

IN THE SUPREME COURT OF MISSISSIPPI

No. 97-CC-01410

JOHN WILBUR McFADDEN, Jr., M.D.

APPELLANT

v.

**MISSISSIPPI STATE BOARD OF
MEDICAL LICENSURE**

APPELLEE

**ON APPEAL FROM THE CHANCERY COURT OF THE
FIRST JUDICIAL DISTRICT OF HINDS COUNTY, MISSISSIPPI**

**BRIEF OF AMERICAN PAIN SOCIETY AND
AMERICAN ACADEMY OF PAIN MEDICINE**
AMICI CURIAE

Oral Argument NOT requested

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I. INTRODUCTION

Pain is woefully under-treated in this country.¹ This tragic state of affairs, which has devastating consequences for individuals, families and communities, is rooted not so much in technology as in ignorance and persistent prejudice about pain, opioids, and addiction. Pain is needlessly perpetuated and suffering prolonged when, in the name of drug control, or for the ostensible purpose of preventing drug addiction, a pain medicine specialist is stripped of the power to pursue his or her vocation for actions taken in the exercise of sound medical judgment and in conformity with generally accepted standards of practice. When sanctions are imposed in such circumstances, the unfortunate message is sent to all physicians that in heeding their training, oath, and duty to their patients, they risk losing their job, livelihood and professional reputation.

In the case at bar, Appellant, Dr. John Wilbur McFadden, an experienced pain medicine specialist, was effectively banished from practicing medicine for a period of five years. Because the decision of the Mississippi Board of Medical Licensure's ["the Board"] is likely to have harmful reverberations for scores of Mississippi patients in need of pain care, and to heighten barriers for physicians who seek to provide effective pain management, *amici curiae* respectfully ask that this Court to consider the information set forth in this amicus brief in deciding whether to reverse the Board's decision.

¹ The failure of physicians to relieve the pain of dying patients has been extensively documented. See e.g., The SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 J. Am. Med. Ass'n 1591, 1591-93 (1995); Robyn S. Shapiro, Health Care Providers' Liability Exposure for Inappropriate Pain Management, 24 J.L. Med & Ethics 360, 360 (1996); Ben A. Rich, A Legacy of Silence: Bioethics and the Culture of Pain, 18 J. Med & Human. 233 (1997).

II. INTERESTS OF THE AMICI

Amici Curiae American Pain Society (“APS”) and American Academy of Pain Medicine (“AAPM”) are the two foremost organizations in the United States devoted to the treatment and study of pain. APS, a national chapter of the International Association for the Study of Pain, is a non-profit educational and scientific organization that comprises over 3,000 clinicians and researchers. APS’s mission is to serve people in pain by advancing research, education, treatment, and professional practice through the joint efforts of scientists and healthcare professionals around the world. APS produces several publications, including the APS Journal, the APS Bulletin and the professional reference guide Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain, which contains information on analgesic selection, dosage, and side effects.

AAPM, founded in 1983, is currently the primary professional organization for physicians specializing in treating pain in the United States. AAPM strives to ensure comprehensive quality medical care for pain patients by promoting a socioeconomic and political climate conducive to the effective and efficient practice of pain medicine.

In response to inquiries from state legislatures, medical examiners, regulators, and doctors regarding the appropriate use of opioids by physicians, the boards of directors of APS and AAPM have promulgated a consensus statement, Use of Opioids for the Treatment of Chronic Pain,² which urges states to recognize the importance of opioid therapy for the treatment of pain and to eschew legal, regulatory, or philosophical barriers that hinder or prevent the appropriate medical use of opioids for pain relief.

² APS & AAPM, Consensus Statement: Use of Opioids for the Treatment of Chronic Pain (1996).

The American Pain Society and the American Academy of Pain Medicine recognize the imperative of developing adequate medical responses to the needs of patients who suffer from chronic, severe, non-malignant pain.³ In particular, amici are dedicated to fostering an environment in which patients who are in pain can obtain appropriate opioid therapy⁴ so that needless suffering can be reduced, lives prolonged, and suicides averted. *Amici* believe that the Board's decision will have a chilling effect on the willingness of physicians in Mississippi to prescribe opioid analgesics to chronic, non-cancer pain patients in accordance with their best medical judgment and the teachings of medical science. Accordingly, *amici* respectfully submit this brief.

III. CHRONIC PAIN IS A SERIOUS MEDICAL CONDITION

“Pain is a more terrible lord of mankind than even death itself.”⁵ Pain can be

³ “Chronic nonmalignant pain” “is defined by persistence [of pain] for one month or more beyond the usual course of an acute illness or injury, a pattern of recurrence at intervals over months or year[s], or by association with a chronic pathological process.” New York State Public Health Council, Breaking Down the Barriers to Effective Pain Management: Recommendations to Improve the Assessment and Treatment of Pain In New York State 3-4 (1998) [hereinafter Breaking Down the Barriers].

⁴ “Opioids” constitute a class of natural and synthetic substances used medicinally to control pain. Although the term was originally used to refer only to synthetic compounds chemically similar to the natural opioids, such as methadone, current usage includes natural substances derived from the sap of the opium poppy, such as morphine and codeine. See Marc Galanter & Herbert Kleber, Textbook of Substance Abuse Treatment 191 (1994) (editors’ note).

⁵ Statement of Dr. Albert Schweitzer, quoted in Stuart Davidson, Pain and Opiophobia, 40 *Healthcare Forum J.* 64, 64 (May/June 1997).

debilitating.⁶ Persistent pain can destroy the quality of life and erode the will to live.⁷ Thus, relieving pain and suffering has been a core duty of physicians since ancient times.

Modern medicine has the ability to relieve or reduce suffering caused by nearly all types of pain.⁸ Nevertheless, the under-treatment of pain is a serious and wide-spread health issue.⁹ A lack of public understanding about the nature of pain therapy and overbearing actions of regulatory authorities have combined to impede access to pain treatment, deter physicians from practicing pain medicine,¹⁰ chill the legitimate prescription practices of physicians who do treat pain,¹¹ and thereby deny patients in this country their constitutionally protected right to relief

⁶ “Pain accounts for more than one quarter of workdays lost, increases health care utilization, and disrupts family and social functions.” Breaking Down the Barriers at 3.

⁷ See Bernard Lo, Karen Rothenberg, & Michael Vasko, Appropriate Management of Pain: Addressing the Clinical, Legal, and Regulatory Barriers, 24 J.L., Med., & Ethics 285, 285 (1996) (“ [A]dequate palliation of pain may be likely to reduce requests for physician-assisted suicide.”); Robin Bernhoff, How We Can Win the Compassion Debate, Citizen Magazine (June 24, 1996) (noting that “patients often want to die because of undertreated pain” and arguing that the response is better palliative care rather than legalization of suicide); Kathleen M. Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 J. Pain Symptom Mgt. 289 (1991). See also Washington v. Glucksberg, ---U.S.---, 117 S. Ct. 2258, 2273 (1997) (noting that “many people who request physician assisted suicide withdraw that request if their depression and pain are treated”).

⁸ See Institute of Medicine Committee on Care at the End of Life, Approaching Death: Improving Care at the End of Life 132 (1997) [hereinafter Approaching Death]. The Institute of Medicine is an elite body of medical professionals “chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public.” Id. at ii.

⁹ Approaching Death at 131.

¹⁰ See Hoover v. Agency for Health Care Admin., 676 So. 2d 1380, 1382 (Fla. App. 1996) (noting that physicians avoid treating pain patients “perhaps to avoid prosecutions”); id. at 1381 n.4 (“Many physicians avoid caring for patients who require Schedule II substances to relieve their suffering.”).

¹¹ There is a substantial and consistent body of research that indicates that clinicians are deterred from prescribing opioids out of concern that doing so will invite regulatory scrutiny.

from unnecessary suffering.¹²

The attitudes that deter the use of opioid analgesics to treat pain stem from the addictive potential of opioids and our nation's commitment to eradicate drug addiction. While addiction is a hazard in the field of pain medication, it is important to differentiate between opioid addiction,

See, e.g., Approaching Death at 195 (“There is still, it seems, an inappropriate sense of distrust on the part of the medical boards [regarding prescription of opioids for pain], which this committee believes has developed, in part, on the basis of misperceptions . . . about the nature and consequences of dependence and addiction.”); Breaking Down the Barriers at 10; Russell K. Portenoy, Opioid Therapy for Chronic Nonmalignant Pain: Clinicians’ Perspective, 24 J.L., Med., & Ethics 296, 297 (1996); American Society of Addiction Medicine Position Statement (April 1997) (“[P]hysicians’ concerns regarding possible legal regulatory, licensing or other third-party sanctions related to the prescription of opioids contribute significantly to the undertreatment of pain.”); David Joranson & Aaron Gilson, Controlled Substances, Medical Practice, and the Law, in Psychiatric Practice Under Fire 188 (H. Schwartz ed., 1994); Shapiro, supra note 1, at 363 (noting “fear of legal penalties, especially disciplinary action,” as important reason for under-treatment of pain); Undertreatment of Pain Seen as Unintended Effect of Drug War, 9 Alcoholism and Drug Abuse Week 1 (June 23, 1997) (noting that “fear of professional censure by medical review boards and prosecution by the [DEA] . . . prevents doctors from adequately treating dying patients with chronic, severe pain.”) (citing Dr. Christine Cassell); Davidson, supra note 5, at 64-67 (“Physicians who would depart from prevailing cultural practices [regarding opioid prescription for pain] are quickly penalized, adding fear of repercussions (legal and otherwise) to the list of reasons why physicians may withhold narcotic pain relief.”); Sandra H. Johnson, Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act, 24 J.L., Med., & Ethics 319, 320 (1996); Shannon Brownlee & Joannie Schrof, The Quality of Mercy, U.S. News & World Rep. 54, 56 (March 17, 1997) (noting doctors’ fear of prosecution); Russell K. Portenoy and Richard Payne, Acute and Chronic Pain, in Substance Abuse, A Comprehensive Textbook 563, 582-84 (Joyce H. Lowinson et al. eds., 1997) [hereinafter “Comprehensive Textbook”]. See also Chris Hyman, Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment, 24 J.L., Med., & Ethics 338, 338 (1996); Christine Cassel, Narratives on Pain and Comfort: Dr. M’s Story, 24 J.L., Med., & Ethics 290, 290-91 (1996) (discussing case of physician whose suspension from practice for pain medication was reversed).

¹² See Robert A. Burt, The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care, 337 New Eng. J. of Med. 1234, 1234 (1997) (stating that a majority of the Court in Washington v. Glucksberg ___ U.S. ___, 117 S. Ct. 2258 (1997) “effectively required all states to ensure that their laws do not obstruct the provision of adequate palliative care”); Kathryn L. Tucker, The Death with Dignity Movement: Protecting Rights and Expanding Options after Glucksberg and Quill, 82 Minn L. Rev. 923, 935 (1998).

dependence, and tolerance in order better to understand how trained physicians can provide effective treatment for pain while minimizing the risks that attend opioid therapy.

Tolerance, Physical Dependence, and Addiction

Tolerance, physical dependence and addiction are three separate terms with distinct medical meanings. Tolerance refers to the body's tendency to become accustomed to a substance such that, over time, more of the substance is needed to produce the same physical effect,¹³ an effect often observed with respect to the caffeine in coffee or tea, for example.¹⁴ Physical dependence, by contrast, is defined solely in relationship to withdrawal: a person who suffers from withdrawal symptoms when she stops taking a drug is said to be physically dependent.¹⁵ Again, caffeine is a commonplace example: regular tea- coffee-drinkers may experience withdrawal symptoms, typically headaches, if they are deprived of their morning brew.¹⁶

Addiction is a wholly separate phenomenon.¹⁷ Whereas tolerance and physical

¹³ Portenoy & Payne, supra note 11, at 563 (“Tolerance is a pharmacologic property of opioid drugs defined by the need for increasing doses to maintain effects.”) (footnotes omitted).

¹⁴ See John F. Greden & Adale Walters, Caffeine, in Comprehensive Textbook 294, 295.

¹⁵Portenoy & Payne, supra note 11, at 564 (Physical dependence “is defined solely by the occurrence of an abstinence syndrome (withdrawal) following abrupt does reduction or administration of an antagonist [which strips the drug from the body].”). Many substances, including corticosteroids (e.g., hydrocortisone antiinflammatory cream), as well as several of the medications that Appellant prescribed to his patients, can also produce the dual physical phenomena known as tolerance and physical dependence. See Approaching Death at 193; Physician’s Desk Reference 1953-54 (51st ed. 1997).

¹⁶ See John F. Greden & Adale Walters, Caffeine, in Comprehensive Textbook 294, 295.

¹⁷ See Approaching Death at 193 (“Neither physical dependence nor tolerance should be equated with addiction or substance abuse.”).

dependence focus on the pharmacological and physiological effects of drugs, addiction refers to the behavioral attributes of a drug user. The identifying features of addiction are a craving for, compulsive use of, and fixation on, the drug or behavior in question.¹⁸ As these definitions make clear, tolerance to, and physical dependency on a drug do not necessarily lead to addiction, and conversely, people may exhibit addictive behavior (e.g., gambling) that does not involve any physical dependence on a drug. Pain patients who undergo opioid treatment often develop tolerance and physical dependence but have little difficulty decreasing or stopping their opioid intake as the pain subsides or disappears.¹⁹

¹⁸ See Portenoy & Payne, *supra* n.11, at 564 (characterizing addiction as “a psychological and behavioral syndrome in which there is drug craving, compulsive use, and a strong tendency to relapse after withdrawal, [combined with] rumination about the drug and an intense desire to secure its supply”); *id.* (“[A]ddiction is a chronic disorder characterized by ‘the compulsive use of a substance resulting in physical, psychological or social harm to the user and continued use despite that harm.’”) (citing AMA task force). See also 21 U.S.C. § 802(1) (“The term ‘addict’ means 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.”); *Approaching Death* at 192-94; Mark S. Gold et al., *Eating Disorders*, in *Comprehensive Textbook* 319; Sheila B. Blume, *Pathological Gambling*, in *Comprehensive Textbook* 330 (discussing eating disorders, compulsive gambling, and other non-drug addictive-type disorders).

¹⁹Portenoy & Payne, *supra* note 11, at 564; Institute of Medicine, *Federal Regulation of Methadone Treatment* 10 (Richard Rettig & Adam Yarmolinsky eds. 1995) (“The pain patient . . . will develop tolerance and physical dependence but will not exhibit the illicit or inappropriate drug-seeking behavior.”); Joranson & Gilson, *supra* n. 11, at 182-83; American Pain Society, *Principles of Analgesic Use in the Treatment of Cancer Pain* (3d ed. 1992).

IV. LONG-TERM OPIOID TREATMENT FOR CHRONIC PAIN IS MEDICALLY ACCEPTED

Opioids Have Long Been Used Successfully to Treat Malignant / Cancer Pain.

The doctor's ethical and professional duty to alleviate pain and suffering must be

balanced against the principle that the doctor shall “do no harm.”²⁰ Over the years, practitioners have struck the balance at different places when it comes to prescribing potentially addictive opioids to alleviate pain. For instance, for most of the previous century, surgeons refused patients anesthesia during surgery,²¹ a practice that would today be condemned as barbaric. The perceived harm of opioid therapy for pain patients stemmed from the possibility that the prolonged use of opioid analgesics can lead to the patient’s physical or psychological dependence upon the medication, or perhaps even to a full-blown drug addiction. Today, however, there is a strong medical consensus that opioid therapy is a responsible and highly effective method for relieving acute and chronic pain, and that the fear of opioid addiction among pain patients has been greatly overstated. In order to understand the paradigmatic shift in recent decades, a brief history of pain medicine is instructive.

Medicine has understood since the beginning of this century that opioids such as morphine can relieve pain but also can also produce tolerance, physical dependence, and addiction in patients. For its part, law enforcement has closely policed the dispensing of opioid drugs to protect against diversion. Physicians who abused their prescribing privileges and acted outside of the legitimate scope of medical practice have traditionally been sanctioned harshly by state and federal authorities.²² As a result, for much of this century, physicians were quite

²⁰ See Shapiro, supra note 1, at 363 (discussing duty to treat pain); Rich, supra note 1, at 235-37 (same); Tom L. Beauchamp & LeRoy Walters, Contemporary Issues in Bioethics 25 (4th ed. 1994) (discussing duty to “do no harm”).

²¹ See Davidson, supra note 5, at 64-67.

²² See David F. Musto, Historical Perspectives, in Comprehensive Textbook 1, 3-5. See also United States v. Jin Fuey Moy, 241 U.S. 394 (1916); see generally Annotation, Federal Criminal Liability of Licensed Physician for Unlawfully Prescribing or Dispensing "Controlled Substance" Or Drug in Violation of the Controlled Substances Act (21 Uscs § 801 et seq.), 33

conservative in their use of opioids to treat even the most obviously needy pain sufferers: terminal cancer patients. Consequently, many cancer victims endured excruciating pain during their final days, weeks, and even years,²³ even though doctors had at hand the means to alleviate such pain. In recent decades, however, the tide has turned such that there is firm consensus within the medical profession that the risk of addiction does not justify the withholding of adequate pain treatment for patients facing imminent death.²⁴

At the same time that this consensus was developing, researchers were growing increasingly adept at fighting cancer through early detection, chemotherapy, radiation therapy, and surgical techniques, all of which dramatically extended the life expectancy of cancer patients.²⁵ These medical advances, however, did not necessarily remove the pain caused by cancer; indeed, some of these treatments themselves — such as chemotherapy — cause considerable pain. The medical community meanwhile was shedding much of its prejudice against treating cancer pain patients with opioids, and so became more willing to provide *non-terminal* cancer patients with opioid therapy, including high doses over extended periods. As the

A.L.R. Fed. 220 (1997).

²³ This state of affairs persisted at least into the mid-1980s. See Astrid James, Painless Human Right: Treatment of Cancer Pain in Developing Countries, 342 *Lancet* 567, 567 (1993) (“In the developed world in 1985 more than 50 percent of cancer patients has unrelieved pain. Yet cancer pain can be relieved in 75-90 percent of patients with appropriate analgesia.”); see generally John P. Morgan, American Opiophobia: Customary Underutilization of Opioid Analgesics, in Controversies in Alcoholism and Substance Abuse 163 (B. Stimmel, ed. 1986).

²⁴ See Portenoy & Payne, supra note 11, at 567 (“Opioids are accepted treatment in cancer pain . . .”).

²⁵ See Approaching Death at 34 (“The dying process today tends to be more extended, in part, because medical treatments can control pneumonia, kidney failure, and other immediate causes of death that accompany cancer, heart disease, and other “slow killers.”).

medical community learned that such pain treatment was safe and effective, it was forced to reassess some of its old assumptions regarding opioid therapy.²⁶ First, it became clear that people in pain react differently to opioids than do persons who use opioids to feed a drug habit or addiction. Specifically, pain patients rarely experience the sense of euphoria that recreational users do; to the contrary, powerful opioid treatment most often produces dysphoria in pain patients.²⁷ Second, pain patients did not become addicted even after receiving long-term, high-dose opioid therapy.²⁸ In fact, it was found that once the source of the pain was removed, patients voluntarily decreased or stopped altogether their use of opioids, notwithstanding any tolerance or physical dependence they may have developed to the opiates.²⁹ Third, clinicians came to understand that behavior that might suggest drug abuse or addiction in a non-pain patient was not necessarily cause for alarm when exhibited by a pain patient.³⁰ For example, a recovering addict who requests large amounts of a specific drug or who hoards his medication is

²⁶Russell K. Portenoy, Opioid Therapy for Chronic Nonmalignant Pain: Clinicians' Perspective, 24 J.L., Med., & Ethics 296, 296 (1996).

²⁷ Portenoy & Payne, supra note 11, at 581.

²⁸ Approaching Death at 193 (“Research indicates that addiction in patients appropriately receiving opioids for pain is very small, ranging from roughly 1 in 1,000 to less than 1 in 10,000.”) (citations omitted); Portenoy & Payne, supra note 11, at 581; Morgan, supra note 23, at 171. See Samuel Perry & George Heidrich, Management of Pain During Debridement: A survey of U.S. Burn Units, 13 Pain 267, 274 (1982); Jane Porter and Hershel Hick, Correspondence, Addiction Rare in Patients Treated with Narcotics, 302 New Eng. J. of Med. 123 (1980). These numbers are comparable to the rates of addiction in American society as a whole. See Portenoy & Payne, supra note 11, at 581. See also Davidson, supra note 8 (reporting that the evidence to support the “fear that dosages large enough to relieve pain will cause addiction” is merely anecdotal).

²⁹ See Approaching Death at 193.

³⁰ Id. at 194 (“[S]ome behaviors suggestive of addiction may be confused with those resulting from inadequately managed pain or anxiety about the reliability of pain management.”)

cause for concern: such behaviors often indicate relapse.³¹ However, a pain patient may exhibit identical behaviors for entirely different (and understandable) reasons: for example, the patient may quite reasonably have learned through experience that one medication works better and has fewer side effects than another; or, the patient may be so apprehensive at the thought of being without pain medication in the event of an acute or prolonged bout that he or she sets aside medication for a future emergency.³²

Finally, it is important to bear in mind that non-malignant pain can be just as excruciating and debilitating as cancer pain. Although, as the Board recognized in its opinion, Order at 25-26, it is today widely accepted that opiates are appropriate for long-term treatment of non-cancer pain, some physicians — particularly those who do not specialize in pain management — view cancer pain as unique and discount the quality and severity of other types of pain. Yet, as experience makes clear, the etiology of the pain does not necessarily determine the magnitude of the pain or the degree to which the sufferer is debilitated: pain is pain, whether caused by cancer, a car crash, or burns.³³ Thus, the considerations that justify aggressive treatment of cancer pain often apply equally to alleviating non-cancer pain. And, although, as mentioned above, drug abuse and addiction are real risks that physicians must try to avert, a fear of these risks rarely justifies withholding opioid therapy from patients where, as in the four

³¹ See Portenoy & Payne, supra note 11, at 564.

³² See id.

³³ See Sandra H. Johnson, Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act, 24 J.L., Med. & Ethics 319, 324 (1996) (“Pain does not discriminate.”) It is, of course, necessary to take precautions to ensure against addiction and abuse by making an individualized assessment of each patient, the efficacy of the prescribed course of treatment, and the potential for addiction or abuse of prescription drugs. See id.

patients here at issue, their pain is serious and persistent, and there is little or no evidence that the patients are prone to addiction.³⁴ The record below fails to reveal that Dr. McFadden practiced pain management inappropriately, ineffectively, or unethically.

V. THE SEVERE SANCTIONING OF A PHYSICIAN FOR PRESCRIBING OPIOID TREATMENT FOR CHRONIC PAIN ABSENT A CLEAR SHOWING THAT THE PHYSICIAN ACTED OUTSIDE THE COURSE OF PROFESSIONAL PRACTICE WILL DETER OTHER PHYSICIANS FROM PROPERLY TREATING PAIN PATIENTS.

The experiences of conscientious physicians who are punished for employing effective and accepted pain therapies will remain in the minds of physicians long after a medical lecture or journal article on the efficacy of opioid analgesics.³⁵ As discussed above, physicians who fear official censure will be chilled from providing effective treatment to patients in chronic pain.³⁶

Thousands of people suffering from chronic severe pain sought treatment from Appellant, Dr. John McFadden.³⁷ Dr. McFadden prescribed low-dose opioids to many of these patents, four of whose medical records were presented to the State Board of Medical Licensure. The Board then severely disciplined Dr. McFadden for his treatment of these four patients.³⁸ To

³⁴ Dr. McFadden is not accused of providing drugs to any known addicts. Notwithstanding a pain patient's predisposition to substance abuse or addiction, it would be inappropriate for a doctor to assume that a patient with a history of substance abuse does not experience pain to the degree that others do and thus fail to try to alleviate this pain with by taking appropriate palliative measure. See id.

³⁵ See Portenoy & Payne, supra note 11, at 582.

³⁶ Id.; Breaking Down the Barriers at 10 (noting that physicians' fears in this regard are real and "by no means unfounded").

³⁷ See Op. of Chancery Ct. at 10.

³⁸ Amici Curiae note that physicians sanctioned in the manner of Appellant inevitably face prohibitively high liability insurance premiums that render clinical practice financially unfeasible.

be sure, not all physicians would have recommended the same course of treatment for the patients under Appellant's care. Some practitioners might not have prescribed opioid therapy, or might have tapered or ceased opioid treatment at different points. Other clinicians might have recommended higher-dose opioids than did Dr. McFadden, while prescribing fewer pills.³⁹ Some pain specialists might maintain their patient charts differently than Appellant, while many others might recognize in Dr. McFadden's charting practices the realities of a pain specialist's demanding practice. Indeed, professional disagreements and divergent philosophies abound in virtually every field of medicine, and palliative care is no exception. Inasmuch as medicine is a science, it is also an art, and must be tailored to fit the infinite variety of circumstances and physiologies of patients who come in all ages, shapes, and sizes.⁴⁰ Against this backdrop, it is unjust to use the heavy hand of disciplinary sanctions to address reasonable divergences in treatment philosophies. Such differences alone should not be punished as if malpractice had

³⁹ Nearly all of the substances at issue in the case at bar are available in tablet form at significantly higher dosages than those prescribed by Appellant. MS Contin, for example, is available in 15 mg to 200 mg. tablets. Physicians' Desk Reference 2149 (51st ed. 1997). Similarly, hydrocodone bitartrate (Vicodin), which Appellant prescribed in 5- and 7.5 mg tablets, is also available in 10 mg tablets. Id. at 1403. Codeine-containing tablets (Tylenol 3 and APAP Codeine 30), which Appellant prescribed in 30 mg tablets are also available in 60 mg tablets. Id. at 1592. Oxycodone, which Appellant prescribed in 5 mg tablets, is available in time-release capsules of up to 40 mg, to be taken every 12 hours. Id. at 2163 (a single 40 mg. tablet is considered the equivalent of eight 5 mg doses taken over the course of 12 hours). The prescription of a greater number of lower dose tablets may be preferable in some cases because it allows the patient to calibrate more carefully his medication to the intensity of pain he is experiencing. Under the Board's apparent reasoning in this case, however, a physician who chooses to prescribe a large quantity of lower dose medications is more likely to become the target of investigation and disciplinary sanction.

⁴⁰ "The existence of severity of pain is that reported by the patient; each person experiences, communicates, and copes with pain differently." Breaking Down the Barriers to Effective Pain Management Appendix A (General Principles of Pain Management ¶ 4). See Rich, supra note 1, at 248.

been committed or clear laws violated. Consequently, the Board's decision, if let stand, may dissuade other skilled and caring medical practitioners from effectively treating pain and reducing suffering in Mississippi.

VI. CONCLUSION

For the reasons stated above this Court should consider the information set forth in this amicus brief in deciding whether to reverse the decision of the Mississippi Board of Medical Licensure and to direct the Board to reinstate Dr. McFadden's privileges to prescribe controlled substances.

Dated this ___ day of June, 1998.

Respectfully Submitted,

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