

How Can We Make the Pain Go Away? Public Policies to Manage Pain at the End of Life

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The continued undertreatment of pain at the end of life is a substantive public health problem that has not been resolved through increased public awareness, the issuance of clinical guidance for providers, or expanded organizational commitments. In this forum, we illuminate the role of public policies in promoting pain management. We review federal and state policies and consider empirical evaluations that compared the quality of state policies and the factors that contributed to their formation. We resolve that any organized interest in improving end-of-life care should begin by focusing on the development and expansion of those state policies that support the provision of evidence-based medicine for reducing the amount of pain an individual experiences at the end of life. Although empirical research is needed to determine which particular aspects of state pain policy are most critical and how these policies can be implemented most effectively, any organized effort that advances state medical board activity or another state policy would appear to be making an important

step toward making the pain at the end of life go away.

Key Words: Pain management, Pain policy, State medical boards, End of life

Although Americans are living longer, they also are taking longer to die. Most Americans prefer not to prolong their end of life; they wish to avoid the use of extensive medical technology and do not want to die in a hospital or nursing facility. Most Americans prefer to die at home, surrounded by family, and free from pain (Singer, Martin, & Kelner, 1999). Moreover, 3 out of 4 Americans do not fear death as much as they fear being in pain at the time of death (Yankelovich Partners, 2000). These attitudes are stable across individuals regardless of age, ethnicity, or religious background (LastActs, 1997). Yet many Americans do not experience a good death. Few Americans die at home, surrounded by family, having their physical and emotional needs attended to, and having their pain managed adequately (Fried, van Doorn, O'Leary, Tinetti, & Drickamer, 1999; Steinhauer et al., 2000; Ternstedt, Andershed, Eriksson, & Johansson, 2002).

Pain management has emerged as a top priority for improving end-of-life care because it is so notably underapplied, even though it is desired universally (Fishman, 2005; National Consensus Project, 2004). Research has shown that less than 20% of people between the ages of 65 and 74 who died in hospital received palliative care consultation and pain

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management (Pan et al., 2001; Smits, Furletti, & Vladeck, 2002), and that less than 20% of people older than 75 years old who passed away in nursing homes received an adequate treatment for pain (Flory et al., 2004; Herr & Garand, 2001). A report by the Medicare Payment Advisory Commission (2006) documented that fewer than 30% of all Medicare decedents, regardless of where they died, received an adequate amount of pain management. The pervasive undertreatment of pain is even more puzzling given the widespread availability of clinical guidelines (American Academy of Pain Medicine and American Pain Society, 1997; American Geriatrics Society, 2002; American Nurses Association, 2003) and organizational commitments to improving pain management at the end of life (American Bar Association Legal Commission on Problems of the Elderly, 2002; Berry & Dahl, 2000; Haugen, 2000; Joint Commission on Accreditation of Healthcare Organizations, 2002; Lorenz et al., 2004).

Researchers such as Kaufman, Shim, and Russ (2006) have identified a number of barriers that impede the translation of what is known about pain management into routine end-of-life care. These include individual patient attitudes, provider characteristics, organizational policies, financial incentives (or lack thereof), and public policies. In this forum, we focus on the public policies pertaining to pain management at the end of life because they appear to be the least considered, yet most readily modifiable, among the known barriers. Our objectives are to (a) define the role of public policies, (b) identify the most relevant federal and state policies across all three branches of government, and (c) consider what might be done to advance the formation of those policies that appear critical to the provision of pain management at the end of life.

The Role of Public Health Policies

Joranson and Maurer (2003) resolved that the varied clinical approaches to pain management relate to the public policies that define and dictate the lawful practice of medicine. They specifically proposed that the provision of proper pain management is alternatively promoted or constrained by statutes and regulations regarding the use of controlled substances, including those used at the end of life. To this point, the Institute of Medicine (Field & Cassel, 1997) reported that many of the states' drug-prescribing laws, regulations, and medical board guidelines are outdated and scientifically flawed relative to current medical knowledge about pain management. For instance, some state laws continue to indicate that opioids are not a common part of medical practice and should be used only as a last resort and in very limited amounts (Pain & Policy Studies Group [PPSG], 2003a). Under such a policy constraint, the provision of opioids as a form of pain

management is compromised and often considered illegal.

Furthermore, public policies that emphasize an overaggressive enforcement in combating the diversion of licit drugs for illicit purposes without sensitivity to patient needs hamper effective pain management because practitioners alter their prescribing patterns (Edmondson, 2006). Quill and Meier (2006) specifically argued that when federal and state policies either support or do not limit an expanded role for the Drug Enforcement Agency (DEA) to scrutinize physician practice patterns, they emit a "chilling effect" on clinicians' willingness to adequately treat patients' terminal symptoms. Indeed, physicians have reported that they limit pain prescriptions out of fear of regulatory scrutiny (Joranson, Gilson, Dahl, & Haddock, 2002). In contrast, if public policies supported a balanced, contemporary, and evidence-based approach to treating pain, then it is logical to expect an improvement in patient outcomes would occur stemming from the reduction in barriers to the provision of pain management.

These cause-and-effect observations provides sufficient reason to conduct a more formal analysis of the terrain of public health policies pertaining to pain management at the end of life. Having conducted this examination, we present two outcomes here. First, we determine the extent to which the public has shaped the provision of pain management at the end of life through legislation, regulation, and other forms of policy. Such formal analyses of policy activity pertaining to the aging population and the end of life are rare (Brace & Jewett, 1995; Kaskie, Knight, & Liebig, 2001). Second, our examination can assist advocates interested in defining directions for public policy activity, and we point researchers toward critical issues that require further attention.

Federal Pain Policies

Each branch of the federal government has created policies that directly or indirectly influence pain management at the end of life. The most far-reaching federal policy pertaining to pain management is the Controlled Substances Act (CSA) adopted by Congress in 1970 (National Center on Addiction and Substance Abuse, 2005; PPSG, 1998). The CSA affects the practice of pain management because it (a) created a system for classifying prescription drugs; (b) required registration with the U.S. Drug Enforcement Administration by all health care providers who prescribe, dispense, and administer controlled substances; and (c) set the parameters and disciplinary measures related to prescribing controlled substances. What is particularly important is that the CSA recognized that opioid analgesics were necessary for the relief of pain and their availability for medical purposes had

to be ensured by restraining federal interference with physicians' prescribing practices (Gilson, Maurer, & Joranson, 2005). This policy affirmed that practitioners (including physicians, pharmacists, and licensed nurses) are responsible for the proper prescribing and dispensing of controlled substances for the relief of pain and provided the authority for the use of controlled substances for pain management at the end of life.

Beyond this 30-year-old act, congressional action pertaining to the treatment of pain at the end of life has been limited. Several bills have been introduced in Congress but have not passed. These include the Compassionate Pain Relief Act of 1984, which highlighted that pain was poorly treated (Dahl, n.d.); the Pain Relief Promotion Act of 1999, which called for amendments to the CSA to distinguish between pain management and euthanasia in terms of the "intent" of the prescribing physician (Library of Congress, 2005; Pain & the Law, 2004); the Conquering Pain Act, which called for the establishment of pain as a fifth vital sign and a national advisory committee on pain and palliative care; and the National Pain Care Policy Act, which called for a White House conference on pain management (Library of Congress, 2006; Pain & the Law, 2004; Reb, 2003).

The only action Congress has taken in recent years was the insertion of a one-line provision—a dedication of the calendar decade beginning January 1, 2001, as the "Decade of Pain Control and Research"—into an unrelated bill that became Public Law 106-386 (Library of Congress, 2006). The fact that no other congressional action concerning pain management has become law is not surprising. Gerber and Teske (2000) argued that when public problems, such as pain management at the end of life, involve highly technical points of discussion and also have low salience with the voting public, few elected officials are compelled to advance policy alternatives. In other words, even though the overwhelming majority of Americans do not want to die in pain, few elected officials have advanced a national policy because the issue is complicated and a candidate's position on pain management has never impacted the results of an election.

Supreme Court

The U.S. Supreme Court has influenced pain management at the end of life indirectly by hearing cases on physician-assisted suicide and medical marijuana. In 1997, the Court determined that assisted suicide is not a constitutionally protected right but that state and local authorities must decide for themselves if they will allow the act within their borders (*Vacco v. Quill*, 1997). The state of Oregon has since legalized assisted suicide, but the U.S. Attorney General reacted by claiming that Oregon

physicians prescribing controlled substances for assisted suicide were in violation of federal law. However, in *Gonzales v. Oregon* (2006), the Court majority reinforced state authority for regulating the practice of medicine and did not override Oregon's assisted suicide law. In contrast, the Supreme Court (*Gonzales v. Raich*, 2005) supported federal authority concerning medical marijuana when it decided that patients and caregivers who, according to state law, legitimately possess or grow marijuana for pain management are not exempt from prosecution under federal anti-drug statutes.

These cases confirm that the federal courts are reactionary to both federal- and state-level legislative and executive branch activities (Rowland & Todd, 1991). Still, the Supreme Court does have some discretion in the particular cases that are heard. In their study of how cases were eventually selected, Rowland and Todd found that the justices evidenced particular biases in selecting or avoiding cases. Arguably, the Supreme Court may be presented cases concerning pain management at the end of life in reaction to a congressional law or a state court decision (i.e., the legal model), but they may choose to hear these cases only because they intersect with the prevailing ideology of the Court or carry a personal interest to one or more aging justice.

Executive Agency

Historically, the presidency has appeared disinterested in matters pertaining to the end of life. One possible exception was President George W. Bush's reaction to the Terri Schiavo right-to-life case in which he signed Public Law 109-3 to facilitate intervention by a federal district judge to ensure that Ms. Schiavo's rights were not being violated by the state of Florida (Findlaw, 2005; Library of Congress, 2005). Yet despite presidential interest in this case, which indirectly concerned the treatment of pain, state, not federal, policy guided the decision concerning Ms. Schiavo.

The executive branch has pursued other efforts to influence end-of-life policy. As indicated earlier, under the current administration, the Office of the Attorney General has taken an interest in placing a check on state legislative initiatives and court decisions that promote the treatment of pain at the end of life (i.e., assisted suicide and medical marijuana). The executive branch also has affected pain policy via the DEA. Since the CSA of 1970, the DEA has been responsible for enforcing the controlled substances laws. This role includes not only registering practitioners, pharmacists, and other health care personnel who participate in the prescription or distribution of controlled substances for health care purposes but also bringing to justice those organizations or individuals involved in the illicit growing, manufacture, or distribution of

controlled substances (DEA, 2005). The DEA also proclaims to support the use of controlled substances for achieving pain management at the end of life (Joranson, 1995). In 2004, the DEA joined a working group of pain experts to promote adequate pain management and clarify issues relevant to health care providers and law enforcement officers regarding controlled substances (Pain & Policy Studies Group, 2006). In September 2005, the DEA posted a ruling making it easier for persons with chronic pain to receive the pain management they need (Drug Enforcement Agency, 2005).

State Pain Policies

The lack of comprehensive federal pain policies is consistent with the tradition of leaving health policy matters to state and local officials, especially those matters dealing with technological aspects of clinical care (Buzzee, 2001; Rich & White, 1996). Furthermore, the lack of federal policy pertaining to such a personal matter as pain management at the end of life is likely to continue as a function of the New Federalism and devolution in American government (Weil, Wiener, & Holahan, 1998).

New Federalism was touted as a financial strategy for solving the problem of an overextended federal government during the 1970s. New Federalism led to management reforms, a consolidation of federal funding, and an increased flexibility for states to create policies in the name of efficiency (Conlan, 1998). New Federalism then transformed into devolution during the 1980s and 1990s, a political ideology concerned with decreasing the size, power, and influence of the federal government (Conlan, 1998). Under devolution, state governments assumed more policy-making responsibility. Meanwhile, the federal government maintained a hands-off approach on matters pertaining to individual preferences (Holahan, Weil, & Wiener, 2003; Sparer, 1998). As such, we looked to the states to hold broad legislative, judicial, and executive powers to develop and implement pain management policies pertaining to end-of-life care.

State Legislatures

All 50 state legislatures adopted a version of the federal CSA to establish the necessary legal structure to control drugs with abusive potential (Joranson & Gilson, 2003). However, these state laws often lacked the explicit language included in the federal version and were thought to contribute to varying pain management practices (Gilson et al., 2005; Joranson & Gilson, 2003). In response to this shortcoming, 12 state legislatures adopted Intractable Pain Treatment Acts. These were intended to address physician fears of regulatory scrutiny and

ensure that patients who suffered pain would not be denied opioids for pain relief (Gilson et al., 2005; Joranson, 1995; PPSG, 2000). Legal experts agreed that these 12 state laws provide immunity from disciplinary action by state medical boards (Gilson et al., 2005), but the laws are limited in scope.

State Courts

Historically the state courts have upheld the principle to err on the side of caution and have handed down rulings that reprimanded clinicians and organizations that appeared to overprescribe opioids as a form of pain management at the end of life. However, more recent state court decisions concerning end-of-life care have considered the undertreatment of pain as negligence, and these rulings have become a contemporary legal phenomenon (Haugh, 2005). For example, a California court recently held a physician liable for the inadequate treatment of pain according to current medical standards and awarded \$1.5 million to the family of an elderly man who suffered intolerable pain before his death (Compassion in Dying Federation, 2005). A nursing home in North Carolina was held liable for providing inadequate pain control to its residents (McIntire, 2003).

State Executive Agencies

Besides supporting pain policies established by the legislature and state agencies, governors in at least 18 states have established task forces to study pain policies, tie them with scientific advancements, and eliminate barriers to appropriate pain management (National Conference for State Legislatures, 2003). Furthermore, the National Association of State Attorneys General recently championed end-of-life issues and passed a resolution calling for a balanced approach for state public pain policies (Edmondson, 2006).

State Medical Boards.—Given the highly technical nature of medicine, state medical boards have been organized in every state. These boards function as independent policy-making authorities with extensive oversight over the clinical practice of medicine (Galusha, 1988; Gerber & Teske, 2000; Hill, 1993). State medical boards generally are granted public authority to regulate medical practice and to license and discipline clinician members. More pertinent here is the considerable amount of responsibility boards assume for policies associated with pain management.

Hill (1993) was among the first to link state medical board pain management policies to the quality of care received at the bedside. Given an analysis of medical regulatory acts in four states as well as personal involvement serving as expert and

counsel in cases of violations of opioid policies for prescribing, dispensing, and administering opioids, he found that medical boards exert both subtle and direct negative influences on pain treatment. Negative influences include misinterpreting legislative statutory language or its intent; determining customary practice policy based on nonscientific principles of pain management or misinformation about opioid use for treating pain; making arbitrary decisions about opioid dosing parameters without knowledge of opioid pharmacodynamics or without distinction between acute and chronic and persistent pain or between patients and drug abusers; and unjustly applying discipline based on faulty and outdated definitions of addiction, with disregard for the physiologically appropriateness of physical dependency on pain medications by persons suffering chronic pain. Unless boards take actions to minimize or reverse these negative influences (e.g., clearly distinguishing between physical and psychological [addiction] dependence), they may negatively impact pain management in significant and practical ways.

Comparative Evaluation of State Pain Policies

Our analysis of the public policies pertaining to the management of pain at the end of life suggests that there has been a diffusion of state activity within legislative, judicial, and executive branches and by state medical boards in particular. We suspect that the diffusion of state activity has resulted in substantial differences from one state to the next. The PPSG at the University of Wisconsin has studied state medical board activities and collected state pain policies for the past decade. With the input of expert clinicians, they developed a benchmark to compare state pain management policies. This benchmark includes eight provisions that are critical to reaching the long-standing and well-supported principle of “balance” in pain management (see Table 1). When state pain policies contain all or most of these provisions, the resulting framework allows the practice of pain management to be consistent with current clinical research and patient preferences.

Three times in the past 6 years PPSG (2000, 2003a, 2006) has compared state pain policies against this benchmark and assigned a grade to each state. A higher grade represents a state with more balanced policies. PPSG found that 18 states have improved their grade by at least one full letter since 2000, mainly by adopting more pain-management-enhancing policy provisions. Despite these recent advancements, much room for improvement remains. In 2006, only two states (Michigan and Virginia) received an A, and 23 states still earned C- and D-level grades.

These comparative evaluations supported three conclusions. First, PPSG established that substantial variation in pain management policies exists from one state to the next; no state has developed all eight

Table 1. Pain-Management-Enhancing Policy Provisions

Controlled substances are necessary for public health.
Pain management is part of medical practice.
Opioids are part of professional practice.
Pain management is encouraged.
Fears of regulatory scrutiny are addressed.
Prescription amount alone does not determine legitimacy.
Physical dependence or analgesic tolerance are not confused with addiction.
Other provisions that may enhance pain management are included (e.g., encouraging multidisciplinary collaboration when treating pain, policies aimed specifically for treating end-of-life care pain, development of practice standards for assessing and treating patients' pain).

provisions, and many states actually continue to uphold policies that impede the provision of pain management (Gilson et al., 2005). Second, PPSG concluded that state medical boards are the primary authority for developing and advancing pain management policies, and in many states boards are the only active policy-making body. Third, there is little to no understanding of how policies are made from one state board to the next, and the reasons state medical boards adopt such varying policy language are largely unexplored.

State Medical Board Policy Making

Understanding the policy activities of state medical boards is both strategic and informative. It can be strategic for politicians and advocates who seek to advance state policy making. It can be informative for analysts and researchers who wish to ascertain why state governments create such variable outputs (Biggs & Helms, 2006; Brace & Jewett, 1995). In consideration of this, Imhof and Kaskie (in press) applied an event history analysis and tested how well a theoretical model of policy formation explained the passage of four different types of state board policies pertaining to pain management: (a) integrating pain management as a part of medical practice, (b) establishing that opioids are part of professional practice, (c) determining that pain management should not be defined by restrictive dosage levels, and (d) protecting practitioners' fear surrounding professional scrutiny of the dispensation of medications to relieve pain. The theoretical model they tested assumed that these policies were shaped by economic, political, extrinsic, and institutional characteristics of the state medical boards (Kaskie et al., 2001; Ringquist, 1993a, 1993b).

Their analysis identified multiple factors that worked independently and in combination: Political systems, extrinsic demands, and institutional characteristics all influenced a board's decision to adopt pain policies. However, the most prominent effect was the presence of legal counsel on the medical

board. Sonnenfeld (2002) would suggest that the skills of legal counselors make them useful to advancing medical board policy, and the American Bar Association (Anonymous, 2003) recognized that lawyers could assist with analyzing compliance of pain policies with applicable laws and regulations as well as evaluate the risks associated with practicing pain management.

The frequency of board meetings (i.e., how many times the boards met in a given year) also held a relatively strong and consistent role in shaping pain policies, albeit not in the anticipated direction. Boards that met more frequently adopted fewer policies than boards that met less frequently. It may be that rather than having more time to address policy issues, boards that met more frequently did so because they were charged primarily with clinical case reviews—the responsibility that often consumes the greatest amount of physician members' time on the board (S. Johnson, personal communication, March 15, 2006). For example, in any given year the California medical board may investigate 10,000 complaints regarding physician practices or omissions (Morrison & Wickersham, 1998). As such, the nature of what a board does is determined by the demands placed on it, which may reflect peer evaluations and complaint resolutions more than policy making.

Although Nice (1984) hypothesized that more liberal states would be more likely to develop pain management policies, Imhof and Kaskie (in press) found that two of the four policies examined were not related to political ideology and the other two were more likely to be advanced in more conservative states. Given that the purpose of these particular policies was to make it more difficult for government officials to have the authority to intervene in the provision of pain management (i.e., that prescription amount alone does not determine the legitimacy of a pain prescription and that practitioners' fears of regulatory scrutiny are addressed), it may be the case that boards in more conservative states were interested in providing up-front policies that established the parameters for limited government intervention (Brown, 1995; Hedge & Scicchitano, 1994). Imhof and Kaskie also found that the adoption of one of the pain policies was associated with neighboring state activity. Because states in the same region tend to share similar policy issues, medical board members, legal counsel, or board administrators in neighboring states may look to their counterparts when developing pain policies (Berry & Berry, 1990).

Resurrecting Advocacy Efforts to Improve End-of-Life Care

The comparative evaluations completed by the PPSG pointed toward specific states (e.g., those with

grades C and D) that may benefit the most from a concerted interest in advancing pain management policies. Furthermore, because no state has adopted a fully comprehensive pain policy platform and many state policies remain inconsistent with current recommendations for evidence-based practice (PPSG, 2006), all states have room for some improvement. Unfortunately, since the discontinuation of a once strong and influential Last Acts campaign—a Robert Wood Johnson Foundation campaign that was active in the 1990s and that established a broad consensus about advancing end-of-life issues and raised awareness throughout public, clinical, research, and policy-making domains (Robert Wood Johnson Foundation, 2002)—no other comparable efforts have been made in recent years to further advance the cause.

Therefore, in this forum, we attempt to renew interest in advancing end-of-life care and make a deliberate attempt to shift collective attention toward the role of public policies. Although federal policies most readily capture relatively broader public interest (e.g., intervention in the Terri Schiavo case by all three federal branches), they are rarely comprehensive or targeted. We also resolve that current federal policy-making efforts are reactionary. Congress and the executive branch take little interest in proactively disentangling the highly technical aspects of pain management because such efforts rarely gain votes among constituents; they would rather wait for end-of-life care issues to be placed on their agendas. When this does happen, they appear to uphold the authority of existing state policies.

Conversely, states have crafted richer, more targeted, and more varied policy responses to issues surrounding pain and have been able to do so because pain management policies are neither mandated nor standardized at the federal level. Many state legislatures have adopted variations on Intractable Pain Treatment Acts, state court rulings have defined the undertreatment of pain as a liability, governors' task forces have been established to focus on pain management issues at the end of life, and state medical boards have played a variety of roles primarily influencing health care organizational policies and clinical practices pertaining to the management of pain. Advocacy efforts, then, should focus on the states.

Imhof and Kaskie (in press) provided some indication about how these efforts to advance policy may proceed. In particular, their research suggested that change initiatives might be navigated most effectively by state medical boards whose memberships include legal counsel who can inform policy discussions, consider how policies can be developed in compliance with existing state laws and regulations, and evaluate the potential liability associated with practicing pain management. For states without such expertise on medical boards, a first step for advocacy efforts (e.g., state medical and nursing

associations dedicated to pain and end-of-life care, oncology professional associations, state hospice and palliative care professional organizations, etc.) could be to focus on expanding and diversifying the boards' membership rosters.

Advocates should also work to encourage boards to devote sufficient time and opportunity to focusing on matters concerning end-of-life care. State medical boards can initiate efforts to incorporate the Federation of State Medical Boards model guidelines into a policy-making framework so that policies incorporate evidence-based care for the treatment of pain (LastActs, 2002b; PPSG, 2003a). Supporting public education and professional training campaigns, hosting interstate conferences, and pursuing other forms of communication about best practices are additional possible means for promoting the advancement of pain management policies and practice.

It is worth mentioning that Imhof and Kaskie (in press) found that the ideology of the state governments and citizen wealth had minimal effects on medical board policy-making activity, suggesting that pain management policy adoption by medical boards remains somewhat independent from political majorities, ideological posturing, and economic cycles. As such, the boards can focus on addressing the complex, technical aspects of pain management. Arguably, as board policy making increases, there will be several reactions (both positive and negative) within state legislatures and courts and, perhaps, within federal policy-making bodies as well.

Focal Points for Future Research

We have assumed that public health policies pertaining to pain management at the end of life provide the legal structure that shapes organizational procedures, clinical practices, and individual outcomes, and that the impact of these public policies may be positive or negative depending on the specific language and legal parameters of the particular policy. In support of this assumption, we have highlighted numerous case studies and deductive arguments (Edmondson, 2006; Gilson et al., 2005; Haugen, 2000; Joranson et al., 2002). Our assumption also is supported by an emerging research literature that has used quantitative methodology (i.e., longitudinal designs, large samples, and statistical analyses that account for covariates and random effects) to tie other public health policies to specific clinical practices and individual outcomes (Miller, 2005; Walker, 1989).

Nonetheless, researchers should further illuminate the effects of public policies pertaining to pain management, and this forum could be a departure point for the development of empirical research that addresses two critical issues. First, policy implementation studies must determine which particular pain

policies had their intended effect of improving patient outcomes at the end of life. In other words, research needs to identify the most critical policies for improving end-of-life care (Kaufman et al., 2006). Second, given that the undertreatment of pain may be more of a problem than just outdated and scientifically flawed public policies (National Consensus Project, 2004), researchers need to consider how covariates of the "best" policies (e.g., other pain policies, individual characteristics, provider behaviors, organizational policies, etc.) mitigate or moderate the effect on end-of-life care. Research also should illuminate the pathway of effect. Does a state policy that works through an organization (i.e., as an instrumental variable) differ from one that directly targets the patient and his or her provider (e.g., a public information and professional education campaign)?

These certainly appear to be important topics. However, Spitz and Abramson (2005) cautioned that efforts to advance public policies, such as those discussed in this forum, should not necessarily wait on research results. Although research can inform discussions about what should or should not be done, we agree with Spitz and Abramson in that the inevitable lack of conclusiveness of any particular research study can contribute to the perpetuation of the status quo. If we conclude that advancements in public policy should not be made without a sufficient amount of induction, then the undertreatment of pain at the end of life will not go away any time soon.

Conclusion

The continued undertreatment of pain at the end of life is a substantive public health problem that has not been resolved through increased public awareness, the issuance of clinical guidance for providers, or expanded organizational commitments. In this forum, we illuminated the role of public policies in promoting pain management. We reviewed federal and state policies and considered empirical evaluations concerning their quality and the factors that contributed to their formation. It is our assumption that any organized interest in improving end-of-life care should begin by focusing on the development and expansion of those state policies that support the provision of evidence-based medicine for reducing the amount of pain an individual experiences at the end of life. Although empirical research is needed to determine which particular aspects of state pain policy are most critical and how these policies can be implemented most effectively, any organized effort that advances state medical board activity or another state policy would appear to be making an important step toward making the pain at the end of life go away.

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