

THE ROLE OF NURSES IN INTERNATIONAL PAIN CARE

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I. INTRODUCTION

“[N]urses in several countries have key roles to play in the management of acute and chronic pain.”¹

On the face of things, our global community maintains a strong commitment to adequate pain management, including the use of opioids. The leading international treaty regulating opioids, the United Nations' Single Convention on Narcotic Drugs (Single Convention), has 184 parties as of 2010. The Single Convention recognizes that “the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering” and that “adequate provision must be made to ensure the availability of narcotic drugs for such purposes.”² In

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1. Molly Courtenay & Nicola Carey, *The impact and effectiveness of nurse-led care in the management of acute and chronic pain: a review of the literature*, 17 J. CLIN. NURS. 2001, 2011 (2008).

2. Single Convention on Narcotic Drugs, as amended by the Protocol Amending the Single Convention on Narcotic Drugs, Aug. 8, 1975, 18 U.S.T. 1407, 976 U.N.T.S. 105 [hereinafter

practice, however, only a fraction of chronic or acute pain sufferers receive appropriate medicinal intervention.³ Although the reasons for this failure are complex, nurses may be able to make significant contributions towards alleviating it.

First, nurses have a relatively short training period as compared to physicians,⁴ so they can be trained and deployed to assess and treat pain more quickly. Second, a nurse's unique and important relationship with a patient allows them to bond in ways that other providers cannot. As such, nurses are accurate and effective assessors of their patients' conditions, which ensures that their patients feel well cared for.⁵ Third, as advocates,⁶ nurses are the crucial voice in assuring that their patients' medical, physical, and psychological needs are met, either in a clinical setting or in the context of patient care. Finally, as facilitators of communication, nurses typically act as intermediaries between their patients and other health care providers.⁷ The global community should capitalize on the unique contributions nurses can make by giving them proper training and policy

Single Convention].

3. See Allyn L. Taylor, *Addressing the Global Tragedy of Needless Pain: Rethinking the United Nations Single Convention on Narcotic Drugs*, 35 J. LAW., MED. & ETHICS 556, 556 (2007) ("Pain remains severely under treated worldwide, particularly in developing countries. The tragic consequence is that for millions of people around the globe, excruciating pain is an inescapable reality of life.").

4. See, *More About RNs and Advanced Practice RNs*, NURSING WORLD, <http://www.nursingworld.org/EspeciallyForYou/StudentNurses/RNsAPNs.aspx> (last visited Nov. 1, 2010) (indicating that advanced practice registered nurses have a minimum of a Master's degree, beyond the basic nursing education and licensing required of all RNs); *Nursing Education*, NURSING WORLD, <http://www.nursingworld.org/EspeciallyForYou/StudentNurses/Education.aspx> (last visited Nov. 1, 2010) (indicating that to obtain an RN in the United States, an individual must graduate from a two-, three-, or four-year state-approved school of nursing and pass a state RN licensing examination); see also *Becoming a Physician: Graduate Medical Education and Residency Program*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician.shtml> (last visited Nov. 1, 2010) (indicating that physician education in the United States involves four years of undergraduate education, four years of medical school and three to seven years of graduate medical education); Dorothy E. Logie & Richard Harding, *An Evaluation of a Morphine Public Health Programme for Cancer and Aids Pain Relief in Sub-Saharan Africa*, 5 BMC PUB. HEALTH 82, 86 (2005) (noting that training to become a palliative care nurse takes nine months in Uganda).

5. Mary Carol Ramos, *The Nurse-Patient Relationship: Theme and Variations*, 17 J. ADVANCED NURSING 496, 497 (1992); Esther Mok & Pui Chi Chiu, *Nurse-patient Relationships in Palliative Care*, 48 J. ADVANCED NURSING 475, 475 (2004).

6. See Nancy Gaylord & Pamela Grace, *Nursing Advocacy: An Ethic of Practice*, 2 NURSING ETHICS 11, 18 (1995) (noting that advocacy is a philosophical component of the practice of nursing); see generally Stephanie Tate, *Patient Advocacy: The Nurse's Responsibility*, TOPICS IN ADVANCED NURSING EJOURNAL (Aug. 3, 2005), <http://www.medscape.com/viewarticle/508563> (commenting that nurses' greatest responsibility is patient advocacy).

7. See Gaylord & Grace, *supra* note 6, at 16 (stating that nurses coordinate patient care and transmit "vital information to other health care providers, thus ensuring each member has the data necessary to make an accurate assessment of the patient's needs or requirements").

support. By making nurses decision-making partners in addressing and managing pain, a patient's right to be free from pain will be more fully realized.

Freedom from pain has been identified as a basic human right.⁸ However, a 2009 World Health Organization (WHO) report estimated that "5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for severe pain."⁹ In any given year, this includes as many as 1 million end-stage HIV/AIDS patients, 5.5 million terminal cancer patients, 800,000 patients with violent injuries, and 110 million women giving birth.¹⁰ It also includes millions more, suffering from chronic illness or other trauma or recovering from surgery, who go without sufficient pain management.¹¹

The lack of access to pain care is most acute in developing countries, where the occurrence of cancer and AIDS is highest.¹² A 2010 WHO report indicates that "at least 30 million patients and a possible 86 million suffer untreated pain annually."¹³ The report also states that "the number of people who would benefit from the availability of basic palliative care has been estimated to be as high as one hundred million."¹⁴

While already striking, these numbers will only continue to increase for two reasons. First, the global population over the age of sixty is expected to double in the next twenty years.¹⁵ Second, the disease burden is projected to shift further to the developing world, where opioid analgesics are least accessible.¹⁶ Despite the fact that Asia and Africa hold almost eighty percent of the world's population, they "account for only six percent of global consumption of morphine."¹⁷

Access to opioids is impeded by a complex web of social, cultural, and political obstacles. These can be roughly divided into three categories: (1)

8. See N.I. Cherny et al., *Formulary Availability and Regulatory Barriers to Accessibility of Opioids for Cancer Pain in Europe: A Report from the ESMO/EAPC Opioid Policy Initiative*, 21 ANNALS ONCOLGY 615, 615 (2010) (citing generally HUMAN RIGHTS WATCH, "PLEASE, DO NOT MAKE US SUFFER ANY MORE..." ACCESS TO PAIN TREATMENT AS A HUMAN RIGHT, 35-36 (2009)) (indicating that adequate pain relief is recognized as a human right).

9. World Health Org., *World Health Organization Briefing Note – February 2009*, 1 (2009), available at http://www.who.int/medicines/areas/quality_safety/ACMP_BrNoteGenrl_EN_Feb09.pdf [hereinafter *Briefing Note 2009*].

10. *Id.*

11. *Id.*

12. Ruth Webster et al., *Palliative Care: A Public Health Priority in Developing Countries*, 28 J. PUB. HEALTH POL'Y 28, 28 (2007).

13. WORLD HEALTH ORG., *ESSENTIAL MEDICINES BIENNIAL REPORT 2008-2009* 4 (2010), available at http://whqlibdoc.who.int/hq/2010/WHO_EMP_2010.1_eng.pdf (reporting the health impact of the economic crisis in 2008 and 2009) [hereinafter *ESSENTIAL MEDICINES*].

14. Jan Stjernswärd & David Clark, *Palliative Medicine—A Global Perspective*, in OXFORD TEXTBOOK OF PALLIATIVE MED. 1199-222 (Derek Doyle et al. eds., 2d ed. Oxford Univ. Press 2004), available at <http://health.osf.lt/downloads/news/Stjernsward-handout.pdf>.

15. Taylor, *supra* note 3, at 558.

16. *Id.*

17. *Id.* at 557; Webster et al., *supra* note 12, at 30.

regulatory and legal issues; (2) inadequate education and training for health care providers; and (3) shortages of health care providers. None of these categories is self-contained; each impacts and overlaps the other. The persistence of the opioid shortage, even in countries whose governments provide free pain medication,¹⁸ indicates that the problem goes beyond cost. Moreover, this highlights a lack of political will to make pain care a priority.¹⁹ Because of the myriad political, regulatory, social, and even geographical obstacles affecting the distribution of pain medication across the globe, there can be no universal blueprint for balancing sufficient access to pain care with adequate deterrence of opioids abuse. Countries that have succeeded in this quest have followed individualized and divergent paths to develop appropriate solutions, addressing one or more of these obstacles along the way.²⁰

This article will begin by touching briefly on examples from around the world that highlight each of these three main obstacles – regulatory, educational, and adequacy of workforce. These sections will address the manner in which each obstacle impacts a patient's ability to access adequate pain relief through opioid analgesics. Finally, the paper discusses nurses' potential to ameliorate inadequate pain management access. While there are many examples of nurses playing a role in providing pain relief, substantial research must be done before a model of care delivery can be perfected and expanded.²¹ The full promise of nurse involvement in pain care has yet to be realized and the severity of the problem demands innovative strategies.

II. LEGAL AND POLITICAL BARRIERS TO PAIN CARE

*"As with any health initiative, the most important factor is government commitment."*²²

Opioids are powerful drugs that are heavily regulated by governments on both an international and national scale.²³ The regulatory structure surrounding opioids

18. David Clark et al., *Hospice and Palliative Care Development in Africa: A Multi-Method Review of Services and Experiences*, 33 J. PAIN SYMPTOM MGMT. 698, 701 (2007) (noting that Uganda provides free morphine for cancer and HIV/AIDS patients' pain management).

19. See HUMAN RIGHTS WATCH, "PLEASE, DO NOT MAKE US SUFFER ANY MORE..." ACCESS TO PAIN TREATMENT AS A HUMAN RIGHT 35-36 (2009), available at http://www.hrw.org/sites/default/files/reports/health0309webwcover_1.pdf (indicating that adequate pain relief is recognized as a human right) [hereinafter PLEASE, DO NOT MAKE US SUFFER].

20. See Scott C. Burris & Corey S. Davis, *A Blueprint for Reforming Access to Opioid Medications*, TEMP. UNIV. CTR. FOR HEALTH L. POL'Y & PRACTICE 1, 4 (2008), available at http://www.painpolicy.wisc.edu/internat/DCAM/Burris_Blueprint_for_Reform.pdf (analyzing past efforts at opioid access reform and setting out interventions that can help nations at "any stage of readiness" for reform); see generally Evan D. Anderson et al., *Closing the Gap: Case Studies of Opioid Access Reform in China, India, Romania & Vietnam*, TEMP. UNIV. CTR. FOR HEALTH L. POL'Y & PRACTICE (2008), available at <http://ssrn.com/abstract=1356769> (outlining case studies of four countries' opioid access reform efforts).

21. See Courtenay & Carey, *supra* note 1, at 2012-13.

22. Webster et al., *supra* note 12, at 31.

attempts to correctly and safely use these drugs to their best medical advantage, while at the same time preventing them from being diverted into illegal and unsafe non-medical use.²⁴ This dual purpose has created tension between groups that tend to prioritize one goal over the other.²⁵ The pervasive fear that medical opioid use leads inevitably to addiction, coupled with evidence that the abuse and illegal trade of opioids are both on the rise, has generally pushed drug regulators to emphasize deterrence and policing at the expense of adequate availability.²⁶

However, many of the fears about the hazards posed by opioid use go beyond any factual basis, demonstrating the need for education about the true extent of the risks involved.²⁷ Indeed, a growing number of organizations and experts are recognizing that the current drug-control regime is failing and are actively working toward adoption of a more balanced approach.²⁸ In 2007, the WHO launched the Access to Controlled Medications Programme to work with countries to reduce barriers to opioid access and increase full compliance with the international drug treaties, anchored by the Single Convention.²⁹

Yet, despite this growing support, policies have been slow to change.³⁰ For instance, many Eastern European countries remain non-compliant with WHO recommendations that codeine, morphine, and other opioids be included in formularies and, therefore, available to patients as analgesics.³¹ Additionally, even when these products are technically available, burdensome regulations often create practical obstacles to the provision of medically sound pain treatment.³² These regulations include restrictive measures such as complex forms and/or reporting

23. WORLD HEALTH ORG., ACHIEVING BALANCE IN NATIONAL OPIOIDS CONTROL POLICY 1 (2000) (WHO model guidelines for regulation of opioid availability), *available at* <http://apps.who.int/medicinedocs/pdf/whozip39e/whozip39e.pdf>. [hereinafter ACHIEVING BALANCE].

24. *See* Taylor, *supra* note 3, at 561 (describing the national and international efforts to curb illicit drug trafficking and efforts to increase the availability of drugs for medical use).

25. *See id.* at 561-62 (critics argue that “focusing the principal goal of drug policy on prohibition has diverted attention away from treatment and towards punishment”); Burris & Davis, *supra* note 20, at 16 (arguing that strict government control of controlled substances has come at the cost of decreased availability).

26. *Cf.* Anderson et al., *supra* note 20, at 2-4 (arguing that many national drug control policies are based on outdated and overstated fears of addiction); Burris & Davis, *supra* note 20, at 2-3 (“drug control policies and outmoded ideas about addiction have helped perpetuate negative attitudes about opioids, prevented health care professionals from getting experience in their use, and erected often insurmountable regulatory barriers to their availability”); Taylor, *supra* note 3, at 565 (explaining influence international organizations have had on shaping strict national drug control policies).

27. *See infra* Part III.

28. *See e.g.*, Burris & Davis, *supra* note 20, at 4-5 (noting that the WHO has advocated a more balanced approach).

29. ESSENTIAL MEDICINES, *supra* note 13, at 5.

30. *See* Burris & Davis, *supra* note 20, at 24-25 (discussing recent evolution of laws).

31. *See* Cherny et al., *supra* note 8, at 622 (describing that opioid formularies are more restrictive in East-European countries than in West-European ones).

32. *Id.*

requirements for prescriptions, limiting opioid access to a specified group of patients, and harsh legal sanctions, among others.³³ Even in Uganda, where morphine is provided free of charge by the government for palliative care, confusion over the authorization of distribution, difficult storage requirements, and burdensome documentation procedures inhibit the actual distribution of the drug.³⁴

By way of further illustration, India produces more opium for the legal morphine industry than any other country³⁵ but, ironically, the vast majority of the people living in India cannot access it. This is due to strict regulations that require, for example, locking pills in two-key cabinets, obtaining multiple licenses for every shipment, and tracking and returning unused pills.³⁶ These administrative burdens are intended to prevent licensed providers from stockpiling morphine.³⁷ Meanwhile, the Indian health service outwardly supports medical opioid use, and a successful WHO demonstration project in Calicut, India showed that access to pain relief in India is possible.³⁸ But India is governed by a decentralized federal structure, so policies differ significantly among the various states.³⁹ Notwithstanding a court order in 1998 to make opioids accessible for patient care, as of four years later only eight out of twenty-eight states had made the necessary policy change.⁴⁰ Despite these deficiencies, India is actually among the few examples of developing countries that are taking active steps to improve their pain care policy.

In the past decade or so, there have been several organized efforts in Africa aimed at improving hospice-palliative care, of which pain management is a key ingredient. However, a recent study of progress on the continent classified twenty-one African countries as having “no known hospice-palliative care activity.”⁴¹ In addition, thirty-two African countries lack morphine distribution, while only fourteen have oral morphine available. Even in those countries that have morphine, the amount used is minimal, largely because the supply of medicine falls below the demand.⁴²

33. Cherny et al., *supra* note 8, at 622-23.

34. Logie & Harding, *supra* note 4, at 3.

35. Donald G. McNeil, Jr., *In India, a Quest to Ease the Pain of the Dying*, N.Y. TIMES, Sept. 11, 2007, at F1.

36. *Id.*

37. *Id.*

38. Jan Stjernswärd, *Foreword: Instituting Palliative Care in Developing Countries - An Urgently Needed and Achievable Goal*, 17 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY xxix, xxxi (2003).

39. *See id.* at xxxi-xxxv (stating that India has over 500 districts and that the state of Kerala produces a generic morphine tablet that is widely available).

40. R.B. Ghooi & S.R. Ghooi, *Freedom from Pain - A Mirage or a Possibility? Experience in Attempts to Change Laws and Practices in India*, 17 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 1, 4-5 (2003).

41. Clark et al., *supra* note 17, at 702-704.

42. PLEASE, DO NOT MAKE US SUFFER, *supra* note 19, at 11; *see also* Logie & Harding, *supra* note 4, at 1-2 (describing that opioids could alleviate all pain caused by cancer and AIDS, but for the bureaucratic regulations).

In the United States and Western Europe, where regulatory barriers to stocking and distributing opioid analgesics are less onerous, there is nevertheless a strong fear among practitioners that they will be prosecuted if a prescription they write should fall into the wrong hands or is otherwise misused.⁴³ The U.S. Controlled Substances Act couches the definition of misconduct in vague phrasing such as “good faith,” “legitimate medical purpose,” and “usual course of [] professional practice,” which the courts must then attempt to interpret in a somewhat standardized manner.⁴⁴ Based on these definitions, hundreds of physicians have been arrested for drug violations and some are serving sentences for prescribing behavior that arguably fell within the scope of their medical practice.⁴⁵ While the number of prosecutions is relatively small compared to the volume of prescriptions for pain medications that are written and filled without incident each year, the disproportionate publicity garnered by these few cases has caused many physicians to withhold opioids from patients who may have a legitimate need.⁴⁶

The limitation on the prescriptive authority of health care providers, particularly nurses, is another policy barrier to efficient pain management that impacts both developed and developing nations. This problem is increasingly being addressed in the United States, where every state allows advanced practice nurses – nurses with advanced training and education who are able to function similarly to a physician in many capacities⁴⁷ – to prescribe medications with

43. See Cherny et al., *supra* note 8, at 615 (describing generally the barriers to opioid availability in many countries); Michael Potter et al., *Opioids for Chronic Nonmalignant Pain: Attitudes and Practices of Primary Care Physicians in the UCSF/Stanford Collaborative Research Network*, 50 J. FAM. PRAC. 145, 148-50 (2001) (fear of regulatory scrutiny may lead physicians to prescribe less); see generally David E. Weissman et al., *Wisconsin Physicians' Knowledge and Attitudes About Opioid Analgesic Regulations*, 90 WIS. MED. J. 671 (1991).

44. Katherine Goodman, *Prosecution of Physicians as Drug Traffickers: The United States' Failed Protection of Legitimate Opioid Prescription Under the Controlled Substances Act and South Australia's Alternative Regulatory Approach*, 47 COLUM. J. TRANSNAT'L L. 210, 213-14 (2008); see also Stephen J. Ziegler & Nicholas P. Lovrich Jr., *Pain Relief, Prescription Drugs, and Prosecution: A Four-State Survey of Chief Prosecutors*, 31 J. LAW, MED. & ETHICS 75, 75 (2003) (stating that physicians recognize they may be under-treating patient pain in response to their fears of criminal prosecution).

45. See Goodman, *supra* note 44, at 214 (stating that the “DEA has arrested hundreds of practitioners in recent years”).

46. *Id.* at 212; Ziegler & Lovrich, *supra* note 44, at 75-76 (noting that some physicians even fear being charged with euthanasia of their terminally ill patients if they prescribe opioids to relieve their pain); PLEASE, DO NOT MAKE US SUFFER, *supra* note 19, at 37 (“In the United States, many physicians are reported to fear unjustified prosecution or sanctioning for prescribing opioids for pain and, consequently, tend to under-prescribe.”).

47. Robert Cunningham, *Tapping the Potential of the Health Care Workforce: Scope-of-Practice and Payment Policies for Advanced Practice Nurses and Physician Assistants*, NAT'L HEALTH POL'Y FORUM, 5 (Jul. 6, 2010), available at http://www.nhpf.org/library/background-papers/BP76_SOP_07-06-2010.pdf

(stating that an advanced practice nurse (APN) “is an umbrella term that refers to four main types of nurses who have received advanced training beyond what is required for licensing as a registered nurse (RN): nurse practitioner, nurse anesthetist, clinical nurse specialist, and nurse

varying levels of physician oversight and medication restrictions.⁴⁸ Limits on prescriptive authority are also under scrutiny where workforce pressures in healthcare are leading legislatures to expand nurse practitioners' roles and eligible practice scope.⁴⁹ These policy changes are particularly attractive in places where there are too few physicians to adequately address the pain care needs of the population, as is the case in many developing countries.⁵⁰

The literature demonstrates that advanced practice nurses are capable of delivering care that is comparable in quality to that of physicians.⁵¹ As a result, policymakers in the United States and other developed nations are beginning to embrace this able profession as a new type of primary care provider.⁵² However, entrenched cultural presumptions about the roles of physicians and nurses have impeded the progress of legislative and regulatory efforts to further empower nurses as frontline providers.⁵³ These cultural presumptions underlie many of the political and policy barriers outlined in this section, and they feature prominently in the educational concerns outlined below.

III. EDUCATIONAL BARRIERS TO PAIN CARE

*“[P]rofessional fears about morphine proved difficult to shift”*⁵⁴

Policy changes are only one step in the path to meaningful opioid access. They must go hand-in-hand with educating the physicians and nurses who provide the drugs, as well as the public and patients who use them.⁵⁵ As far back as the late nineteenth century, before powerful opioids such as morphine and cocaine were outlawed, the public first began to understand and fear the effects of their use and abuse.⁵⁶ Many providers still harbor the belief that opioid use of any kind will lead to addiction or that prescribing opioids will inevitably lead to non-medical use.⁵⁷

midwife.”). Requirements for licensing as an APN vary widely from state to state. *Id.* Many states require a master of science in nursing degree in order to qualify as an APN. *Id.*

48. See Carla K. Johnson, *Doctor Shortage? 28 States May Expand Nurses' Role*, SEATTLE TIMES, Apr. 13, 2010, available at http://seattletimes.nwsourc.com/html/localnews/2011594266_apusmeddrnurse1stdwritethru.html (noting that 28 states are currently considering expanding the role of nurse practitioners, including removing physician supervision of narcotic prescriptions).

49. *Id.*

50. See *infra* Part IV.

51. See Barbara Sheer & Frances Kam Yuet Wong, *The Development of Advanced Nursing Practice Globally*, 40 J. NURSING SCHOLARSHIP 204, 205-08 (2008).

52. *Id.* at 205-08.

53. See generally Johnson, *supra* note 48 (describing physicians' protests to nurses' expanded roles).

54. Logie & Harding, *supra* note 4, at 4.

55. E.g., Ghooi & Ghooi, *supra* note 40, at 8 (stating that education in morphine use is required at all levels).

56. See Eric E. Sterling, *The Sentencing Boomerang: Drug Prohibition Politics and Reform*, 40 VILL. L. REV. 383, 392-93 (1995) (fears included the myth that cocaine use by African-American slaves in the United States would make them impervious to .32 caliber bullets).

57. See Webster et al., *supra* note 12, at 33-34 (noting that the phenomenon of “opiophobia” is pronounced among healthcare professionals not only in developing countries, but

Even where policies do not formally prevent access to opioids, providers' and patients' negative attitudes and assumptions can be a barrier to effective distribution and use.⁵⁸

For instance, in Chile, when the Ministry of Health first made opioids more accessible through the National Health Service System, practitioners were slow to shift their negative perceptions of opioids, and no training programs were available in the country to change that perception.⁵⁹ As a result, few patients in Chile have received opioid therapy.⁶⁰ In Malaysia, morphine has always been available for therapeutic use without legislative barriers, but the fears of both the medical profession and the public have led to undertreatment for pain nonetheless.⁶¹ Nurses in Uganda resorted to using local radio to spread the word that palliative care was not designed to kill patients, as was the popular belief.⁶² Some have labeled this educational problem "opiophobia"—it afflicts providers throughout the world and is a major cause of underprescription of analgesics to patients who have legitimate medical need.⁶³

Fears of prescribing opioid analgesics are further complicated by non-medical use of opioids. The social costs and morbidity rates due to inappropriate opioid use are rising in the United States and Canada.⁶⁴ These patterns, along with data that indicate that analgesic use of opioids is rising in both countries,⁶⁵ likely fuel a belief that medical use of opioids should be curtailed so as not to exacerbate the social problems attendant to opioid abuse. But the fears of this correlation are out of proportion to the actual problem.

There is evidence that diversion of prescription opioids is on the rise in the United States,⁶⁶ but a recent study found that only four percent of all prescription

in some developed ones as well).

58. See *Briefing Note 2009*, *supra* note 9, at 2 (there is a fear that opioid analgesics will harm patients and cause dependence).

59. See Flavio Nervi et al., *Symptom Control and Palliative Care in Chile*, 17 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 13, 17 (2003).

60. *Id.* (stating that the Chilean medical community's diminished capacity to comprehend the significance of opioid therapy has frustrated attempts to incorporate palliative care into the National Health Service System).

61. Richard Lim Boon Leong, *Palliative Care in Malaysia: A Decade of Progress and Going Strong*, 17 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 77, 84 (2003).

62. Logie & Harding, *supra* note 4, at 4.

63. See Webster et al., *supra* note 12, at 33-34 ("Government sanction of the use of opioids would at least partially address the reluctance of many health-care professionals to prescribe opioids; however, education about use of opioids is still relevant."); see also NAT'L INST. ON DRUG ABUSE, *Prescription Drugs Abuse & Addiction* 7 (2005), available at <http://www.nida.nih.gov/PDF/RRPrescription.pdf> (many healthcare providers under-prescribe opioid medication because they overestimate the potential for patients to become addicted).

64. Benedikt Fischer et al., *Non-medical Use of Prescription Opioids and Public Health in Canada*, 99 CAN. J. PUB. HEALTH 182, 183 (2008).

65. *Id.* at 183.

66. See Aaron M. Gilson et al., *A Reassessment of Trends in the Medical Use and Abuse of Opioid Analgesics and Implications for Diversion Control: 1997-2002.*, 28 J. PAIN & SYMPTOM

opioids dispensed in the United States are being diverted to nonmedical use.⁶⁷ There is no indication of the amount of diversion of prescription opioids in other countries, and the exact place in the supply chain where the drugs are being diverted is unclear.⁶⁸ However, the National Institute on Drug Abuse, part of the National Institutes of Health, cautions providers against underprescribing opioids for pain management subsequent to an overestimation of the potential for patients to become addicted.⁶⁹ The Institute also supports the use of opioids for treating opioid dependence,⁷⁰ a practice that data have proven to be successful when properly implemented.⁷¹

Another issue that educational campaigns should address is the tendency for providers to use their experiences with personal pain management, or that of a family member, as a guide for patient care.⁷² Studies have shown that even nurses who had received some pain management training were swayed by the behavior of the patient and their own personal experiences, despite guidelines that instruct them to rely on their patients' self-reporting of pain.⁷³ In order to create a more evidence-based approach to pain management, more education about the proper role of opioids in pain management is required, especially training that integrates the personal experiences of the provider.⁷⁴

Responding to this dearth of pain management education and training tools, the WHO is in the process of expanding its existing guidelines on the use of controlled substances for the treatment of cancer pain to include guidelines for chronic and nonmalignant pain management as well.⁷⁵ These guidelines will

MGMT. 176, 180-81 (2004) (showing that U.S. Drug Enforcement Administration statistics revealed that the amount of diverted OxyContin more than doubled between 2000 and 2002).

67. Nathaniel P. Katz et al., *Volume of Prescription Opioids Used Nonmedically in the U.S.*, 24 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 141, 141-42 (2010).

68. Fischer et al., *supra* note 64, at 181-82 (more research needs to be done to determine if the extent of the relationship between the prescribing provider and the clinician has any effect on the patient's diversionary actions).

69. NAT'L INST. ON DRUG ABUSE, *supra* note 63, at 7.

70. *Id.*

71. Anderson et al., *supra* note 20, at 3, 5 (describing a position paper from the WHO, UNAIDS and UNODC suggesting individualized opioid use for the treatment of opioid dependence); *see also Briefing Note 2009, supra* note 9, at 1 ("Opioid dependence can be effectively treated with oral substitution therapy using methadone and buprenorphine").

72. *See* Dorit Pud, *Personal Past Experience with Opioid Consumption Affects Attitudes and Knowledge Related to Pain Management*, 5 PAIN MGMT. NURSING 153, 158 (2004) (stating that health care providers should apply their own personal experiences as patients in caring for others); Margo McCaffery et al., *Nurses' Personal Opinions About Patients' Pain and Their Effect on Recorded Assessments and Titration of Opioid Doses*, 1 PAIN MGMT. NURSING 79, 85 (2000) (recommending that caregivers rely partly on their prior personal experiences to treat pain in patients).

73. McCaffery et al., *supra* note 72, at 83-84.

74. *Id.*

75. *See* NEETA KUMAR, WHO NORMATIVE GUIDELINES ON PAIN MANAGEMENT 3 (2007), *available at* http://www.who.int/medicines/areas/quality_safety/delphi_study_pain_guidelines.pdf (suggesting possible guidelines to be developed by WHO for pain management, including acute pain, chronic

specifically address issues of opioid use in order to demystify the drugs and increase adherence to clinical guidelines.⁷⁶ The WHO has even gone so far as to say that “most, if not all, cancer pain *could* be relieved if . . . *existing* medical knowledge” was implemented, with similar results anticipated for nonmalignant pain.⁷⁷ Indeed, the WHO believes that education can help to narrow the gap between current levels of treatment and what is actually required.

IV. WORKFORCE SHORTAGES AS A BARRIER TO PAIN CARE

*“Although there are recurring reports of manpower shortages in many other professional fields, nursing seems to enjoy the dubious distinction of continually suffering from this condition.”*⁷⁸

Even when policy is not an obstacle and providers are willing to prescribe analgesic opioids, workforce shortages are an additional hurdle to overcome. In some instances, workforce problems are a sheer numbers game. The available supply of health care providers simply cannot meet the demands of the population. In fact, the supply of nurses is low in both developed and developing countries.⁷⁹ At the fifty-fourth World Health Assembly, the global shortage of nurses was recognized as a problem deserving attention, and the Assembly passed a resolution calling for “the enhancement of nursing and midwifery services.”⁸⁰ The fact that even the limited number of available nurses may not be able to participate in the administration or prescription of opioids due to the regulatory rules discussed above⁸¹ only aggravates the lack of available pain care. As one author has noted, “[s]hortage is not just about numbers but about how the health system functions to enable nurses to use their skills effectively.”⁸²

Many African countries are prime examples of how the first category of provider shortages manifests itself in practice. For instance, there is approximately one physician for every 19,000 people in Uganda.⁸³ As a result, though the

malignant pain, and chronic nonmalignant pain).

76. See WHO STEERING GROUP ON PAIN GUIDELINES SCOPING DOCUMENT FOR WHO TREATMENT GUIDELINE ON NON-MALIGNANT PAIN IN ADULTS 1 (2008), *available at* http://www.who.int/medicines/areas/quality_safety/Scoping_WHOGuide_non-malignant_pain_adults.pdf (“These guidelines could serve as a guide to health care professionals, policy makers and regulatory authorities for facilitating legal access and ensuring proper use of analgesics and other modalities to achieve rapid, effective and safe pain control.”)

77. ACHIEVING BALANCE, *supra* note 23, at 3 (emphasis added).

78. Robert Spohn, *Some Facts About the Nursing ‘Shortage’*, 54 AMER. J. NURSING 865, 865 (1954).

79. James Buchanan, *The Global Nursing Shortage*, 324 BRIT. MED. J. 751, 751-52 (2002).

80. WORD HEALTH ORG., STRENGTHENING NURSING AND MIDWIFERY, Fifty-sixth World Health Assemb. Res. WHA54.12, at 1, 4 (Apr. 2, 2003), *available at* http://apps.who.int/gb/archive/pdf_files/WHA56/ea5619.pdf. [*hereinafter* STRENGTHENING NURSING AND MIDWIFERY] (describing efforts made since passage of resolution at fifty-fourth Assembly).

81. See *supra* Section II.

82. Buchanan, *supra* note 79, at 752.

83. Anne Merriman & Richard Harding, *Pain Control in the African Context: The Ugandan*

Ugandan government has made explicit commitments to pro-pain management policies, Uganda has problems distributing opioids due to the shortage of trained palliative care staff.⁸⁴ In an effort to reduce this shortage, Uganda embraced the idea of nurse providers, a development that is discussed further below.⁸⁵ Similarly, in Thailand, medical facilities have trouble recruiting adequately trained nurses and physicians to provide pain care to patients; instead they rely on traveling providers who are in the clinic only a few days a week.⁸⁶

Policies that drive shortages can be divided into two categories. They take the form of either burdensome requirements that dissuade qualified providers from being certified in opioid distribution or laws that prohibit potential providers from being qualified in the first place. In Romania, for example, it is extremely difficult to obtain a license to dispense opioids for medication-assisted treatment of substance abusers.⁸⁷ As a result, there are very few providers who are able to prescribe opioids in that context.⁸⁸ Opioids for a more general pain management purpose were similarly restricted in Romania until recently, when a broad reform effort led to changes in the prescribing laws.⁸⁹ It remains to be seen to what extent these reforms will lead to greater opioid access on the ground level.⁹⁰

Where workforce shortage problems in developed countries exist, they generally take the form of restrictions on the type of provider, such as limiting opioid prescribing authority to physicians. Efforts are underway around the world to test the potential for nurses to take a role in solving the problem of access to opioids for pain management.⁹¹ In the United States, shortages of pain management specialists are driven in part by regulatory policies that subject them to tight scrutiny,⁹² and by restrictions on the prescribing authority of qualified health care providers.⁹³

Introduction of Affordable Morphine to Relieve Suffering at the End of Life, 10(5) PHIL., ETHICS, & HUMAN. IN MED. 2,2 (2010).

84. Logie & Harding, *supra* note 4, at 4.

85. *See infra* note 114 (discussing allowing nurses to prescribe opioids).

86. *See* Meg Spencer, *Pain Relief in Thailand*, 17 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 53, 57 (2004) (“[t]wo days a week a visiting nurse attends the center and one day a month a physician from Médecins Sans Frontières visits”).

87. *See* Anderson et al., *supra* note 20, at 60 (“[i]t is practically impossible for an individual physician or private clinic to get a license to prescribe and dispense methadone”).

88. *See id.*

89. Daniela Mosoiu et al., *Romania: Changing the Regulatory Environment*, 33 J. PAIN SYMPTOM MGMT. 610, 611-12 (2007).

90. *Cf. id.* at 613-14 (suggesting that less restrictive policies controlling opioids directly result in increased access to medication for patients).

91. *See, e.g.*, Courtenay & Carey, *supra* note 1, at 2001 (reviewing twenty-one publications regarding the effectiveness of nurse-led pain management).

92. Goodman, *supra* note 44, at 217.

93. *See supra* Section II (discussing how cultural presumptions regarding the traditional role of nurses may restrict their prescribing authority).

V. NURSES' ROLE IN INTERNATIONAL PAIN CARE

*"Nurses are essential in pain diagnoses and treatment in all health care settings."*⁹⁴

Nurses are an integral part of pain care. However, they are not being trained and used to their full capacity to help bring relief to the millions of patients in need of their services. Their holistic approach represents the "nursing model" of medical care, which "emphasizes treatment of illness in the context of a patient's total well-being and encourages patient education."⁹⁵ As a result of this training, nurses have many skills that positively contribute to high-quality pain care: patience, interpersonal skills, and the ability to communicate effectively.⁹⁶ This makes them ideal assessors of patient condition and needs.⁹⁷ Pain interventions driven by nurses have been shown to help patients identify and understand pain, therefore aiding in its appropriate treatment.⁹⁸ If we were to utilize nurses to their full capacity, we would see global improvements in pain care.

Part of utilizing nurses to the fullest extent is allowing them to educate patients about their pain. Of all health professionals, nurses have the most patient contact.⁹⁹ Because nurses typically spend more time with their patients than physicians,¹⁰⁰ they have a greater ability to help educate patients, and thereby the public, on safe opioid use for pain management. This means that the relationships nurses build with their patients could be leveraged to assist in the identification of addicts and diversion strategies.

Nurses are patient advocates by trade¹⁰¹ and they understand the importance of that role.¹⁰² The WHO recommends a larger role in policy-setting and decision-making in healthcare for nurses, asserting that their involvement is "critical in informing the design and implementation of healthcare policies."¹⁰³ Furthermore, "[i]n order to attain and sustain high-quality care, governments must set up mechanisms, within a legal framework, that include . . . [nursing] leaders and representatives in the health policy debate."¹⁰⁴ One author has suggested that, as

94. KUMAR, *supra* note 75, at 14.

95. CENTER FOR HEALTH WORKFORCE STUDIES, A COMPARISON OF CHANGES IN THE PROFESSIONAL PRACTICE OF NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES: 1992 & 2000 8 (2002), *available at* <ftp://ftp.hrsa.gov/bhpr/workforce/scope1992-2000.pdf>.

96. Courtenay & Carey, *supra* note 1, at 2003.

97. *Id.*

98. *Id.* at 2001.

99. Mimi M.Y. Tse & Brenda S.H. Chan, *Knowledge and Attitudes in Pain Management: Hong Kong Nurses' Perspective*, 18 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 47, 48 (2004); KUMAR, *supra* note 75, at 14.

100. Tse & Chan, *supra* note 99, at 14; *see* McCaffery et al., *supra* note 72, at 80 (stating that nurses spend more time with pain care patients than any other provider in the clinical setting).

101. Gaylord & Grace, *supra* note 6, at 16.

102. Courtenay & Carey, *supra* note 1, at 2003.

103. STRENGTHENING NURSING AND MIDWIFERY, *supra* note 80, at 3.

104. *Id.* at 4.

part of the expansive view of nurse advocacy, “political activity in collaboration with others may be required” of nurses.¹⁰⁵ Bringing nurses to the table to address complex pain care issues would be a natural expansion of a nurse’s advocacy role. Moreover, nurses in countries where legal and policy barriers hinder pain care should be trained as pain care policy advocates.

To maximize their role as pain care managers, nurses must be trained to understand how to accurately acknowledge, assess, and treat pain.¹⁰⁶ Although the inadequate treatment of pain has been perceived as a problem for several decades, many nurses still lack accurate information and education about pain care.¹⁰⁷ For example, recent research among nurses indicates that they tend to believe that patients over-report pain.¹⁰⁸

Nurses must also be trained to understand that, while addictive when used improperly, opioids can be a safe and effective method of treatment, leaving exaggerated fears of addiction and drug-seekers behind. A 1997 literature review pointed out that an “exaggerated fear of causing addiction” by prescribing opioids was well-documented within the available research on nurses.¹⁰⁹ However, the study also showed that accurate beliefs about opioids among nurses were increasing over time.¹¹⁰ These studies have also shown that, as nurses’ levels of training and/or education and experience increase, their knowledge and attitudes about appropriate pain care often become more precise.¹¹¹ Furthermore, although the subject of more uniform training for transnational nursing has been broached as part of the discussion surrounding the international migration of nurses,¹¹² the practice of pain care could still benefit greatly from uniformity in nursing training and education between countries. When appropriately trained, nurses can be knowledgeable assessors of pain and its safe and effective treatment with opioids, both within their home countries and abroad.

To make the best use of the nursing profession in addressing the global pain management crisis, these providers must be granted the legal authority to prescribe opioids independent of onerous physician oversight. For example, in Uganda, the

105. Pamela Grace, *Professional Advocacy: Widening the Scope of Accountability*, 2 NURSING PHIL. 151, 152 (2001).

106. Tse & Chan, *supra* note 99, at 48; *see also* Margo McCaffery & Betty Ferrell, *Nurses’ Knowledge of Pain Assessment and Management: How Much Progress Have We Made?*, 14 J. PAIN & SYMPTOM MGMT. 175, 184 (1997) (stating that the “basic nursing program needs to be examined for relevance and accuracy.”)

107. McCaffery & Ferrell, *supra* note 106, at 176.

108. Tse & Chan, *supra* note 99, at 52; Ruth Vortherms et al., *Knowledge of Attitudes Towards, and Barriers to Pharmacologic Management of Cancer Pain in a Statewide Random Samples of Nurses*, 15 RES. IN NURSING & HEALTH 459, 464 (1992); McCaffery et al., *supra* note 72, at 81.

109. McCaffery & Ferrell, *supra* note 106, at 177.

110. *Id.* at 181.

111. Tse & Chan, *supra* note 99, at 55-56; Vortherms et al., *supra* note 108, at 462.

112. *See generally* Andrea Baumann & Jennifer Blythe, *Globalization of Higher Education in Nursing*, 13(2) ONLINE J. OF ISSUES IN NURSING (2008), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TabbleofContents/vol132008/No2May08/GlobalizationofHigherEducation.aspx>.

prescriptive authority laws were updated to allow nurses to prescribe opioids after the practice of having physicians sign the prescriptions became so cumbersome that it delayed appropriate intervention.¹¹³ Advanced practice nurses in the United States and parts of the United Kingdom, New Zealand, and Australia also have varying degrees of autonomy to prescribe pain relief medication. However, outside of these limited examples, the practice is not widely accepted.¹¹⁴ The inability to prescribe medication is a major hindrance to a nurse's ability to assess and properly treat pain.¹¹⁵

Giving nurses prescriptive authority over opioids does not dismiss the value of physician involvement in pain management. All nurses are part of a broader system of healthcare and they have recognized that, where available, interdisciplinary collaborative teams are essential to the most successful pain management.¹¹⁶ Nor will it alleviate the global shortage of physicians and nurses. Obviously, the international shortage of nurses, just like the international shortage of physicians, is a reality that significantly affects pain care, especially in developing countries.¹¹⁷ However, prescriptive authority does allow the nurses that are already in the field to contribute to the alleviation of patients' pain in the most time and cost-effective manner. This amounts to a more efficient use of a commodity that is in high demand. In particular, where resources are scarce and interdisciplinary collaboration is not practically feasible, prescriptive authority becomes all the more critical for patient well-being.

Nurses are instrumental to the healthcare workforce and extremely effective in many different pain care roles. Because nurses are trained to be health care providers, educators, and advocates they can efficiently and effectively help to alleviate the work force, misinformation, and law and policy barriers that prevent access to pain care.

VI. CONCLUSION

Severe physical pain, whether acute or chronic, is more than just an inconvenience. It is truly a life limitation. Though both the global community and many individual nations have ostensibly made commitments to addressing the ongoing crisis of inadequate pain care, the data demonstrate that a number of barriers are preventing those commitments from becoming a reality.

Of foremost importance, law- and policymakers should make pain care a public health priority. To achieve this, the onerous burdens on the prescribing and distribution of opioids must be reconsidered. Arbitrary limitations on how and how much pain medication may be stocked and dosed only serve to impede

113. Logie & Harding, *supra* note 4, at 4.

114. KUMAR, *supra* note 75, at 15.

115. Courtenay & Carey, *supra* note 1, at 2003.

116. *Id.*

117. See Buchanan, *supra* note 79, at 752 (“Nursing shortages . . . are a health system problem, which undermines health system effectiveness.”).

patients' access to necessary treatments, without any concomitant benefit. Such limitations must be revised in order to create more reasonable and effective regulations. Law- and policymakers also need to promote the use of nurses in pain care by ending restrictions on prescriptive authority and respecting the current requirement in international law to provide pain care.¹¹⁸

Presuming they are empowered to administer pain medication, health care providers need to be sufficiently trained in the nuances of pain assessment, monitoring, and treatment. Doing so will help to alleviate any preexisting concerns or biases held about the risks of opioid use. Clinicians must be reassured that they will not be disproportionately punished for misuse of opioids when distributed through appropriate channels. They also need to be educated about the essential nature of opioid intervention for pain sufferers. Though the risks associated with opioid abuse and diversion are real and not to be discounted, they should not be the sole or overriding focus.

Finally, there needs to be greater support for the professionals who engage in the administration of pain care. In particular, nurses and nurse practitioners are known around the world as caring and skilled professionals. While the use of nurses as frontline providers has increased in other global contexts due to ongoing physician shortages, they have yet to be fully embraced as pain managers, to the detriment of patients worldwide. Appropriate training and utilization of nurses as pain care providers will maximize the scope of pain care delivery options in both developed and developing nations. Ultimately, this will result in the proper administration of pain care to many around the world who needlessly suffer from treatable pain.

118. Single Convention, *supra* note 2.