine and Ethics, the Pain and Policy Study Group at the University of Wisconsin, and pain specialty organizations have resulted in significantly better informed approaches by many professional regulatory boards regarding use of opioid medications for managing pain<sup>8</sup>. The Federation of State Medical Boards (FSMB) has developed a *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, issued in 1998 and updated earlier this year. This policy recognizes that "pain management [is] important and integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain," and that "physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes."<sup>9</sup>

Among state agencies that have adopted policies on pain management since the adoption of the FSMB model policy, the New York State Board for Professional Medical Conduct has issued a policy statement explaining that it "considers prescribing, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted medical practice of the treatment of pain and sound clinical grounds."<sup>10</sup> The Office of Professional Medical Conduct (OPMC) has indicated that it will not initiate disciplinary proceedings against physicians for appropriate prescription of opioid pain medications.

If, in fact, many New York physicians continue to under-treat pain because of fear of discipline, is it because current state regulatory policies and practices are inadequate, because physicians are unaware of them, or because of factors outside the state's control (such as the U.S. Drug Enforcement Administration)? If New York physicians remain inhibited from appropriately prescribing pain medication due to factors other than current state policy and disciplinary activity, it is important to determine what measures are likely to be effective in reducing those fears—whether statutory changes would be more effective than, for instance, heightened efforts to ensure that physicians are familiar with current agency policy and practices.

A.10407 would also provide that failure to provide adequate pain treatment may be grounds for disciplining physicians and other health professionals. The FSMB model policy and the BPMC policy statement address this; the BPMC policy promotes the view of "effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, including pain as a result of terminal illness." The OPMC has indicated that it considers failure to provide adequate pain management to be a violation of standard of practice and thus can subject physicians to professional discipline.

Both of these provisions place the legislature in the unusual position of determining regulatory boards' policies on standards of professional practice. Given that New York agencies regulating physician practice currently have policies in place addressing pain treatment, a starting point should be to assess those policies before determining that changes in statute will be effective.

## **FOCUSING ON SYSTEMS OF CARE**

While professional education and discipline are clearly important, an effective approach to improving pain management must go beyond a focus on individual professions and professionals. Particularly for patients at the end of life, and for patients experiencing chronic pain, good care depends on a multidisciplinary, team approach, and it requires adequate support from health care systems and institutions.

Such support includes “incorporating principles of pain assessment and treatment into patterns of daily practice including documentation systems, policies and procedures, standards of practice, orientation and continuing education programs, and quality improvement programs.”<sup>11</sup>

Organizational protocols for pain management can help to cut through many providers’ traditional misconceptions about pain and use of opioid medication. They can also reduce fragmentation and poor communication between and among providers, which often results in pain assessment failing to result in appropriate pain management. An organizational commitment to pain management can also emphasize needed consultation and interdisciplinary collaboration—for instance, between physicians, physicians and pharmacists.

In 1999, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) adopted standards for pain management. These standards apply to accredited hospitals, home care agencies, nursing homes, behavioral health facilities, outpatient clinics and health plans<sup>12</sup>. The JCAHO standards emphasize systems accountability for assessment and management of pain. Other experts have similarly emphasized that, as the American Pain Society’s Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain explain, failure to recognize and treat pain “suggests a flaw in the design of local systems of care rather than lapses by individual clinicians.”<sup>13</sup> These guidelines stress the importance of systems-based approaches to improving pain management. This is consistent with similar approaches that increasingly characterize other quality improvement efforts, such as efforts to prevent medical errors.

The JCAHO standards represent an important development in pain management and a recognition of the importance of looking beyond the performance of individual clinicians in ensuring good pain management practices. Ongoing evaluation of their implementation and outcomes are needed to assess their impact on pain management in New York and to determine what further efforts may be needed to ensure organizational support for pain management.

## **RECOMMENDATIONS**

Developing effective public policy on pain management must be based on understanding problems and barriers to effective treatment as they currently exist. Efforts to improve pain management should include the following strategies:

1. **Continue to strengthen pain management content in medical education.** This should include an evaluation of current pain management content in both medical school curricula and residency programs, including an assessment of outcomes of the PEAT initiative related to pain management, multidisciplinary collaboration, communication and patient, family and caregiver perspectives. This effort should include comparisons of curricular content across different schools and should identify

- remaining weaknesses or gaps in medical school curricula. Funding should be made available to schools and academic medical centers to implement improvements in education and training, emphasizing incentives for designing and implementing innovative approaches to pain management education and training.
2. **Enhance pain management content in other health professions education programs.** The Vacco Commission noted a need for palliative care content (including pain management) in programs preparing a wide range of professions involved in caring for patients at the end of life. The PEAT initiative focused on curriculum change in medical education. Efforts to evaluate curriculum content and clinical experience in pain management and palliative care should be undertaken in other professions, including nursing, pharmacy and social work. Opportunities for replicating successful approaches across different disciplines should be encouraged. Funding for these efforts should be made available to health professions programs, particularly to consortia of programs.
  3. **Assess the need for change in disciplinary policies and practices.** The impact of regulatory boards' current policies and practices on pain management practices should be carefully evaluated. This effort should include licensing and disciplinary boards for all professions involved in treating patients with pain (including medicine, nursing and pharmacy). This effort should also include an evaluation of professionals' awareness and understanding of current policies and practices regarding prescribing, dispensing and administering opioid medications. In addition, it should also examine desirability of statutory versus regulatory standards on professional discipline related to pain management.
  4. **Enhance health care institutions' capacity to support and improve pain management practices.** This should include assessing current policies on pain assessment, identifying patients at risk for inadequate management of pain, and processes for identifying problems in pain management and engaging in ongoing quality improvement. This effort should also include an evaluation of the implementation of JCAHO standards of pain management in New York facilities and agencies and their impact, as well as an assessment of the need for further regulatory or legislative efforts to assure health care organizations' accountability for quality pain management.
  5. **Reduce disparities in pain management.** Significant disparities in pain management exist, particularly with regard to race and ethnicity<sup>14</sup>. Public policy approaches to pain management must include a goal of reducing and eventually eliminating disparities in assessment, evaluation and treatment of pain, including use of medications in pain treatment. This will require additional research, including development of best practices and interventions for reducing disparities in pain management.

We would again like to thank the Committee for the opportunity to comment on this important issue. I also want to reiterate strongly that we share with this bill's proponents and sponsors a common goal of eliminating barriers to good pain management for all New Yorkers. We would, of course, welcome the opportunity to collaborate on continued efforts to enact effective strategies toward achieving that goal.

---

<sup>1</sup> *Final Report of the Attorney General's Commission on Quality Care at the End of Life* (1998), p.6

<sup>2</sup> *Final Report of the Attorney General's Commission on Quality Care at the End of Life* (1998), p.ix

<sup>3</sup> Meekin, S.A.; Klein, J.E.; Fleischman, A.R. & Fins, J.J. (2000). Development of a palliative education assessment tool for medical student education. *Academic Medicine* 75(10): 986-992.

<sup>4</sup> Wood, E.B.; Meekin, S.A.; Fins, J.J., & Fleischman, A.R. (2002). Enhancing palliative care education in medical school curricula: Implementation of the palliative education assessment tool. *Academic Medicine* 77(4): 285-291.

<sup>5</sup> Johnson, S.H. (2003). Providing relief to those in pain: a retrospective on the scholarship and impact of the Mayday Project. *Journal of Law, Medicine & Ethics* 31: 15-20; Johnson, S.H. (1996). Disciplinary actions and pain relief: analysis of the Pain Relief Act.

<sup>6</sup> Gilson, A.M. and Joranson, D.E. (2001). Controlled substances and pain management: changes in knowledge and attitudes of state medical regulators. *Journal of Pain and Symptom Management* 21(3): 227-237; Joranson, D.E.; Gilson, A.M.; Dahl, J.L.; & Haddox, J.D. (2002). Pain management, controlled substances, and state medical board policy: A decade of change. *Journal of Pain and Symptom Management* 23(2): 138-147

<sup>7</sup> Hoffman, D. E. and Tarzian, A.J. (2003). Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards. *Journal of Law, Medicine and Ethics*. 31: 21-40.

<sup>8</sup> *Journal of Law, Medicine & Ethics* 24: 319-27. Gilson, A.M. and Joranson, D.E. (2001). Controlled substances and pain management: changes in knowledge and attitudes of state medical regulators. *Journal of Pain and Symptom Management* 21(3): 227-237; Joranson, D.E.; Gilson, A.M.; Dahl, J.L.; & Haddox, J.D. (2002). Pain management, controlled substances, and state medical board policy: A decade of change. *Journal of Pain and Symptom Management* 23(2): 138-147

<sup>9</sup> Federation of State Medical Boards (2004), *Model Policy for the Use of Controlled Substances for the Treatment of Pain*; Gilson, A.M.; Joranson, D.E. and Maurer, M.A. (2003). Improving state medical board policies: influence of a model. *American Journal of Law, Medicine & Ethics* 31: 119-129.

<sup>10</sup> Board for Professional Medical Conduct (2000). *Policy Statement of the Use of Controlled Substances for the Treatment of Pain*.

<sup>11</sup> Berry, P.H. and Dahl, J.L. (2000). The new JCAHO standards: implications for pain management nurses. *Pain Management Nursing* 1(1): 3-12.

<sup>12</sup> Joint Commission on Accreditation of Healthcare Organizations (2004). *Hospital Accreditation Standards*. Oak Brook Terrace, IL: JCAHO

<sup>13</sup> American Pain Society Quality of Care Committee (1995). Quality improvement guidelines for the treatment of acute pain and cancer pain. *JAMA* 274(23): 1874-1880.

<sup>14</sup> Bonham, V.L. (2001). Race, ethnicity and pain treatment: striving to understand the causes and solutions to the disparities in pain treatment. *Journal of Law, Medicine & Ethics* 29: 52-68; Green, C.R.; Anderson, K.O., Baker, T.A., et al. (2003). The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Medicine* 4(3): 277-294.