

Improving State Medical Board Policies: Influence of a Model

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Despite advances in medical knowledge regarding pain management, pain continues to be significantly undertreated in the United States. There are many drug and nondrug treatments, but the use of controlled substances, particularly the opioid analgesics, is universally accepted for the treatment of pain from cancer. Although opioid analgesics are safe and effective in treating chronic pain, there is continued research and discussion about patient selection and long-term effects. A number of barriers in the health care and drug regulatory systems account for the gap between what is known about pain management and what is practiced.¹ Among the barriers are physicians' fears of being disciplined by state regulatory boards for inappropriate prescribing.²

State medical boards are in a unique position not only to address physicians' concerns about being investigated, but also to encourage pain management. Prior to 1989, a few state medical boards had policies relating to controlled substances or pain. Subsequently, state medical boards began adopting policies regarding the prescribing of opioids for the treatment of pain; many of these specifically addressed physicians' fear of regulatory scrutiny. Since 1989, forty-one state medical boards have adopted such policies, including regulations, guidelines, and policy statements (see Figure 1). "Regulations" are official rules issued by the medical board pursuant to legislative authority; regulations have the force of law and establish the boundaries of acceptable conduct for licensed physicians. "Guidelines" are official statements that define the parameters of medical practice as viewed by the board. "Policy statements" are position statements that address matters of concern to the board and may clarify the board's expectations. While guidelines and policy statements

may not have binding legal force, they do communicate the board's attitude toward certain medical practices.

Regulations, guidelines, and policy statements reflect the knowledge and attitudes of the board members who develop them, suggesting that the content of board policies may change over time, just as changes occur in board members' understanding of the developments in medical knowledge. For example, in September 1987³ and August 1989,⁴ the Washington State Disciplinary Board issued policy statements that specifically discouraged the use of opioid analgesics for the treatment of pain. A subsequent guideline in 1992 stated that chronic pain is "best not treated with opioids."⁵ Four years later, after reexamining the role of opioids in chronic pain, the board stated:

opioids may be prescribed, dispensed, or administered when there is an indicated medical need without fear of injudicious discipline [by the boards].... Opioid analgesics can be useful in the treatment of patients with intractable non-cancer pain....⁶

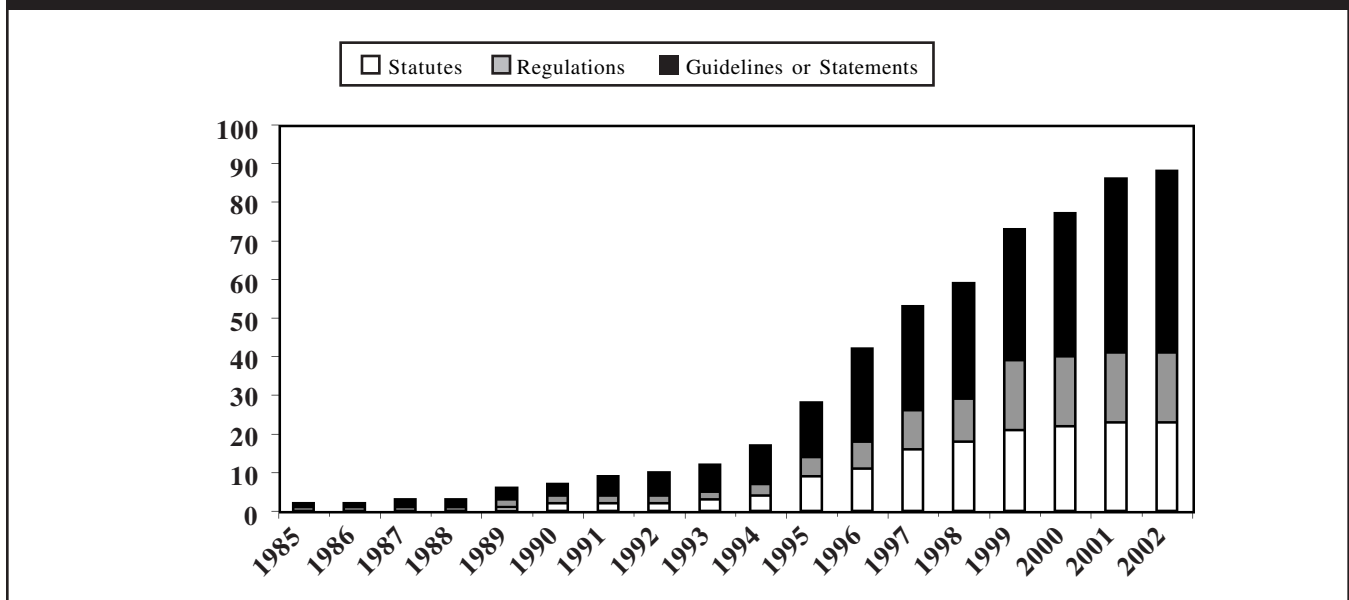
Efforts to revise or develop state medical board policies initially were modeled after California's guidelines. In 1994, the Medical Board of California collaborated with experts in pain policy to draft guidelines on the use of opioids for pain treatment.⁷ The guidelines and accompanying policy statement recognized that opioids are a part of professional practice, encouraged pain management, and addressed physicians' fears of regulatory scrutiny. Several state medical boards, including in Arizona, Colorado, Maryland, and Minnesota, adopted similar policies, acknowledging that California's policy was used as a model.

In 1997, recognizing the need for more consistency in state pain policies, the Federation of State Medical Boards

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FIGURE 1. CUMULATIVE NUMBER OF STATE PAIN POLICIES, 1985–2002.



Source: University of Wisconsin Pain & Policy Studies Group/WHO Collaborating Center, 2002.

(FSMB) convened a workgroup of experts to draft a model guideline for the medical use of controlled substances in pain management. Drafting of the model was informed by a preliminary Pain & Policy Studies Group (PPSG) study that showed substantial variation in the content of existing state medical board pain policies. In May 1998, the FSMB adopted the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.⁸ The FSMB then sent the Model Guidelines to the state medical boards and asked them to consider adopting the policy.⁹

To date, twenty-two states have adopted policies using all or part of the Model Guidelines.¹⁰ Two more states (Massachusetts and Minnesota) have endorsed rather than adopted the Model Guidelines. However, there has been no research to determine precisely how state medical board policies may have changed and to determine the influence of the FSMB Model Guidelines.

Three research aims guide this study. First, we evaluated the influence of the Model Guidelines on medical board policies adopted after May 1998. Second, we evaluated the differences between policies adopted before the Model Guidelines with those adopted subsequently. Third, we evaluated differences according to the type of policy — whether regulations, guidelines, or policy statements — independent of when they were developed.

METHODOLOGY

We collected and evaluated all state medical board regulations, guidelines, and policy statements related to the use of controlled substances for pain management. Excluded were statutes pertaining to the treatment of pain, such as Intrac-

table Pain Treatment Acts (IPTAs), and court cases relating to civil or administrative law, because these are not state medical board policies. Only provisions relating directly to medical practice were considered; we did not consider provisions pertaining to reimbursement, controlled substances scheduling, workers' compensation, continuing medical education, Internet prescribing, hospice care, or advance directives, including power-of-attorney and living wills.

The policies were obtained from several sources, including updated PPSG hard copy files and LexisNexis, an electronic legal database. The policies analyzed for this study were adopted between January 1985 and December 2001, and are listed in Table 1.

Over a two-week period, three PPSG policy analysts conducted independent evaluations of each policy using a set of seventeen criteria that had been developed to evaluate federal and state policies according to the central principle of balance.¹¹ The principle of *balance* provided a framework for developing specific evaluation criteria. In summary, this principle recognizes that governmental policy should be aimed at preventing abuse of narcotic drugs, but also at ensuring availability of opioids, which are essential for pain relief; efforts to prevent drug abuse should not interfere in the legitimate medical use of opioids for patient care. The individual criteria are supported by legal and medical authoritative sources, and are intended to identify key elements of governmental policies for the use of controlled substances in pain management to determine if they are balanced.

The criteria are divided into two groups (see Table 2). The two groups are (1) “positive” criteria, which identify policy language that has the potential to enhance pain man-

TABLE 1. STATE MEDICAL BOARD POLICIES EVALUATED.

STATE	POLICY TYPE	YEAR ADOPTED	TITLE OR REFERENCE NUMBER
Alabama	Regulation	1995	Ala. Admin. Code r. 540-X-4-.08
Alabama	Regulation	2000	Ala. Admin. Code r. 540-X-4-.08 (amended)
Arizona	Guideline	1997	Guidelines for Prescribing Controlled Substances
Arizona	Guideline	1999	Use of Controlled Substances for the Treatment of Chronic Pain
Arkansas	Regulation	1997	Regulation 2(6)
Arkansas	Regulation	1998	Regulation 2(6)
California	Guideline	1985	Guidelines for Prescribing Controlled Substances for Chronic Conditions
California	Guideline	1994	Guidelines for Prescribing Controlled Substances for Intractable Pain
California	Policy Statement	1994	A Statement by the Medical Board
Colorado	Guideline	1996	Guidelines for Prescribing Controlled Substances for Intractable Pain
Florida	Guideline	1996	Management of Pain Using Dangerous Drugs and Controlled Substances
Florida	Regulation	1999	Fla. Admin. Code Ann. r. 64B8-9.013
Georgia	Guideline	1991	Management of Prescribing with Emphasis on Addictive or Dependence-Producing Drugs
Idaho	Guideline	1995	Prescribing Opioids for Chronic Pain
Iowa	Regulation	1997	653 Iowa Admin. Code 13.2 (148,150,150A,272C)
Kansas	Guideline	1998	Guidelines for the Use of Controlled Substances for the Treatment of Pain
Kentucky	Guideline	1996	Guidelines for Prescribing Controlled Substances
Kentucky	Guideline	2001	Model Guidelines for the Use of Controlled Substances in Pain Treatment
Louisiana	Regulation	1997	La. Admin. Code 46:XLV.6923 (<i>et seq.</i>)
Louisiana	Regulation	2000	La. Admin. Code 46:XLV.6915 (<i>et seq.</i>)
Maine	Regulation	1999	Code Me. R. 02-373-011
Maryland	Guideline	1996	Prescribing Controlled Substances
Massachusetts	Guideline	1989	General Guidelines for the Use of Narcotic Analgesics in Chronic Pain
Massachusetts	Guideline	2001	<i>No title</i>
Massachusetts	Guideline	2001	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (adopted by reference)
Minnesota	Guideline	1988	Cancer Pain Management Information
Minnesota	Guideline	1995	The Common Denominator and Common Sense
Minnesota	Policy Statement	2000	Pain Management: A Patient's Right to Adequate Pain Control
Mississippi	Policy Statement	1997	Pain, Pain Management and Mississippi Medical Board of State Licensure Scrutiny
Mississippi	Regulation	1999	Miss. Code Ann. § 50-013-022

Continued on next page

TABLE 1, CONTINUED.

STATE	POLICY TYPE	YEAR ADOPTED	TITLE OR REFERENCE NUMBER
Missouri	Guideline	2001	Palliative Care Guidelines
Missouri	Guideline	2001	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Montana	Guideline	1996	Statement on the Use of Controlled Substances in the Treatment of Intractable Pain, Guidelines for Prescribing Opioid Analgesics for Chronic Pain
Nebraska	Guideline	1999	Guidelines for the Use of Controlled Substances for the Treatment of Pain
Nevada	Regulation	1996	Nev. Admin. Code 630.255
Nevada	Regulation	1999	Nev. Admin. Code 630.020
Nevada	Regulation	1999	Nev. Admin. Code 630.193
Nevada	Regulation	1999	Nev. Admin. Code 630.195
Nevada	Regulation	1999	Nev. Admin. Code 630.197
Nevada	Regulation	1999	Nev. Admin. Code 630.230
Nevada	Regulation	2000	Nev. Admin. Code 630.187
Nevada	Regulation	2000	Nev. Admin. Code 630.230
New Hampshire	Guideline	2000	Guidelines for the Use of Controlled Substances in the Management of Chronic Pain
New Jersey	Regulation	1997	N.J. Admin. Code. § 13:35-7.6
New Mexico	Guideline	1996	Guidelines on Prescribing for Pain
New York	Guideline	2000	Policy Statement for the Use of Controlled Substances for the Treatment of Pain
North Carolina	Policy Statement	1996	Management of Chronic Non-Malignant Pain
North Carolina	Policy Statement	1999	End-of-Life Responsibilities and Palliative Care
North Carolina	Policy Statement	1999	Joint Statement on Pain Management in End-of-Life Care
Ohio	Policy Statement	1994	Scheduled Drug Therapy Including Narcotics for Chronic Benign Pain
Ohio	Policy Statement	1996	Scheduled Drug Therapy Including Narcotics for Chronic Benign Pain (Revised)
Ohio	Regulation	1998	Ohio Admin. Code Ann. 4731-21-01-06
Oklahoma	Guideline	1994	Guidelines for Prescribing Controlled Substances for Intractable Pain
Oklahoma	Regulation	1999	Okla. Admin. Code 435:10-7-11
Oregon	Policy Statement	1991	Statement of Philosophy: Appropriate Prescribing of Controlled Substances
Oregon	Policy Statement	1995	Pain Management on Acute Conditions and Terminal Illness
Oregon	Regulation	1996	Or. Admin. R. 847-015-0030
Oregon	Policy Statement	1999	Current Philosophy on Pain Management
Pennsylvania	Regulation	1985	49 Pa. Code § 16.92
Pennsylvania	Guideline	1998	Guidelines for the Use of Controlled Substances in the Treatment of Pain

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TABLE 1, CONTINUED.

STATE	POLICY TYPE	YEAR ADOPTED	TITLE OR REFERENCE NUMBER
Rhode Island	Guideline	1995	Guidelines for Long Term Pain Management
South Carolina	Guideline	1999	Guidelines for the Use of Controlled Substances for the Treatment of Pain
South Dakota	Guideline	1999	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Tennessee	Policy Statement	1995	Management of Prescribing with Emphasis on Addictive or Dependence-Producing Drugs
Tennessee	Regulation	1999	Tenn. Comp. R. & Regs. R. 0880-2-.14
Texas	Policy Statement	1993	Pain Control and the Texas State Board of Medical Examiners
Texas	Regulation	1995	22 Tex. Admin. Code § 170.1-170.3
Utah	Policy Statement	1992	Prescribing Controlled Substances for Cancer Pain: Position Paper of the Utah Division of Occupational and Professional Licensing
Utah	Guideline	1999	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Vermont	Guideline	1996	Report of the Prescribing Practices Committee
Virginia	Guideline	1998	Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain
Washington	Policy Statement	1987	Bulletin to Physicians Issued by the Medical Disciplinary Board
Washington	Policy Statement	1989	Policy Statement on Chronic Pain Issued by the Medical Disciplinary Board
Washington	Policy Statement	1992	Guidelines on Opiate Usage
Washington	Policy Statement	1996	Guidelines for the Management of Pain
Washington	Regulation	1999	Wash. Admin. Code § 246-919-800
West Virginia	Policy Statement	1997	Positive Statement on the Use of Opioids in the Treatment of Chronic Non-Malignant Pain
West Virginia	Policy Statement	2001	Joint Policy Statement on Pain Management at the End of Life
Wyoming	Policy Statement	1996	Letter to Wyoming Physicians

agement (Criteria 1 through 8), and (2) “negative” criteria, which recognize policy language that has the potential to impede pain management (Criteria 9 through 17). Policy language that was identified by the policy analysts as meeting one or more criteria served as the “data” for this research.

“Positive” criteria identify policies that recognize fundamental legal and medical principles (i.e., that opioids as controlled substances are necessary for public health, and that pain management and use of opioids are part of legitimate medical practice). They also identify policy provisions that encourage pain management and address fears of regula-

tory scrutiny. In addition, these criteria will show whether policies correct outdated notions about opioids that can interfere with pain management (e.g., that the amount prescribed is *not* sufficient to determine the legitimacy of prescribing, and that physical dependence and tolerance are *not* synonymous with addiction). An “other” category identifies policy provisions not specific to one of the other positive criteria but that may enhance pain management

The “negative” criteria are used to identify policy provisions that are outdated or would be otherwise inappropriate in a balanced policy governing the medical use of controlled substances and the treatment of pain. These criteria identify

TABLE 2. CRITERIA USED TO EVALUATE STATE MEDICAL BOARD POLICIES.

Positive criteria: Criteria that identify policy language with the potential to enhance pain management

1. Controlled substances are recognized as necessary for the public health
2. Pain management is recognized as part of general medical practice
3. Medical use of opioids is recognized as legitimate professional practice
4. Pain management is encouraged
5. Practitioners' concerns about regulatory scrutiny are addressed
6. Prescription amount alone is recognized as insufficient to determine the legitimacy of prescribing
7. Physical dependence or analgesic tolerance is not confused with addiction
8. Other provisions that may enhance pain management

Negative criteria: Criteria that identify policy language with the potential to impede pain management

9. Opioids are implied to be a last resort
10. Medical use of opioids is implied to be outside of legitimate professional practice
11. The belief that opioids hasten death is perpetuated
12. Physical dependence or analgesic tolerance is confused with addiction
13. Medical decisions are restricted
 - 13.1 Restrictions based on patient characteristics
 - 13.2 Mandated consultation
 - 13.3 Restrictions regarding quantity prescribed or dispensed
14. Length of prescription validity is restricted
15. Practitioners are required to use government-issued prescription forms
16. Other provisions that may impede pain management
17. Provisions that are ambiguous

language that suggests that opioid use is outside of ordinary medical practice, that opioids are to be used only as a last resort, or that their therapeutic use hastens death. This category also identifies provisions that confuse physical dependence and tolerance with addiction, or that restrict decisions that are medical in nature, such as preventing prescribing opioids to patients with pain who have a history of substance abuse, mandating consultation for every patient who receives opioids, or specifying a limit to the quantity of drug that can be prescribed at one time. Negative criteria also identify policies that unrealistically limit the period for which a prescription is valid after being issued, or that require physicians to use only special government-issued prescription forms. "Other" and "ambiguous" categories identify requirements that may interfere with pain management, but do not relate to the aforementioned negative criteria.

A provision was judged to satisfy a criterion on the basis of the policy's plain language, not by its implication or intent. For example, a guideline adopted by the Idaho State Board of Medicine in 1995, entitled "Prescribing Opioids for Chronic Pain,"¹² may have been intended to encourage physicians to treat pain effectively. However, this policy did not satisfy Criterion 4 because it did not contain an explicit statement encouraging pain management. In addition, if a provision appeared more than once in the same policy, it was counted only once. However, provisions satisfying Criteria

8, 16, and 17 could be counted more than once if they represented different types of policy content.

Using these criteria, the PPSG had previously evaluated 61 percent of the medical board policies; these policies were not reviewed again. The team of policy analysts met to compare their evaluations and identify lack of agreement or discrepancies. The initial agreement rate was 93 percent. The researchers discussed and resolved each discrepancy, which usually resulted from oversights or minor differences in interpretation. Complete consensus was achieved regarding the evaluation of each policy. The results of the evaluation were entered into an Excel database.

Statistical analysis

Frequency distributions were calculated for the number of positive and negative provisions found in each policy, as well as the total for each criterion. The frequencies had statistically nonnormal distributions, requiring the use of a nonparametric method for independent samples. Descriptive statistics were used to compare the Model Guidelines to subsequent policies (Research Aim 1). The chi-square test of association was used to compare policies that were developed prior to the Model Guidelines to those adopted subsequently (Research Aim 2), as well as to compare the content across types of policies (i.e., regulations, guidelines, and policy statements) (Research Aim 3).

RESULTS

Policy provisions

The total sample of state medical board policies was seventy-nine, comprising twenty-six regulations, thirty-two guidelines, and twenty-one policy statements. Forty-one states were represented, with a mean of almost two policies per state (the range was one to eight policies). Forty-three policies (54.4 percent) predated the approval of the FSMB’s Model Guidelines (called “pre-Model” policies), while thirty-six (45.6 percent) were adopted subsequently (called “post-Model” policies).

The frequency of positive and negative provisions varied for each policy. Eleven policies (13.9 percent) contained no positive provisions, twenty-seven (34.2 percent) contained one or two positive provisions, and forty-one (51.9 percent) contained between three and eight positive provisions. We found that thirty-nine policies (49.4 percent) had no negative provisions, twenty-eight (35.4 percent) had one or two, and twelve (15.2 percent) had three to five. In relation to individual criterion, no medical board policies contained language that recognized controlled substances as necessary for public health (Criterion 1), perpetuated the belief that opioids hasten death (Criterion 11), restricted the length of prescription validity (Criterion 14), or required the use of government-issued prescription forms (Criterion 15). Table 3 contains the number and frequency with which each criterion was

identified in the total sample of policies, the Model Guidelines, pre-Model policies, and post-Model policies.

Research Aim 1: Comparison of the Model Guidelines to subsequent policies

It is important to begin with an evaluation of the Model Guidelines. The Model Guidelines met Criteria 2 through 8, and had no provisions meeting Criteria 9 through 17 (see Table 3). Alternatively, over 50 percent of post-Model policies contained provisions that met Criteria 2 through 7, and 47 percent met Criterion 8. Only a few post-Model policies contained negative provisions. When comparing all post-Model policies, guidelines were more likely than regulations or policy statements to contain positive provisions ($\chi^2(6) = 12.815, p < 0.046$), such as recognizing the use of opioids as legitimate professional practice (Criterion 3) ($\chi^2(2) = 8.230, p < 0.016$), encouraging pain management (Criterion 4) ($\chi^2(2) = 13.936, p < 0.001$), and not confusing addiction with either physical dependence or tolerance (Criterion 7) ($\chi^2(2) = 7.599, p < 0.022$).

Research Aim 2: Comparison of policies before and after the Model Guidelines

These analyses compared pre-Model and post-Model policies to identify differences in the number of provisions that have a potential to affect pain management, and to better

TABLE 3. CRITERIA IDENTIFIED IN POLICIES.

CRITERION	TOTAL POLICIES	MODEL GUIDELINES	PRE-MODEL	POST-MODEL
	[# (%)] N = 79		POLICIES [# (%)] N = 43	POLICIES [# (%)] N = 36
Criterion 1	0 (0)	No	None	None
Criterion 2	36 (45.6)	Yes	13 (30.2)	23 (63.9)
Criterion 3	43 (54.4)	Yes	22 (51.2)	21 (58.3)
Criterion 4	33 (41.8)	Yes	11 (25.6)	22 (61.1)
Criterion 5	39 (49.4)	Yes	18 (41.9)	21 (58.3)
Criterion 6	31 (39.2)	Yes	11 (25.6)	20 (55.6)
Criterion 7	32 (40.5)	Yes	10 (23.3)	22 (61.1)
Criterion 8	26 (32.9)	Yes	9 (20.9)	17 (47.2)
Criterion 9	31 (39.2)	No	24 (55.8)	7 (19.4)
Criterion 10	11 (13.0)	No	6 (14.0)	5 (13.9)
Criterion 11	0 (0)	No	0 (0)	0 (0)
Criterion 12	2 (2.5)	No	2 (4.7)	0 (0)
Criterion 13.1	1 (1.3)	No	1 (2.3)	0 (0)
Criterion 13.2	14 (17.7)	No	11 (25.6)	3 (8.3)
Criterion 13.3	2 (2.5)	No	1 (2.3)	1 (2.8)
Criterion 14	0 (0)	No	0 (0)	0 (0)
Criterion 15	0 (0)	No	0 (0)	0 (0)
Criterion 16	10 (12.7)	No	9 (20.9)	1 (2.8)
Criterion 17	7 (8.9)	No	3 (7.0)	4 (11.1)

understand how the Model Guidelines may have influenced state medical board policy development.

Differences in total positive and negative provisions

Pre-Model and post-Model policies were first compared according to their total number of positive and negative provisions. Post-Model policies had significantly more positive provisions ($\chi^2(3) = 14.796, p < 0.002$), and were more likely to have no negative provisions ($\chi^2(2) = 24.602, p < 0.0001$).

The types of pre- and post-Model policies (regulations, guidelines, and policy statements) also were compared according to their total number of provisions. Post-Model regulations were significantly more likely than pre-Model regulations to contain no negative provisions ($\chi^2(2) = 7.317, p < 0.026$). Post-Model guidelines had significantly more positive provisions ($\chi^2(3) = 14.823, p < 0.002$), and no negative provisions ($\chi^2(2) = 12.053, p < 0.002$), when compared to pre-Model guidelines. There were no significant differences between pre- and post-Model policy statements.

Changes in the number of individual provisions

We compared pre- and post-Model policies according to the frequency of individual positive and negative provisions. Pre-Model policies were more likely to contain negative provisions that could restrict prescribing or medical decision-making, including language that implied that opioids are a last resort for pain treatment (Criterion 9) ($\chi^2(1) = 10.871, p < 0.001$), mandated consultation (Criterion 13.2) ($\chi^2(1) = 3.998, p < 0.046$), and created other potential im-

pediments to pain management (Criterion 16) ($\chi^2(2) = 5.941, p < 0.05$). Post-Model policies were significantly more likely to include positive provisions that recognized pain management as part of medical practice (Criterion 2) ($\chi^2(1) = 8.949, p < 0.003$), encouraged pain management (Criterion 4) ($\chi^2(1) = 10.170, p < 0.001$), recognized amount or duration of prescribing as insufficient to determine legitimacy of prescribing (Criterion 6) ($\chi^2(1) = 7.384, p < 0.007$), and did not confuse addiction with physical dependence or tolerance (Criterion 7) ($\chi^2(1) = 11.652, p < 0.001$).

Regulations, guidelines, and policy statements were examined separately to determine how the content of each policy type varied after publication of the Model Guidelines. Post-Model guidelines were significantly more likely to include the following positive provisions: recognizing pain management as part of medical practice (Criterion 2) ($\chi^2(1) = 7.429, p < 0.006$), encouraging pain management (Criterion 4) ($\chi^2(1) = 11.888, p < 0.001$), recognizing amount or duration of prescribing as insufficient to determine legitimacy (Criterion 6) ($\chi^2(1) = 5.427, p < 0.020$), and not confusing addiction with physical dependence or tolerance (Criterion 7) ($\chi^2(1) = 8.016, p < 0.005$). In addition, post-Model guidelines were less likely to include language that implied that opioids are a last resort for pain treatment (Criterion 9) ($\chi^2(1) = 6.419, p < 0.011$) or mandated consultation (Criterion 13.2) ($\chi^2(1) = 8.880, p < 0.003$). Post-Model regulations were more likely to clarify that addiction is not synonymous with physical dependence or tolerance (Criterion 7) ($\chi^2(1) = 7.287, p < 0.007$), while post-Model policy statements were more likely to include language that encouraged pain management (Criterion 4) ($\chi^2(1) = 7.765, p < 0.005$). Table 4 contains a summary of the statistically significant results for Aim 2.

TABLE 4. SUMMARY OF RESULTS FOR RESEARCH AIM 2.

POST-MODEL VS. PRE-MODEL POLICIES				
PROVISIONS	ALL POLICIES	REGULATIONS	GUIDELINES	POLICY STATEMENTS
Total positive provisions	(+) $p < 0.002$	ns	(+) $p < 0.002$	ns
Total negative provisions	(0) $p < 0.0001$	(0) $p < 0.026$	(0) $p < 0.002$	ns
CRITERIA				
2	(+) $p < 0.003$	ns	(+) $p < 0.006$	ns
4	(+) $p < 0.001$	ns	(+) $p < 0.001$	(+) $p < 0.005$
6	(+) $p < 0.007$	ns	(+) $p < 0.020$	ns
7	(+) $p < 0.001$	(+) $p < 0.007$	(+) $p < 0.005$	ns
9	$p < 0.001$	ns	(-) $p < 0.011$	ns
13.2	$p < 0.046$	ns	(-) $p < 0.003$	ns
16	$p < 0.050$	ns	ns	ns

(+) = more provisions in post-Model policies; (-) = fewer provisions in post-Model policies; (0) = no provisions in post-Model policies; ns = not significant. The bolded significant levels indicate that the pre-Model policies, rather than post-Model policies, were more likely to contain language that met negative criteria.

Research Aim 3: Comparison of policy types

Analyses were conducted to determine the extent that the frequency of provisions varied according to type of policy, independent of the year they were adopted. For this research aim, guidelines and policy statements were combined, because neither policy has the force of law, and were then compared to regulations. The comparison between the two groups revealed no significant difference in the total number of positive provisions; however, regulations had more negative provisions ($\chi^2(2) = 6.544, p < 0.038$). Regulations were significantly more likely to imply that the medical use of opioids is outside legitimate professional practice (Criterion 10) ($\chi^2(1) = 13.844, p < .0001$), and have more ambiguous language (Criterion 17) ($\chi^2(1) = 9.699, p < 0.002$). Guidelines and policy statements were significantly more likely than regulations to address physicians' concerns about regulatory scrutiny (Criterion 5) ($\chi^2(1) = 5.363, p < 0.021$).

DISCUSSION

This study suggests that, since their publication in May 1998, the FSMB's Model Guidelines have positively influenced many state medical board policies addressing pain management—twenty-two states have adopted the Model Guidelines either in whole or in part. More than half of the post-Model policies contained language similar to the Model Guidelines, recognizing that pain management is part of medical practice, encouraging pain management, and using correct definitions of addiction-related terms. In addition, most post-Model policies did not include language that could unduly restrict physician decision-making, medical practice, and patient care.

The Model Guidelines appeared to have different effects on the content of regulations, guidelines, and policy statements. State medical board guidelines evidenced the greatest change in content after the Model Guidelines were published, both in terms of more positive provisions and fewer negative provisions. Although regulations adopted after the Model Guidelines were less likely to have potentially restrictive language, policy statements showed no significant changes over time (despite a moderate trend toward fewer negative provisions, $p = 0.062$). When examining only those policies developed after the Model Guidelines, we found that guidelines were more likely than either regulations or policy statements to include language that has the potential to enhance pain management. As a result, the Model Guidelines appear to have had the most influence on the content of medical board guidelines. Overall, however, post-Model policies showed notable improvement over policies adopted prior to the Model Guidelines (as demonstrated in Table 3).

Despite these improvements in pain management policies, it is evident that some boards developed policies independent of the Model Guidelines. These policies con-

tained provisions that had the potential to impede pain management, indeed to regulate it strictly. A small proportion of the policies adopted after the Model Guidelines suggested that the prescribing of controlled substances for the treatment of pain is a last resort and not within the ordinary practice of medicine, and required consultation with a specialist for all physicians with patients who receive opioids. The prevalence of negative provisions like these was more frequent in regulations. Such provisions appear to restrict physicians' flexibility in the management of patients with pain, regulating rather than guiding pain management and medical practice with controlled substances, and doing so more strictly than federal law and the policies in most other states. In contrast, the Model Guidelines recommend flexibility by stating that the physician will not be disciplined for failing to follow the guidelines if good cause can be shown.¹³

The FSMB developed the Model Guidelines to encourage effective pain management and to view such practice as within the bounds of legitimate professional practice, to serve as an alternative to legislative action, and to achieve a greater degree of consistency among the states with respect to pain and controlled substances policy.¹⁴ The evidence presented here indicates that these goals are being achieved in many, if not all, states.

Another principal aim of the Model Guidelines was to address directly physicians' concerns about regulatory scrutiny by clarifying the policy of medical boards, as this was recognized as a significant barrier to the adequate treatment of pain.¹⁵ However, when pre- and post-Model medical board policies were compared, we found no difference in the extent to which they addressed practitioners' concerns about regulatory scrutiny (Criterion 5; $p = 0.145$). This nonsignificant result can be attributed, at least in part, to the influence and timing of the 1994 California Medical Board policy, Guidelines for Prescribing Controlled Substances for Intractable Pain.¹⁶ Of the twelve state medical board pain management policies adopted before California's 1994 guidelines, only one (Minnesota's) contained a statement aimed at reducing physicians' fears of unwarranted sanctions for prescribing controlled substances. Indeed, additional analyses found that state medical board pain policies adopted within a few years of the 1994 California guidelines were more likely to contain language that met Criterion 5. Although language from the Model Guidelines addressing regulatory scrutiny was based on the 1994 California policy, the California guidelines had already substantially influenced state policy development in the mid-1990s.

Criterion 1 was not identified in these analyses; it was developed to evaluate federal and state laws affecting pain management.¹⁷ Typically, such policy language is designed for controlled substances statutes or regulations, rather than medical practice policy, and is based on a different model, the Uniform Controlled Substances Act.¹⁸ It is not surprising, therefore, that state medical board policies did not contain

provisions satisfying this criterion. Although language that perpetuates the belief that opioids hasten death (Criterion 11), restricts length of prescription validity (Criterion 14), or requires the use of government-issued prescription forms (Criterion 15) was not found to exist in any medical board policies, such provisions do appear in controlled substances, medical practice, or other state statutes.¹⁹

CONCLUSIONS

Undertreatment of pain continues to be a serious problem due in part to barriers that are found in the language of some state medical board policies. For example, we found that many policies aimed at providing immunity to physicians for prescribing controlled substances for pain actually contained language that suggests that opioid analgesics are not part of generally accepted medical practice and are to be used as a treatment modality of last resort.

State medical boards have the authority to regulate medical practice; they have also evidenced a willingness to promulgate board policy that encourages treatment of pain and addresses some of the barriers to effective pain relief, such as physicians' concerns about being investigated for prescribing controlled substances. Based on our policy analysis, it is clear that greater uniformity in policy is being achieved, but complete consistency remains an elusive goal. Professional licensing boards are once again encouraged to review and update their policies, if they have not done so recently. Indeed, the Model Guidelines provide a carefully thought-out template for judicious prescribing for better pain management, while also requiring compliance with federal and state controlled substances laws and regulations. With increased misuse of opioid pain medications and associated media coverage, efforts to address drug abuse and diversion must not interfere with the use of these drugs for pain management.

Once a state board adopts balanced policy, it must be successfully implemented. This process is essential because it informs practitioners of the availability and messages of the board's policy. Such activities could involve the following three-tiered process:

- training of investigators about the current standards of pain management;
- disseminating the policy to licensees via the board's newsletter and website; and
- using radio and television to reach the general public.

For example, the North Carolina Board of Medical Examiners has used its newsletter to issue and discuss its policies, and has participated in television coverage to disseminate its message to a large audience.²⁰ The Maryland Board of Physician Quality Assurance created a videotape about "balance" that is viewed by each new licensee.²¹ State medical boards also can sponsor workshops about pain management and

board policy; the Minnesota State Board of Medical Practice has sponsored twelve such workshops. Activities like these can effectively communicate a positive attitude and policy toward pain management and can address directly physicians' concerns about regulatory scrutiny and, ultimately, improve patient care.

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