Morphine or Malpractice: Should Courts Recognize a Legal Duty to Prescribe Opiates for Treating Chronic Pain

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MORPHINE OR MALPRACTICE: SHOULD COURTS RECOGNIZE A LEGAL DUTY TO PRESCRIBE OPIATES FOR TREATING CHRONIC PAIN

INTRODUCTION

Pain is the leading reason patients seek medical attention and the primary symptom in over 80% of all physician visits.\(^1\) Although pain is universally experienced and increasingly understood,\(^2\) the undertreatment of chronic pain continues to be a major public health concern\(^3\) affecting over 50 million people and costing over $70 billion per year in health care spending and lost productivity.\(^4\) In fact, a 1994 survey found that nearly 25 million people sought help from alternative therapy professionals for pain relief because

2. See Howard L. Fields et al., eds., 9 Advances in Pain Research and Therapy 617, 617-28 (1985); see also J. David Haddox & Gerald M. Aronoff, Commentary: The Potential For Unintended Consequences From Public Policy Shifts in the Treatment of Pain, 26 J.L. Med. & Ethics 350, 351 (1998) (stating that means, knowledge and medications exist to manage all pain more effectively than it is presently being managed); Sandra H. Johnson, End-Of-Life Decision Making: What We Don't Know, We Make Up; What We Do Know, We Ignore, 31 Ind. L. Rev. 13, 33 (1998) (noting that medical capacity to relieve pain is greater than it has ever been).
traditional therapies were insufficient.\textsuperscript{5}

Opioid medications\textsuperscript{6} have proven to be the most effective analgesics\textsuperscript{7} available in treating moderate to severe pain,\textsuperscript{8} and the use of opioids to treat acute pain\textsuperscript{9} and managing chronic cancer pain\textsuperscript{10} has been clearly recognized. Both the medical\textsuperscript{11} and regulatory\textsuperscript{12} communities, however, continue to debate the proper


\textsuperscript{6} See Jerome H. Jaffe & Ari B. Jaffe, Neurobiology of Opiates/Opioids, in MARC GALANTER & HERBERT KLEBER, TEXTBOOK OF SUBSTANCE ABUSE TREATMENT 11-12, 17-18 (2nd ed. 1998) (referring to opioids as any natural drug derived from opium which is meant to be used in treatment of moderate to severe pain).

\textsuperscript{7} See TABER'S CYCLOPEDIC MEDICAL DICTIONARY 71 (12th ed. 1974) (defining analgesia as absence of normal sense of pain); see also id. (defining analgesic as medicine that relieves pain).

\textsuperscript{8} See E. Leong Way, A Pharmacologist's Concept of Narcotics, as reported in C. STRATTON HILL & WILLIAM S. FIELDS, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 39, 46 (1989) [hereinafter 11 ADVANCES IN PAIN RESEARCH AND THERAPY] (explaining that term opioid serves as better description than narcotic for this class of medications since these compounds, especially synthetic compounds, readily relieve pain without producing narcosis or state of stupor).

\textsuperscript{9} See Ada Jacox & Daniel Carr, Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline no. 1, Agency for Health Care Policy and Research ("AHCPR") publication no. 92-0032 (1992) (referring to opioids as any natural drug derived from opium which is meant to be used in treatment of moderate to severe pain).

\textsuperscript{10} See Ann Alpers, Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying, 26 J.L. MED. & ETHICS 308, 310 (1998) (pointing out that major group of drugs used in cancer pain management are opioid analgesics); Ada Jacox et al., New Clinical-Practice Guidelines for the Management of Pain in Patients With Cancer, 330 NEW ENG. J. MED. 651, 651-55 (1994) (discussing use of opioids to manage pain in cancer patients); Stephen A. Schug et al., A Long-Term Survey of Morphine in Cancer Pain Patients, 7 J. PAIN & SYMPTOM MGMT. 259, 259 (1992) (noting that during past 20 years morphine has become mainstay pharmacological treatment for cancer pain); V. A. Walker et al., Evaluation of WHO Guidelines for Cancer Pain in a Hospital-Based Palliative Care Unit, 3 J. PAIN & SYMPTOM MGMT. 145 (1998); see also Kathleen M. Foley, The Treatment of Cancer Pain, 313 NEW ENG. J. MED. 84, 84-95 (1985).

\textsuperscript{11} See Michael Zenz et al., Long-Term Oral Opioid Therapy in Patients With Chronic Nonmalignant Pain, 7 J. PAIN & SYMPTOM MGMT. 69, 76 (1992) (concluding there is no justification for withholding opioids for chronic nonmalignant pain patients when all other therapeutic measures have failed); see also Russell K. Portenoy, Chronic Opioid Therapy in Nonmalignant Pain, 5 J. PAIN & SYMPTOM MGMT. 546, 546-562 (1990) (advocating use of opioids for this patient group). But see Christoph Stein, Opioid Treatment of Chronic Nonmalignant Pain, 84 ANESTHESIA & ANALGESIA 912, 913 (1997) (concluding that efficacy of opioids in chronic nonmalignant pain remains scientifically unproven); Dennis C. Turk, Clinicians' Attitudes About Prolonged Use of Opioids and the Issue of Patient Heterogeneity, 11 J. PAIN & SYMPTOM MGMT. 218, 220-23 (1996) (questioning validity of current studies on opioid efficacy in nonmalignant pain patients).

\textsuperscript{12} See C. Stratton Hill, Jr., Government Regulatory Influences on Opioid Prescribing and Their
use of opioids to treat long-term, non-malignant intractable pain.

As the debate continues over the proper indications of opioid medications, the result is that millions of Americans are forced to endure intractable, unremitting pain and needless suffering as part of their daily existence. This Note advocates that chronic pain patients should utilize tort law to vindicate their rights. Such a theory would permit state courts to recognize a tort claim in medical malpractice against physicians who underprescribe opioid medications for those suffering chronic pain.

Part I of this Note reviews the controversial issues current in the debate and explains some of the barriers that exist in reaching a rational outcome. Part II examines the proposed medical malpractice cause of action, including the argument for its recognition, as well as defense counter-arguments. Part III evaluates acceptance of this theory, concluding that it is necessary for the courts to fashion a remedy for these plaintiffs.

I. REASONS FOR THE PROBLEM

A. Federal Government’s Regulatory Influences

The Controlled Substances Act ("CSA"), administered by the Drug Enforcement Administration, is the principal federal law that regulates the prescribing of controlled substances. Opioids are


13 See Koch, supra note 1; Bonica, supra note 4, at 83.
15 See 21 C.F.R. § 1306.04(a) and § 1306.07(c) (1996) (authorizing DEA to monitor and regulate use of controlled substances for medical use); see also Pisano, supra note 14, at 310 (stating that CSA falls under regulatory authority of DEA).
included in Schedule II of the CSA because of their potential for abuse.\footnote{16 See 21 C.F.R. § 1306; see also Pisano, supra note 14, at 311-12 (discussing CSA “scheduling” scheme for prescription medications based on drug’s abuse potential).}

The CSA, however, implicitly recognizes the medical value of opioids in treating chronic pain. For example, the definition of “addict” under the CSA does not include chronic pain patients.\footnote{17 See CSA § 102(16) (defining addict as “any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction”); see also 28 U.S.C. § 2901 (1999) (defining same); Hyman, supra note 12, at 339-42 (defining term “addict”).}

Further, the CSA and the corresponding federal regulations do not limit the amount of drug that a physician can prescribe at one time.\footnote{18 See 21 C.F.R. § 1306.}

Thus, when read together, the CSA and the corresponding regulations clearly recognize the legitimate use of opioids to treat chronic, intractable pain.\footnote{19 See Robert T. Angarola & Susan D. Wray, Legal Impediments to Cancer Pain Treatment, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 213, 216 (1989) (stating DEA has not intentionally impeded access to medically needed controlled substances); Haislip, supra note 12, at 206 (acknowledging that federal drug policy recognizes importance of prescribing and dispensing controlled substances for legitimate medical purposes); David E. Joranson, Federal and State Regulation of Opioids, 5 J. PAIN & SYMPTOM MGMT. S12, S12-23 (1990) (analyzing federal policy and reaching same conclusion); Rich, supra note 9, at 91 n.186 (pointing out that DEA disclaims any intent to discourage appropriate use of controlled substances by physicians to deal with patients’ genuine medical needs).}

B. State Government Regulatory Schemes

State substance abuse laws (similar to federal law) recognize that controlled substances have accepted medical uses and allow physicians to prescribe these drugs in the course of their professional practice.\footnote{20 See Hill, supra note 12, at 287-88 (recognizing that although opioids are used to treat pain, physicians are reluctant to prescribe these drugs because of fears over regulatory scrutiny); David E. Joranson & June L. Dahl, Achieving Balance in Drug Policy: The Wisconsin Model, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 197, 200 (1989) (discussing state policies). But see Martino, supra note 9, at 335 (detailing causes for underprescribing opioids); F. J. Skelly, Fear of Sanctions Limits Prescribing of Pain Drugs, AMERICAN MEDICAL NEWS, Aug. 15, 1994, at 19.}

Contrary to federal law, however, state laws generally do not contain provisions recognizing the efficacy of opioid use in treating chronic pain.\footnote{21 See Joranson, supra note 19, at S12-23 (stating that state laws generally do not contain affirmative language recognizing essential value of controlled substances, or provisions recognizing opioid treatment of intractable pain); see also Haddox & Aronoff, supra note 2, at 350-52 (discussing shift in public policy regarding legitimacy of treating chronic pain with opioids and rise of state laws known as Intractable Pain Treatment Acts, commonly referred to as “IPTAs”, or adopted administrative rules or guidelines meant to alleviate risks of...}
to define essential terms like "addict" or "dependence." When they do, the definition is so broad that it encompasses not only the traditional drug abuser, but also the chronic pain patient.\(^2\) Furthermore, some states, as part of their legislative scheme, require physicians to report suspected "addicts" or "habitual users" of controlled substances to state authorities.\(^3\)

Eleven states have gone farther by adopting either a multiple copy or electronic prescription program as an additional measure to curb illicit drug diversion.\(^4\) Evaluations of these programs demonstrate that they have an immediate impact on the prescribing practices of physicians, substantially reducing the prescribing of Schedule II medications.\(^5\) For example, the empirical data in a Texas study showed that after the program started in 1982, prescriptions dropped for the more potent Schedule II opioids but increased for less potent pain medications which were not subject to regulatory scrutiny.\(^6\) Commentators have suggested that these


See, e.g., New York Public Health Law § 3302 (1) ( McKinney 1999) (defining "addict" as "a person who habitually uses a narcotic drug and who by reason of such use is dependent thereon"); see also Joranson, supra note 19, at S12-23 (noting longstanding problem in attempts to clarify term "addict" and discussing Texas physicians' concerns about how provision in Texas Medical Practice Act concerning writing prescriptions for "habitual users", where this term is undefined, affects prescribing opioids for patients with intractable pain); Portenoy, supra note 11, at S46-S62 (discussing confusion in nomenclature of drug dependence).

See, e.g., New York Public Health Law § 3372 (requiring physicians to report "addicts" to Commissioner of Health); Rhode Island Uniform Controlled Substances Act, G.L. 1956 (1989 Re-enactment) § 21-28-3.20 (requiring physicians to report extended treatment of patients, defined as treatment greater than three months, to Director of Health).

See David E. Joranson & Aaron M. Gilson, Improving Pain Management Through Policy Making and Education for Medical Regulators, 24 J.L. MED. & ETHICS 344, 345 (1996) (describing multiple prescription system and discussing restrictions system places on physicians and patients); Rich, supra note 9, at 46 (noting that DEA endorses MCPP as deterrent to illegal diversion of controlled substances); Mike Troy, Dealing with Diversion; Abuse of Prescription Drugs, 16 DRUG STORE NEWS 1 (1994) (listing states requiring some form of multiple prescription for controlled substances and those also using electronic systems for monitoring controlled substance prescriptions).

See Katherine A. Sigler et al., Effect of a Triplicate Prescription Law on Prescribing of Schedule II Drugs, 41 AM. J. HOSP. PHARMACY 108, 109-10 (1984) (showing a 60.4% decrease in Schedule II prescriptions in 1,200 bed teaching hospital one year after enactment); see also James M. Cooper et al., Prescription Drug Diversion Control and Medical Practice, 268 JAMA 1306, 1307 (1992) (noting same results, and questioning clinical implications for patients); Joranson, supra note 19, at S12-23 (discussing results documented from evaluation of programs); M. Weintraub et al., Consequences of the 1989 New York State Triplicate Benzodiazepine Prescription Regulations, 266 JAMA 2392, 2392-97 (1991) (noting dramatic decrease in benzodiazepine prescriptions one year after enactment).

See Sigler, supra note 25, at 110.
shifts in prescription practices (done in an effort to avoid government regulators) substantially contribute to the undertreatment of pain.\(^\text{27}\)

State medical boards and regulatory agencies exert subtle to moderate influence on physician practices by monitoring the prescription of certain medications and sanctioning practitioners who over-prescribe with the loss or suspension of their license.\(^\text{28}\) Fear of legal or disciplinary action are a major reason physicians have under-prescribed opioids for pain.\(^\text{29}\)

A recent case from Florida illustrates this point. In *Hoover v. Agency for Health Care Administration*,\(^\text{30}\) the Florida Court of Appeals overturned its state board’s decision which required a doctor to pay a $4,000 fine, complete continuing medical education on the prescribing of “abusable” drugs, and serve two years probation.\(^\text{31}\) The state board sanctioned the physician for helping seven different patients who suffered from intractable pain.\(^\text{32}\) These penalties were assessed by the state board despite a finding from one of the agency’s own hearing officers that the board had failed to prove any of its charges against the doctor.\(^\text{33}\)

The board had relied on the testimony of two physicians whom had supported the charges.\(^\text{34}\) These purported experts, however, never examined the patients nor did they review their medical

\(^{27}\) See Hill, *supra* note 12, at 289-92. The author argues essentially that the physician, who often has no knowledge of the rules followed by the regulatory agency will play it “safe” and choose a less potent or unregulated drug to avoid attention. This practice then leads to inherent undertreatment of pain. It is important to remember that undertreating pain is distinct from no treatment of pain. When a patient requires a stronger opioid medication like oxycodone or oral morphine for proper analgesia, but winds up receiving a weaker drug from the physician because it does not appear on the list of Schedule II medications, the system is self-defeating. The patient’s pain will not be relieved. *Id.* at 294-95. *But see* David L. Ralston, *Pain Management: Texas Legislative and Regulatory Update*, 24 J.L. MED. & ETHICS 328, 334-35, n.8 (1996). Mr. Ralston tested the hypothesis of whether the propensity of physicians to treat pain adequately would be lower among physicians who perceived themselves at risk for regulatory sanctions. He found the data shows that other variables (such as lack of education and training in the proper use of opioid analgesia) contributed to the inadequate treatment of pain. He states: “The greater a physician’s knowledge level as expressed by the five knowledge factors surveyed . . . the more likely the physician was to treat pain adequately.” This factor would be consistent independently of the physician’s knowledge of the current regulatory environment. *Id.*

\(^{28}\) See *infra* notes 37 & 38 and accompanying text.


\(^{30}\) 676 So.2d 1380 (Fla. Dist. Ct. App. 1996).

\(^{31}\) *See Hoover, 676 So.2d at 1382* (describing agency action).

\(^{32}\) *See id.* at 1381.

\(^{33}\) *See id.* at 1382.

\(^{34}\) *See id.* at 1381.
records. Moreover, neither of these physicians had any experience treating patients in chronic pain; and their testimony were conclusions based on a review solely of pharmacy records detailing the type and amounts of the prescribed medications. The defendant’s experts testified that the defendant had followed protocols within the guidelines for treating patients with intractable pain. Furthermore, the facts demonstrated that two of the patients achieved relief from their pain and showed functional improvement while under the defendant’s care.

The appellate court reversed the board’s decision noting that the paucity of evidence offered did not justify the sanctions imposed, emphasizing that neither doctor testifying for the state had any experience in treating this type of patient. The court was also surprised that the board would sanction a doctor with such little evidence of misconduct.

The plight of Dr. Hoover has created a chilling effect on physician’s use of opioids in treating chronic, non-malignant pain. In response, some states have enacted legislation aimed at remedying this problem. A review of recent cases, however, leads to an interesting conclusion. Courts have reversed adverse medical board decisions when the physician has followed accepted medical practices with respect to using opioids in treating chronic pain.

35 See id.
36 See id. at 1381-82.
37 See id. at 1382, 1384.
38 See id. at 1382 (dismissing complaint as to two patients).
39 See id. at 1384.
40 See Hoover, 676 So.2d at 1384-85.
43 See McNeil v. Tennessee Bd. of Med. Exam’rs, No. 01-A-01-9608, 1997 Tenn. App. LEXIS 152, at *30 (Tenn. Ct. App. Mar. 5, 1997) (reversing medical board decision to suspend physicians’ licenses because board failed to show that treatment of patients with narcotics violated standard of care); In re DiLeo, 661 So.2d 162, 167-68 (holding that state medical board...
Likewise, courts have upheld state board actions suspending or revoking a physician's license for over-prescribing narcotics when the physician has failed to follow accepted medical practices.\textsuperscript{44} Thus, courts recognize that long-term use of opioids to treat intractable pain is an accepted standard of medical care when physicians follow medically accepted practices; and the chilling effect of these state board actions on physician prescribing practices may be an overstatement.\textsuperscript{45} The persistent under-prescription of opioids among physicians, however, may reflect a more pervasive problem that cannot simply be explained as a perceived fear of


\textsuperscript{45} In these decisions, many of the courts discussed expert medical testimony introduced by either party at the administrative hearings regarding the efficacy of long-term use of opioids in treating chronic intractable pain. See Hooter, 676 So. 2d at 1382; Johnson, 456 So. 2d at 942; McFadden, 735 So. 2d at 149; Holladay, 689 So. 2d at 725-26; McNeil, 1997 Tenn. App. LEXIS, at *22-29; DiLeo, 661 So. 2d at 165-67. In fact, the Holladay court paid particular attention to the state's expert, and enumerated several factors deemed important that physicians should follow in treating intractable pain with opioids. See Holladay, 689 So. 2d at 725. None of the courts disputed the use of opioids as appropriate care in treating chronic intractable pain. The conclusion follows that the courts believed that long-term use of opioids fell squarely within accepted medical practice in treating chronic pain as long as physicians followed accepted medical standards of diagnosis, charting and follow-up regarding these patients.
C. Cultural and Attitudinal Barriers

Americans feel that the chronic use of narcotics should be avoided. Historically, narcotics have been associated with opium dens and drug addicts. The core of this problem is the failure of medical professionals to distinguish between physical dependence and addiction in the use of opioid medications. Physicians, nurses and other health care professionals have often been identified as those most responsible for the undertreatment of chronic pain. Their attitudes, practice patterns, and lack of

46 See Martino, supra note 9, at 339-41 (describing physician's concern with loss of internal and external rewards of practice).

47 See David F. Musto, Physicians Attitudes Toward Narcotics, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 51, 54-55 (describing shifts in attitude toward narcotics at turn of century); see also Reuven Dar et al., Cancer Pain in the Marital System: A Study of Patients and Their Spouses, 7 J. PAIN & SYMPTOM MGMT. 87, 90 (1992) (showing that 69% of cancer pain patients surveyed endorsed statement that "I feel I should not take narcotic medications on a regular basis but only when the pain is extreme"); Finn, supra note 41, at 121-22 (explaining ambivalence toward narcotic use); Shannon Brownlee, The Quality of Mercy: Effective Pain Treatments Already Exist: Why Aren't Doctors Using Them? U.S. NEWS & WORLD REPORT, Mar. 17, 1997, at 55-57, 60-65 (explaining that patients contribute to their own misery because of attitudes toward narcotics).


49 See Russell K. Portenoy, Opioid Therapy for Chronic Nonmalignant Pain: Clinicians' Perspective, 24 J.L. MED. & ETHICS 296, 300-03; Hill, supra note 12, at 292; see also Kathleen M. Foley, The "Decriminalization" of Cancer Pain, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 5, 7 (1989). The fear of addiction stems from a confusion within the medical community and among the general public with respect to physical dependence, psychological dependence and tolerance when administering narcotics. Id. Physical dependence describes the symptoms associated with withdrawal when an opioid is suddenly stopped. Tolerance describes the effect that larger doses of a medication may be needed to produce the same pain relief for the patient because the disease has progressed or the patient's neuron response has built a resistance to the drug. Psychological dependence describes a pattern of drug use characterized by a continued craving for a drug, manifested by compulsive behavior aimed at doing whatever it takes to procure a new supply. Id.

Rarely do chronic pain patients develop the symptoms of psychological dependence or addiction. See J. Porter & H. Jick, Addiction Rare in Patients Treated with Narcotics, 302 NEW ENG. J. MED. 123 (1980). The authors found only four cases of documented addiction among over eleven thousand patients treated with at least one dosage of opioids. Id. See also Russell K. Portenoy & Kathleen M. Foley, Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases, 25 PAIN 171-86 (1986).

It is thought that the mechanism associated with severe pain exhausts the effects of opioids, thus the patient rarely experiences any euphoria or "high" when using these medications. See Brownlee, supra note 47, at 57. Yet this confusion persists within the medical community over physical and psychological dependence, leading to under-prescribing. Id.

50 See Margo McCaffery & Betty R. Ferrell, Nurses' Knowledge of Pain Assessment and Management: How Much Progress Have We Made?, 14 J. PAIN & SYMPTOM MGMT. 168, 170-78 (1997) (showing that gaps still exist in nurses' perceptions and management of pain patients); Barbara S. Shapiro et al., Sickle Cell-Related Pain: Perceptions of Medical Practitioners, 14 J. PAIN &
knowledge are the problem. Most healthcare professionals lack the education and training necessary for the use of opioids to treat chronic pain.

Evidence of this phenomenon is illustrated by a 1991 survey of 861 oncologists conducted by the Eastern Cooperative Oncology Group. This study revealed that just over 10% said they had received good to excellent pain management training in medical school, and only 50% felt pain management was good to excellent in their own hospital settings. In fact, these surveys show that the lack of education and training on pain management is endemic within the health care professions.

Reports also suggest that physician "opiophobia" leads to the undertreatment of pain. Physicians are overly concerned with the use of narcotics for fear of their patients becoming addicted to these medications. In spite of the growing body of evidence that

SYMPTOM MGMT. 168, 171-74 (1997) (finding that 53% of emergency room physicians and 23% of hematologists thought that more than 20% of patients in this subject class were addicted to pain medications; see also Francoise LaRue et al., Underestimation and Undertreatment of Pain in HIV Disease: Multicenter Study, 314 BRITISH MED. J. 23, 23-28 (1997) (showing that physicians routinely underestimate and under treat pain in HIV patients); Richard M. Marks & Edward J. Sachar, Undertreatment of Medical Inpatients with Narcotic Analgesics, 78 ANNALS INTERN. MED. 173, 173-81 (1973) (documenting poor pain treatment for post-operative surgical patients).

See Turk, supra note 11, at 224-28 (describing results of national survey of physicians and their differing perceptions on treating chronic pain patients; see also Rebecca A. Drayer et al., Barriers to Better Pain Control in Hospitalized Patients, 17 J. PAIN & SYMPTOM MGMT. 434, 437-38 (confirming prior findings that physicians and nurses consistently underestimate severity of patients' pain).

See Joanne E. Mortimer & Nancy L. Bartlett, Assessment of Knowledge About Cancer Pain Management by Physicians in Training, 14 J. PAIN & SYMPTOM MGMT. 21, 25-28 (1997) (showing that graduate medical students were not adequately trained in pain assessment or management, and had lack of understanding in pharmacological advantages and side effects associated with opioid medications).


See McCaffery & Ferrell, supra note 50; Mortimer & Bartlett, supra note 52; see also Brian D. Greenwald & Elizabeth J. Narcissian, Opioids for Managing Patients with Chronic Pain: Community Pharmacists' Perspectives and Concerns, 17 J. PAIN & SYMPTOM MGMT. 369, 373 (1999) (showing pharmacists share common misperceptions regarding tolerance, physical dependence and addiction with opioids).

See Martino, supra note 9, at 336 (attributing "opiophobia" to principles at work in physicians' under-prescribing of opioids); John P. Morgan & Karoline S. Puder, Postoperative Analgesia: Variations in Prescribed and Administered Opioid Dosages, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 175, 178 (1989) (coining term and describing phobia).

See John P. Morgan, American Opiophobia: Customary Underutilization of Opioid Analgesics, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 181, 186-88 (1989) (describing this concern; see also Foley, supra note 49; Portenoy, supra note 3; Schuster, supra note 48; Shapiro et al., supra note 50. But see Stein, supra note 11, at 913 (questioning safety of long-term opioid use); Turk, supra note 11, at 220-23 (pointing out that addiction rate in some studies approached 10%); Brownlee, supra note 47.
supports the efficacy of treating chronic pain with opioids, the 
opiophobes have resisted education and training on the clinical uses 
of opioids, and have avoided the effects of these decisions by 
neglecting the proper assessment of pain. The under-treatment of 
chronic pain is a result of ignorance and neglect rather than poor 
education.

Physicians have learned to prescribe medications chiefly by 
custom, and they regulate their prescribing behavior by 
comparison with their peers. The problem with customary behavior 
is that people frequently ignore the results of such behavior. The 
adherence to customary behavior among physicians is pervasive, 
and involves an ethic within the medical establishment to avoid 
risks.

None of these perceived threats attach when a physician under-
treats a chronic pain patient. Physicians have been sanctioned for 
the over-prescription of opioids, yet have never been disciplined for 
the under-prescription of these medications. Since under-treating 
pain has been the accepted practice within the medical community, 
peers have exerted minimal pressure to change the norm. Therefore, 
some external incentive is needed to alter physician-prescribing 
practices from the customary undertreatment of pain to the 
appropriate level.

57 See id. See also Drayer et al., supra note 51; LaRue et al., supra note 50; Marks & Sachar, supra note 50; Mortimer & Bartlett, supra note 52; Porter & Jick, supra note 49; Portenoy & Foley, supra note 49.

58 See Morgan, supra note 56, at 188 (disputing claim that undertreatment results from poor education or training but from conscious choice physicians make to undertreat); see also Charles S. Cleeland, Pain Control: Public and Physicians’ Attitudes, 11 ADVANCES IN PAIN RESEARCH AND THERAPY 81, 82-84 (1989) (echoing similar sentiments and attitudes among sample of physicians in Wisconsin study).


60 See id.

61 See Martino, supra note 9, at 334, 336-342 (explaining how ethics form and describing both internal and external rewards that force conformity to norms).

62 See id.

63 See supra notes 37, 38 and accompanying text. See also Martino, supra note 9, at 346 (noting that “not a single case is on record in which a medical board has taken a formal disciplinary action against a physician for underprescribing”). But see Rich, supra note 9, at 84 & n.439 (noting that first case of this kind has been filed in California, captioned as, Bergman v. Chin, No. H205732-1 (Cal. App. Dep’t. Super. Ct., Feb. 16, 1999)).

64 See Cleeland, supra note 58, at 82; Martino, supra note 9, at 339-341 (describing how institutionalized pressures reinforce ethic of under-prescribing).
II. THE MEDICAL MALPRACTICE CAUSE OF ACTION

A. Theory of the Cause of Action: The Prima Facie Case

In an action for medical malpractice the plaintiff must show that the physician (1) owed a duty of reasonable care in providing medical treatment to the patient; (2) the breach of this duty by the physician by failing to exercise reasonable care; (3) that the breach of duty proximately caused the patient’s injury; and (4) that the plaintiff suffered damages as a result of the physician’s negligence. Courts have universally held that a physician owes a legal duty of care to his patient. The origin of this legal duty arises either through contract or through a consensual fiduciary relationship between the parties. Once a physician agrees to treat a patient he/she must do so skillfully. The legal duty requires a physician to use reasonable care, skill and judgment in treating the patient, holding him/her liable for injury to the patient arising from lack of the requisite knowledge, skill or the failure to exercise reasonable care.

The threshold question in medical malpractice litigation is: “What is the standard of care?” Unlike other areas of negligence law where the task of defining the applicable standard of care is left to the judge or jury, courts in medical malpractice actions have delegated

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this task to the medical profession.\textsuperscript{69}

Courts have granted great deference to physicians by allowing them to establish their own legal standard of conduct.\textsuperscript{70} This deference shown the medical profession stands in stark contrast to ordinary negligence actions where adherence to customary practices is merely evidence of reasonableness.\textsuperscript{71}

To satisfy this legal standard a physician need only comply with the customary practices within the profession.\textsuperscript{72} This standard, however, leaves physicians free to practice by force of habit, which may not necessarily reflect a "good standard of care."\textsuperscript{73} A physician who is only responsible for following and keeping up with customary practice standards has little incentive to improve his/her skills beyond a level of minimum competency.\textsuperscript{74} Blind adherence to custom thwarts the adoption of innovative advances in medical science, and a new technique or clinical improvement cannot, by definition, be customary until the general medical community has adopted it.\textsuperscript{75}

Expert testimony, usually introduced by both parties, has been required to establish whether the defendant's conduct has complied with or deviated from the customary practices within the medical profession.\textsuperscript{76} Under the cause of action proposed in this Note, the plaintiff would be required to call an expert witness to testify that the standard of care in treating chronic pain called for the use of opioid medications, and the physician's omission or reluctance to institute this type of treatment represented sub-standard care. This may prove to be a daunting task due to the judicial deference courts have granted to the medical profession—allowing customary practices to define the appropriate standard of care.\textsuperscript{77} This

\textsuperscript{69} See McCoid, supra note 66, at 606; see also Richard N. Pearson, The Role of Custom in Medical Malpractice Cases, 51 IND. L.J. 528 (1976).

\textsuperscript{70} See KEETON ET AL., supra note 65, \S \textsuperscript{32} at 189; see also James A. Henderson, Jr. & John A. Siliciano, Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice, 79 CORNELL L. REV. 1382, 1384 (1994).

\textsuperscript{71} See McCoid, supra note 66, at 606.

\textsuperscript{72} See Henderson & Siliciano, supra note 65, at 1384; McCoid, supra note 66, at 606.

\textsuperscript{73} See W. Page Keeton, Medical Negligence – The Standard of Care, 10 TEX. TECH L. REV. 351, 354 (1979).

\textsuperscript{74} See Henderson & Siliciano, supra note 70, at 1390-91.

\textsuperscript{75} See id. at 1395.

\textsuperscript{76} See Keeton, supra note 73, at 351.

\textsuperscript{77} See 1 BARRY R. FURROW ET AL., HEALTH LAW, \S \textsuperscript{6-2} at 361 (1995) (explaining that "[m]ost jurisdictions give professional medical standards conclusive weight, so that the trier of fact is not allowed to reject the practice as improper").
adherence to custom would leave the plaintiff with the unenviable
task of proving that the standard of practice in the profession is
unreasonable.  

The legal consequence of such deference has cost society. The
current standard in medical malpractice actions has failed to
adequately compensate victims of medical negligence, or act as an
incentive to the profession to raise standards of medical care. Furthermore, the litigation costs have often prohibited worthy plaintiffs from receiving relief because highly expensive medical experts has been needed to testify in an attempt to establish the proper medical standard. These experts have become hired guns within this legal arena, and their testimony should be suspect because they invariably agree with whichever side has payed their bill. The dissatisfaction with the current system has led to a call for the use of practice guidelines in establishing the standard of care in medical malpractice litigation. Historically, courts have been reluctant to accept medical practice guidelines as the standard of care. Some courts, however, have allowed the admission of such guidelines, viewing them as neutral and unbiased evidence on the issue.

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79 See Deborah W. Garnick et al., Can Practice Guidelines Reduce the Number and Costs of Malpractice Claims?, 266 JAMA 2856, 2856-60 (1991) (stressing that current malpractice system fails to compensate injured patients); Russell A. LoCalio et al., Relation Between Malpractice Claims and Adverse Events due to Negligence, 325 NEW ENG. J. MED. 245, 245-51 (1991) (reporting that 95% of adverse events due to negligence do not result in malpractice claims). See generally R.H. Brooks et al., The Relationship Between Medical Malpractice and Quality of Care, 1975 DUKE L.J. 1197, 1197-1221 (1975) (discussing fact that current threat of malpractice liability provides weak incentive for doctors to elevate their standard of care).


81 See Garnick, supra note 79, at 2857 (referring to "hired gun" analogy in malpractice litigation); Gary W. Kuc, Practice Parameters as a Shield Against Physician Liability, 10 J. CONTEMP. HEALTH L. & POL'y 439, 442 (1994) (describing experts as "hired guns"); Trail & Allen, supra note 80, at 245-46 (listing "hired gun" analogy within criticisms of experts).

82 See Kuc, supra note 81, at 442; Mellman, supra note 80, at 376-79; Trail & Allen, supra note 80, at 242-43; see also Richard Leahy, Comment, Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines, 77 CAL. L. REV. 1483 (1989) (advocating adoption of practice guidelines as standard of care); Robyn S. Shapiro, Health Care Provider Liability Exposure for Inappropriate Pain Management, 24 J.L. MED. & ETHICS 360, 361-62 (1996) (calling for use of guidelines as measure of standard of care in treating chronic pain).

83 See Garnick et al., supra note 79, at 2858 (describing relationship between guidelines and litigation); Trail & Allen, supra note 80, at 245 (describing same).
In *Pollard v. Goldsmith*, a patient died from a tetanus infection because the physician failed to administer tetanus human-immune globulin after a serious injury. The trial court granted summary judgment for the defendant finding that the physician could not have breached the duty of care. The Arizona Court of Appeals reversed, based on the defendant’s deposition testimony, where he admitted that he accepted as authority the guidelines issued by the Committee on Trauma of the American College of Surgeons. The guidelines clearly stated that human-immune globulin should be administered to patients "with wounds which indicate an overwhelming possibility that tetanus will develop." The defendant testified that he did not believe there was an overwhelming possibility that tetanus would develop in the victim.

In *Roach v. Springfield Clinic*, the court took one step further in a case involving the admissibility of a publication by the American College of Obstetricians and Gynecologists ("ACOG"). The defendant physicians admitted that they were familiar with the guidelines and acknowledged that obstetricians commonly used the publication to prepare for their certification examinations. The court held that they were admissible, noting that the guidelines constituted a relevant industry standard of care. If a court allows one party to admit guidelines as evidence of the standard of care, it would follow that the opposing party should be given the opportunity to rebut that standard. This situation occurred in the blood bank cases during the 1980’s. Blood banks around the country faced a growing crisis because of the emerging awareness of the potential spread of the HIV virus through blood transfusions.

85 See id. at 1203.
86 See id.
87 See id.
89 See id. at 1079.
90 See id. (noting that relevant industry standards are admissible to show standard of care in negligence action).
91 See Andrew L. Hyams et al., *Practice Guidelines and Malpractice Litigation: A Two-Way Street*, 122 ANNALS INTERNAL MED. 450, 454-55 (1995) (reporting that guidelines are currently being used for inculpatory as well as exculpatory purposes in medical malpractice litigation).
Some of these centers ignored the warnings of AIDS specialists, and resisted implementing more stringent screening and testing procedures to ensure blood products were not contaminated with HIV. Plaintiffs who had subsequently contracted the HIV virus from transfusions of tainted blood initiated actions against these blood centers claiming professional negligence. In United Blood Services v. Quintana, the Colorado Supreme Court held that the defendant blood bank was negligent by adhering to out-dated professional standards existing in government guidelines.

Prior to trial, United Blood Services ("UBS") successfully argued that the expert testimony of AIDS specialists lacked scientific validity and should not be received by the jury. At trial, UBS showed that it met or exceeded all federal standards issued by the Food and Drug Administration, and followed all of the applicable guidelines for the regulation of blood banks issued by the American Association of Blood Banks and the Red Cross. The trial judge instructed the jury that if they found that UBS did comply with the professional standards, then this finding would be conclusive proof that UBS was not negligent. Based on these instructions, the jury found for UBS.

On appeal, UBS argued against implementation on the new standards advocated by AIDS specialists, claiming that any additional interrogation of donors would be intrusive and would violate their right to privacy. They argued that the scientific evidence was less than conclusive in showing that HIV could be transmitted via blood transfusions. Moreover, they feared that implementing these policies would reduce the number of willing donors, and that the negative publicity (the potential for infection

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94 See id.

95 827 P.2d 509 (Colo. 1992) (en banc).

96 See id. at 522-24.

97 See id. at 512 (discussing factual history).

98 See id. at 516-17.

99 See id. at 517-18 (detailing jury instructions given at trial).

100 See id. at 518.

101 See id. at 512-16 (describing controversy surrounding HIV transmission through blood donations).

102 See id.
from transfusions) would drive potential clients away from not-for-profit centers toward source plasma centers, which used the stringent screening processes recommended by AIDS experts.\textsuperscript{103}

The Colorado Supreme Court disagreed. In its opinion the court stated:

In a professional negligence case, therefore, a plaintiff should be permitted to present expert opinion testimony that the standard of care adopted by the school of practice to which the defendant adheres is unreasonably deficient by not incorporating readily available practices and procedures substantially more protective against the harm caused to the plaintiff than the standard of care adopted by the defendant's school of practice.\textsuperscript{104}

The court held that if the standard of care within an existing profession has not been updated with current scientific data, a court could admit evidence that shows that the continued adherence to the standard is negligent.\textsuperscript{105} Plaintiffs should be afforded an opportunity to rebut a claim that traditionally accepted practices within a profession constitute the standard of due care when new relevant scientific data indicates that the standard should be heightened.\textsuperscript{106} The decision in this case was instrumental in changing the practices of blood banks around the country, benefiting society as a whole by guaranteeing a safer blood supply.\textsuperscript{107}

When applying the same reasoning to chronic pain patients, it becomes apparent that the traditional standard of care of under-prescribing opioid medication is negligent. In this cause of action, the use of guidelines as evidence of the standard of care may allow a plaintiff's claim to survive a summary judgment motion.

Medical practice guidelines have been proposed and adopted by several states as a major component for tort reform in medical malpractice actions.\textsuperscript{108} When properly used, these guidelines can

\textsuperscript{103} See id. at 512-15 (discussing stringent donor screening programs instituted by source plasma centers in response to concern that blood transfusions could transmit HIV).

\textsuperscript{104} See United Blood Serv., 827 P.2d at 521.

\textsuperscript{105} See id. at 525-26 (finding that adherence to deficient custom or practice may itself be negligent conduct).

\textsuperscript{106} See Hyams, supra note 91, at 454-55.

\textsuperscript{107} See Tom Abate, Genetic Bloodhound/New Test From Rival Bay Area Firms Can Sniff Out Viral Infections in Donations, S.F. CHRON., May 31, 1999 at E1 (chronicling advances made in late eighties that insured safe blood supply).

\textsuperscript{108} See Trail & Allen, supra note 80, at 235.
reduce defensive medicine and the frequency of medical malpractice claims by providing physicians with an affirmative defense. The American Medical Association and the General Accounting Office have strongly endorsed the adoption of medical practice guidelines as an objective standard to assess claims raised in malpractice.

States experimenting with this process have adopted different approaches. For example, the Maine Board of Registration in Medicine promulgated guidelines that have the full effect of law. The goals of the Maine statute are to: (1) create practice parameters for defined specialties; (2) avoid malpractice claims; and (3) increase the defensibility of malpractice claims by creating an affirmative defense for doctors who substantially complied with the published guidelines. In Maine, a physician can introduce these guidelines as the appropriate standard of care, and plead an affirmative defense to any malpractice charges if he or she can show substantial compliance with the guidelines. Courts in Maine are required to instruct juries that the guidelines are the standard of care in determining malpractice.

Florida has adopted a similar approach, and the state Agency for Health Care Administration ("AHCA") is required to develop practice guidelines that physicians can voluntarily use as protection against malpractice claims. However, unlike the Maine statute that expressly prohibits a plaintiff from introducing the guidelines as part of their case-in-chief, the Florida statute is silent regarding the plaintiff's ability to use the guidelines against the physician in proving a malpractice claim. There is concern in Florida that this omission will lead to increased litigation. The overarching purpose of these statutes was to create a shield for physicians in defending claims for negligence, and not to provide a sword to plaintiffs in pursuing

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109 See id. at 233, n.17.
110 See id. at 241, nn. 67-68.
112 See ME. REV. STAT. ANN. tit. 24, § 2973 (West 1999).
113 See ME. REV. STAT. ANN. tit. 24, § 2855 (West 1999) (creating affirmative defense by showing compliance with guidelines).
114 See Begel, supra note 111, at 82-88 (discussing use of guidelines at different stages of litigation).
115 See FLA. STAT. ANN. § 408.02 (West 1998).
116 See Trail & Allen, supra note 80, at 246, n.104; see also Hyams, supra note 91, at 454 (showing that plaintiff's attorneys are likely to use guidelines when there is clear deviation from standard).
these actions. A compromise would allow the plaintiff to offer the guidelines adopted by the AHCA as evidence of the standard of care, but non-compliance by a physician would not create a prima facia case of negligence. The physician would still be allowed to use compliance with the adopted guidelines as conclusive proof that he/she practiced within the standard of care and juries would be instructed that a finding that the physician followed the guidelines would preclude any finding of negligence.

Both parties may face problems using guidelines that the medical establishment has not accepted as the standard of care within the medical institution. Guidelines, especially clinical practice guidelines, which reflect optimal or ideal treatment, measure the physician's conduct against too high a standard. The use of guidelines at trial would still require the use of experts, since both parties would need someone to explain how the guidelines apply to the defendant's conduct. The guidelines would, however, supply the jury with a neutral, impartial tool in assessing the credibility of each party's expert.

A recent study shows that plaintiffs use practice guidelines in medical malpractice disputes more often than physicians. The

117 See Begel, supra note 111, at 72-75 (discussing purpose for guideline use in medical malpractice litigation).
118 See Trail & Allen, supra note 75, at 247 (discussing compromise).
119 See Hyams, supra note 91, at 454-55. The authors point out that the most significant finding of the study showed that both parties to the litigation employed guidelines as evidence of the standard of care. Id. at 454. Allowing this process to continue may in fact be the best way to employ guidelines. For example, cases where plaintiffs can show a clear deviation from a widely accepted guideline are likely to settle rather than continue through the protracted process and expense of a jury verdict. In addition, a plaintiff's attorney who knows there is little chance of prevailing on the claim will not pursue cases where a defendant clearly complied with an accepted guideline. Id. at 455.
120 See Garnick, et al., supra note 79, at 2856-58. The authors explain that in order for guidelines to be an effective tool in reducing malpractice claims, they should be developed for events that frequently lead to malpractice claims, widely accepted in the medical community as the standard of care, and straightforward and easily interpreted by juries in any litigation. Id. Reasons for physician resistance to adopting guidelines in clinical settings have been explored by scholars. See Michael D. Cabana et al., Why Don't Physicians Follow Clinical Practice Guidelines? 282 JAMA 1458, 1463 (1999).
121 See Trail & Allen, supra note 80, at 245-53. The authors point out that in many instances the clinical guidelines that have been developed reflect the optimal standard of care in treatment or diagnosis of a particular condition. Following such a guideline as the standard of care in medical malpractice would arguably be the wrong approach. A physician is liable in tort for malpractice when his conduct falls below a minimal acceptable standard of care. Holding all physicians to an optimal standard would mean that more than half of all physicians would be liable for sub-standard care. This standard would create a system of strict liability for physicians, which would be self-defeating. Id.
122 See Garnick et al., supra note 79, at 2859; Hyams, supra note 91, at 454.
123 See Hyams, supra note 91, at 454 (finding guidelines were twice as likely to be used by
study also suggests that the growing use and acceptance of guidelines as evidence of the standard of care may have the beneficial effects of reducing the overall number of claims brought against physicians, and facilitate the early settlement of these disputes without resorting to trial. These improvements are necessary for our system which is now fundamentally flawed by the reliance of custom as the measure of the standard of care.

In order to prevail in a medical malpractice claim, the plaintiff must also show that he/she was injured and that the defendant caused that injury. The causation element needs careful consideration in this proposed cause of action. The plaintiff cannot reasonably contend that the physician caused the initial pain. Instead, the plaintiff would claim that the defendant's negligence was a substantial factor in prolonging and increasing the plaintiff's pain—by doing so the defendant deprived the patient of a reasonable chance at a better result. The plaintiff would be required to show that the physician's neglect or refusal to use opioid medications caused this lost chance. Courts that recognize the loss plaintiffs than by defendants in malpractice litigation).

124 See id.

125 See Henderson & Siliciano, supra note 70, at 1392-94 (describing flaws that exist in current system); LoCalio, supra note 79, at 245-50 (detailing abysmal results of current system in compensating victims of medical negligence).


of chance doctrine and provide the patient with a means of recovery view the compensable injury as the diminished or destroyed opportunity for a more desirable medical result, not the undesirable result itself.\textsuperscript{130} The plaintiff must only prove that the deprivation more likely than not prevented a better result.\textsuperscript{131} Underlying the lost chance doctrine, the basic premise is that "[n]o matter how small that chance may have been, and its magnitude cannot be ascertained, no one can say that the chance of prolonging one's life or decreasing suffering is valueless."\textsuperscript{132}

The liability of a physician should extend only to the portion of the patient's harm caused by the physician and not include any injury/harm the patient suffered prior to the physician's treatment.\textsuperscript{133} The valuation of the injury would have to be discounted due to the pre-existing condition that caused the chronic pain.\textsuperscript{134} This may prove to be a difficult task since opioid therapy may not have relieved the pain, or only provided marginal relief compared with the therapy the physician did employ.\textsuperscript{135}

\textsuperscript{130} The loss of chance doctrine has typically been applied in cases where a patient dies prematurely due to the preexisting condition. This Note would stress that an extension of that doctrine can apply in cases where the failure to treat the patient with opioid medication prolonged the patient's pain. For a thorough listing of jurisdictions recognizing the lost chance doctrine, and the corresponding theories surrounding its application, see Crosby v. United States, 48 F. Supp. 2d 924, 927-29, nn.13-16 (D. Alaska 1999) (listing cases and jurisdictions); John D. Hodson, Medical Malpractice: "Loss of Chance" Causality, 54 A.L.R.4th 10 (1987) (reviewing major cases); Mangan, supra note 128, at 290, n.117 (listing cases and jurisdictions recognizing doctrine); Martin J. McMahon, Medical Malpractice: Measure and Elements of Damages in Actions Bases on Loss of Chance, 81 A.L.R.4th 485 (1990) (reviewing cases).


\textsuperscript{132} See James v. United States, 483 F. Supp. 581, 587 (N.D. Cal. 1980) (holding that plaintiffs met burden of proving that patient would have benefited from earlier medical treatment).

\textsuperscript{133} See Leubner v. Sterner, 493 N.W.2d 119, 122 (Minn. 1992) (recognizing that "aggravation of a preexisting condition" is legitimate damage measure where damages occur to patient for already present condition); Bruer, supra note 109, at 973-74; King, supra note 127, at 1356-60; Mangan, supra note 128, at 284, 310.

\textsuperscript{134} See Sterner, 493 N.W.2d at 122; Oddi, supra note 109, at 639-40; see also Dillon v. Twin State Gas & Elec. Co., 163 A. 111 (1932) (explaining damage valuation when court encounters multiple, concurrent causes); Bruer, supra note 109 (discussing valuation issue).

\textsuperscript{135} See Brownlee, supra note 47, at 59. A physician can never guarantee that opioids will either totally or partially relieve certain conditions. For example, there are several conditions where narcotics offer little if any relief for patient's pain. Examples of such conditions include
The elements of causation and damages may be deemed too speculative to meet the plaintiff's burden of proof in establishing a prima facie case. In Corbin v. Wilson, the patient had an underlying illness that would continue to create episodes of moderate to severe pain even when properly diagnosed and treated with pain medication. The court struggled to determine how much of the patient's continued pain and suffering was attributable to the underlying disease and the amount caused by the physician's alleged negligence in not instituting opioid therapy. The Corbin court avoided the issue by declaring, "pain is of course incapable of exact pecuniary compensation in any case."

B. Probable Defense Counter-Arguments

The prima facie case is vulnerable to attack through the standard of care, causation, and the damage elements of the cause of action. Defense counsel would rely on both precedent and factual argument to counter such claims.

1. Standard of Care

There is no disputing that over the last ten years researchers have made progress in documenting the efficacy of long-term use of opioids in treating chronic, non-malignant pain. Yet most of the studies conducted to date dealt with the use of long-term opioid therapy with terminally ill and cancer patients. Although similarities exist between chronic patients and cancer patients they are not exact and the medical research for the proper long-term use of opioid medication in chronic patients has not been as enlightening as research done on cancer patients. Guidelines that

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137 See Wilson v. Corbin, 41 N.W.2d 702, 708 (Iowa 1950) (examining patient's pain after physician failed to diagnose fracture).

138 See id.

139 See Portenoy, supra note 11, at S46-S62; Portenoy, supra note 49, at 300-03; Portenoy & Foley, supra note 49, at 171-86; Porter & Jick, supra note 49, at 123; Zenz, supra note 11.

140 See Portenoy, supra note 49, at 297-98; Stein, supra note 11, at 913; Turk, supra note 11,
currently exist for treatment of chronic, non-malignant pain serve as useful models but they have not as of yet gained any widespread acceptance within the medical community. One factor that has exacerbated this problem has been that general practice physicians have rarely seen the majority of chronic patients. Chronic patients treated by pain specialists differ markedly from acute pain patients who have usually been followed by general practitioners. Patients referred to pain centers have had higher levels of psychological distress, more frequent psychiatric problems, greater functional impairment, more work-related injuries, more frequent use of health care services, and more frequent reports of constant pain without pain-free periods. Furthermore, they have most likely been taking opioid medications prescribed by their primary care physician. Moreover, studies have shown that the majority of patients who suffer from chronic pain have not sought treatment for their conditions. Little has been learned about them.

Although the dangers associated in the use of opioids may be overstated, these medications can pose significant risks to patients. Most of the data on the use of opioids in chronic, non-malignant pain have been non-randomized, retrospective studies that have subjectively measured patient response. Current studies

at 219-21.

141 See Martino, supra note 9, at 333 (describing physicians resistance to use of narcotics in treating chronic, non-malignant pain); Pratt, supra note 135, at 205-07 (discussing inadequate measures taken to control pain); see also Alpers, supra note 10, at 309 (noting knowledge deficiency among physicians in treating pain).

142 See Turk, supra note 11, at 220; see also Preben Bendtsen et al., What Are the Qualities of Dilemmas Experienced When Prescribing Opioids in General Practice?, 82 PAIN 89, 89-96 (1998) (describing lower incidence of treating chronic pain in general practice and different diagnostic and treatment decisions faced by general practitioners).

143 Compare Bendtsen et al., supra note 142 with Charles Chabal et al., Prescription Opiate Abuse in Chronic Pain Patients: Clinical Criteria, Incidence, and Predictors, 13 CLIN. J. PAIN 150, 151-55 (1997). Dr. Bendtsen describes very different dilemmas facing a general practice physician from those faced by Dr. Chabal, who manages a specialty pain practice. For example, the profile of a patient being treated by a general practitioner is markedly different than the patient profile presented in a pain clinic. In addition, the lower incidence of treating chronic pain in general practice raises different problems and solutions regarding the appropriateness of the use of opioids and possible addiction to narcotics than those employed by pain specialists. Id.

144 See Chabal et al., supra note 143, at 153-55; Turk, supra note 11, at 220, 224-28.


146 See Portenoy, supra note 49, at 299 (noting addiction rate has approached 10%); Turk, supra note 11, at 220-28 (noting addiction rates from previous studies); see also Pratt, supra note 135, at 229-30 (noting that opioids have been controlled since 1914).

147 See Stein, supra note 11, at 913; Turk, supra note 11, at 220-23.
have failed to document any improvement of functional status for patients on opioids. The question remains whether improved functioning should be the goal or pain management is a satisfying justification for using opioids.

A court will likely require evidence in the form of long-term, randomized studies which show that the significant risk present in the use of these drugs has been offset by some substantial gain in functional status since the failure rate in patients using opioid medication has approached 10%. The available data on the effects of long-term opioid use has been encouraging, but may not be sufficient for a court or jury trying to decide if a particular patient would have benefited functionally from the treatment. Given the current scientific knowledge, the defendant would likely argue that the proper standard of care should be the customary practice of using opioid medications sparingly, erring on the side of caution.

The above defense argument overlooks the fact that the medical profession's failure as a whole to adopt and apply readily available treatment modalities that could improve a patient's outcome or relieve their pain and suffering is in fact a breach of professional duty. In the past, courts have not hesitated to intervene and declare what the standard shall be when the deficiencies in the prevailing custom and practice within a profession are clearly inconsistent with the recognized duties. This type of judicial standard-setting would seem absolutely appropriate in the area of pain management where clinical practice guidelines developed by nationally recognized experts already exist. The fact that

148 See Dianne E. Hoffmann, Pain Management and Palliative Care in the Area of Managed Care: Issues for Health Insurers, 26 J.L. MED. & ETHICs 267, 269-70 (1998) (noting that physicians reported some patients became non-functioning while taking opioids); Stein, supra note 11, at 913.

149 See Pratt, supra note 135, at 206-07 (indicating that undertreatment of pain in and of itself is failure of modern medicine).

150 See Portenoy, supra note 3 (showing that approximately 10% of patients showed signs of addiction); Zenz, supra note 11 (showing same).

151 See Rich, supra note 9, at 38.

152 See The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932) (holding that maritime profession was negligent in failing to adopt radios for receiving current weather reports); United Blood Services v. Quintana, 827 P.2d 509, 521 (Colo. 1992) (holding that customary practices of bloodbanks was negligent when they failed to use modern tests to screen for HIV); Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974) (holding that customary practice of not administering glaucoma testing to patients under 40 was negligent).

physicians in general have failed to incorporate these guidelines into their practice should not be dispositive on the issue of liability, and should not preclude the plaintiff from introducing the guidelines as evidence of the standard of care.154

2. Error of Judgment vs. Professional Negligence

Assuming a court is inclined to accept the developing body of scientific data regarding the efficacy of opioids as evidence of the standard of care, the plaintiff would need to show that the physician’s alternative choice of therapy constituted negligent conduct, and not merely an acceptable alternative treatment under the circumstances.155 In the context of medical malpractice, a physician is required to use his/her best judgment, but the law has not held a physician liable for mere error in judgment.156

Courts have held that if an alternative form of treatment was available for a particular medical condition, either of which would have been acceptable, the physician may not be found negligent because the treatment he/she chose failed to remedy the patient’s medical condition.157 The choice between alternative treatments was a question of professional judgment and cannot be the basis for a breach of duty action.158 If the physician’s judgment had a

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154 See United Blood Serv., 827 P.2d at 521; Hyams, supra note 91, at 454-55; Rich, supra note 9, at 81; Shapiro, supra note 82, at 361-62.

155 See McDonald v. The Tom Lyle, 48 F. 690, 693 (W.D. Pa. 1891). Courts recognize the distinction between negligence and error of judgment. In a case involving the negligence of a riverboat captain, the court stated:

The distinction between an error of judgment and negligence is not easily determined. It would seem, however, that if one, assuming a responsibility as an expert, possesses a knowledge of the facts and circumstances connected with the duty he is about to perform, and, bringing to bear all his professed experience and skill, weights those facts and circumstances, and decides upon a course of action which he faithfully attempts to carry out, then want of success, if due to such a course of action, would be due to error of judgment, and not to negligence. But if he omits to inform himself as to the facts and circumstances, or does not possess the knowledge, experience, or skill which he professes, then a failure, if caused thereby, would be negligence.

Id.


157 See Spadaccini v. Dolan, 63 A.D.2d 110, 120, 407 N.Y.S.2d 840 (N.Y. App. Div. 1978). In discussing the appropriateness of whether an error of judgment charge should have been given to the jury, the court stated, “An error of judgment charge is appropriate in a case where a doctor is confronted with several alternatives and, in determining appropriate treatment to be rendered, exercises his judgment by following one course of action in lieu of another.” Id.; see also Kroll v. United States, 708 F. Supp. 117, 118 (D. Md. 1989).

158 See Delaney v. Cade, 873 P.2d 175, 187 (Kan. 1994). The Kansas Supreme Court stated: In many, if not most, instances there is more than one acceptable approach to treatment, and the fact that one doctor selects one method as opposed to another does not in and
reasonable basis, and the judgment is ultimately determined to be erroneous, the physician will not be found negligent.159

Applying this analysis, the plaintiff may not be entitled to compensation because the physician chose an alternative treatment rather than using opioids in treating his/her chronic pain. The question that would ultimately need to be decided is whether the physician was negligent in continuing the treatment after observing little or no positive results. In an effort to protect a patient's rights to humane treatment, however, a court could conclude that a physician's persistent failure to acquire and apply current knowledge and skills in effective pain management would be, as a matter of law, negligent conduct rather than an error in judgment.160

The court must remember, however, that a physician cannot guarantee success since "[i]n most situations the best medical treatment in the world cannot provide an absolute guarantee of success; medicine is not an exact science in that sense."161

3. Proximate Cause and Measurement of Damages

Even if a plaintiff were to prove negligence, the court might struggle to find an objective methodology to accurately measure damages; however, courts successfully deal with similar issues in all tort cases.162 Treating chronic pain with opioid medications cannot itself mean one method is better than or preferable to another. For every treatment there are undoubtedly other doctors who might have performed or used a different one. Courts should use extreme caution in second-guessing the methods used by medical care providers, particularly in an area as nebulous as the loss of a chance for a better or more satisfactory recovery.

159 See NORMAN S. BLACKMAN & CHARLES P. BAILEY, LIABILITY IN MEDICAL PRACTICE: A REFERENCE FOR PHYSICIANS 96 (1990) (discussing liability for error in judgment); Mangan, supra note 128, at 319.

160 See James v. Hillhaven Corp., No. 89CVS64 (N.C. Super. Ct., Nov. 20, 1990) (holding that refusal to administer adequate pain medication was negligence); Rich, supra note 9, at 83 (inferring same finding).

161 See McBride v. United States, 462 F.2d 72, 75 (9th Cir. 1972).

162 The amount of damages available to the plaintiff in lost chance cases is generally equal to the percent of a chance lost as a result of the physician's negligence, multiplied by the total amount of damages that would be awarded. See McKellips v. Saint Francis Hosp. 741 P.2d 467, 476 (Okla. 1987); see also Boody v. United States, 706 F. Supp. 1458, 1464 (D. Kan. 1989).

Other courts have argued that this approach is flawed in that it creates a false sense of accuracy. In Borgen v. United States, 723 F. Supp. 581, 583 (D. Kan. 1989), the court rejected this approach, noting that the methodology to calculate damages in lost chance cases creates a highly subjective decision for a jury under any scenario, and chose instead a different methodology as articulated by the Boody court. Id.

Still other courts have been wary that any precise method of attributing damages can be reconciled in lost chance cases because of the speculative and uncertain nature of damages. In Falcon v. Memorial Hospital, 462 N.W.2d 44, 65-68 (Mich. 1990) (Riley, C.J., dissenting), the
guarantee total relief and in many pain situations opioids may exacerbate rather than ameliorate pain. The pre-existing condition that caused the plaintiff's pain must be factored against any gain the plaintiff should reasonably have expected from the use of opioid medication. It would be ludicrous for a court to hold a physician liable for failing to cure all of his patient's pain. Expert testimony would need to establish that the defendant physician's misconduct was the probable cause, and not merely a possible cause, of some compensable injury.

III. THE LIKELIHOOD OF COURT ACCEPTANCE

A review of recent case law shows a trend: courts have entertained this cause of action in cases involving terminally ill patients. In Estate of Henry James v. Hillhaven Corp., a jury awarded the plaintiff's estate $15 million in damages. A nurse and her employer (a nursing home franchise) had reduced the dosage of pain medication which had been prescribed by the patient's physician. The plaintiff died suffering intolerable pain. The nurse in this case made a unilateral decision to reduce the dosage for oral morphine, despite the physician's orders, because she determined that the patient was addicted to the drug. When the patient had entered the nursing home he was only expected to live six

Chief Justice argued against the adoption of the lost chance doctrine stating that the doctrine imposes uncertainty and speculation upon the medical profession. Justice Riley stated:

I believe it is unwise to impose liability on members of the medical profession in such difficult circumstances as those now before this Court. Rather than deterring undesirable conduct, the rule imposed only penalizes the medical professional for inevitable unfavorable results. The lost chance of survival theory presumes to know the unknowable. ... The desire to compensate for the chance that the decedent might have survived while understandable, is not justifiable.

Id. at 67-68.

See Brownlee, supra note 47, at 59.
See Brandt & Guthmann, supra note 128, at 474-76; King, supra note 127, at 1356-60.
See McBride, 462 F.2d at 75; Delaney v. Cade, 873 P.2d 175 (Kan. 1994).
See Cooper v. Hartman, 533 A.D.2d 1294 (Md. 1987) (holding that expert testimony failed to establish that patient had "substantial possibility of better result" had he received proper treatment); Cornfeldt v. Tongen, 295 N.W.2d 638, 640 (Minn. 1980) ("To avoid a directed verdict a plaintiff must introduce expert medical testimony that it was more probable than not that the death resulted from the doctor's negligence. The jury cannot be permitted to speculate as to whether earlier diagnosis or different treatment would have resulted in a cure").

See Angarola, supra note 167, at 407.
The plaintiff successfully proved that the nurse and her employer breached their duty of care owed to Mr. James and caused him to suffer needlessly, without regard to the consequences. The jury verdict was reserved, pending the parties' settlement. Judge Grant stated in his summary statement approving the settlement that the plaintiff's action was not based on any claim that the actions of the defendants' had caused the death of Mr. James. Rather, the award was appropriate because the negligence of the defendants' had caused Mr. James additional pain and suffering which could have been avoided with appropriate palliative care.

Cases from Georgia and California, which have primarily focused on the right of a patient to request withdrawal of life-sustaining care, seem to apply the same reasoning. In State v. McAffee, the court held that the withdrawal of life support from a terminally ill patient required the physician to initiate pain control to alleviate the patient's subsequent suffering. The court stated that the right to pain treatment was inseparable from a patient's request to withdraw or withhold life support, and that the failure to initiate pain medication was a breach of duty by the physician. The right to pain medication was deemed an inherent element of a patient's right of self-determination in requesting withdrawal of treatment.

In Bouvia v. Superior Court, a California court reached the same conclusion. This case involved a request from a patient to remove a nasogastric tube. In dicta, the court indicated that the caregivers had a responsibility not only to comply with the patient's request, but also "to perform a substantial, if not greater part of their duty, i.e. that of trying to alleviate Bouvia's pain and suffering."

In Continued Care, Inc., v. Fournet, the Texas Court of Appeals, in discussing proximate cause, echoed a similar philosophy. Although the court reversed the trial court, disagreeing with its determination as to proximate cause, it seems that the Texas Court of Appeals was inclined to let the jury verdict stand.

See id.
See id.
385 S.E.2d 651 (1989).
See id. at 652.
Id. at 1145.
Id.
See id. at 422-23 (finding that evidence adduced at trial was too speculative to fulfill
Each of these cases involved a terminally ill patient suffering near the end of their life. Under these circumstances the courts seem less concerned with the normal issues of tolerance, physical dependence or addiction (cited by many physicians as reasons for their caution in prescribing opioid medications). These are particularly inappropriate concerns in the case of a dying patient. Moreover, side-effects such as respiratory depression and somnolence have diminished importance when evaluating the needs of a dying patient. Physicians should not be overly concerned that the adequate administration of opioids to relieve pain for a terminally ill patient may hasten death. Therefore, it seems that the viability of this cause of action has already gained a modicum of acceptance with respect to the terminally ill patient.

CONCLUSION

The history of the common law, both in England and the United States, shows that the evolution of the civil tort system has proven to be a powerful force in advancing social policy and vindicating personal rights. As the needs of society change, courts have been willing to fashion new or expanded causes of action drawn from requirements of foreseeability or cause-in-fact in Mr. Fournet’s death).

177 See Ezekiel J. Emanuel, Pain and Symptom Control Patients Rights and Physician Responsibilities, 10 HEMATOLOGY/ONCOLOGY CLIN. OF NO. AMERICA 41, 42 (1996) (describing these fears of addiction, tolerance and dependence as irrational in context of terminally ill patient).

178 Although beyond the scope of this article, Justice O’Connor’s concurrence in the Supreme Court’s decision in Washington v. Glucksberg, 521 U.S. 702 (1997), focused directly on this issue and may have fundamentally changed the legal landscape for the right to pain medication for terminally ill patients. Justice O’Connor drew a distinction between a generalized right to assisted suicide and a “narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death.” Id. at 2303. Justice O’Connor went on to say that she joined the majority opinion because in these challenges there was no need to address this narrower issue. Implicit in her opinion is the inference that if the Court were to hear the case of a patient who claimed there existed barriers to receiving adequate pain medication to alleviate suffering at the end of life, the Court could recognize a liberty interest in this type of case.

Justice Breyer joined Justice O’Connor’s concurring opinion “except insofar as it joins the majority” and he went on to state that Justice O’Connor’s “views, which I share, have greater legal significance than the Court’s [Chief Justice Rehnquist’s] opinion suggests.” Id. at 2310. Additionally, Justice Ginsburg’s brief comment seemed to mirror the views expressed by Justice Breyer.

Since two of the Justices, Stevens and Souter, were ready to acknowledge the right to physician assisted suicide, it is highly likely that they would also vote to recognize this interest, and their votes would form a majority. Id. at 2275 & 2305. One could reasonably conclude that a terminally ill plaintiff advancing a claim based on a constitutional liberty interest to opioid medications for palliative care would prevail.
traditional concepts of tort theory to accommodate those changes.

Courts should fashion such a civil remedy for patients suffering from non-terminal, intractable pain. For over a decade, physicians have resisted the scientific evidence demonstrating that most pain can be effectively treated with opioid medications. This resistance is based on myths, lack of knowledge, and irrational fears concerning addiction rather than any plausible scientific theory. In order to protect patients from the pervasive, customary practice of undertreating pain, courts should engage in judicial standard-setting by recognizing current pain management guidelines as the standard of care for the treatment of chronic, intractable pain. Allowing recovery under this tort theory will vindicate the rights of the millions of patients forced to endure needless pain as part of their daily existence.

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