[Executive Order 12731 of Oct 17,1990](https://www.practicalpainmanagement.com/amp/753)

["PRINCIPLES OF ETHICAL CONDUCT FOR GOVERNMENT OFFICERS AND EMPLOYEES" By virtue of the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to establish fair and exacting standards of ethical conduct for all executive branch employess, it is hereby ordered that Executive Order 12674 of April 12, 1989, is henceforth modified to read as follows: "EXECUTIVE ORDER " "principles of ethical conduct for government officers and employees "By virtue of the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to establish fair and exacting standards of ethical conduct for all executive branch employees, it is hereby ordered as follows: "Part 1 --PRINCIPLES OF ETHICAL CONDUCT "Section 101. Principles of Ethical Conduct. To ensure that every citizen can have complete confidence in the integrity of the Federal Government, each Federal employee shall respect and adhere to the fundamental principles of ethical service as implemented in regulations promulgated under sections 201 and 301 of this order: "(a) Public service is a public trust, requiring employees to place loyalty to the Constitution, the laws, and ethical principles above private gain. "(b) Employees shall not hold financial interests that conflict with the conscientious performance of duty. "(c) Employees shall not engage in financial transactions using nonpublic Government information or allow the improper use of such information to further any private interest. "(d) An employee shall not, except pursuant to such reasonable exceptions as are provided by regulation, solicit or accept any gift or other item of monetary value from any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency, or whose interests may be substantially affected by the performance or nonperformance of the employee's duties. "(e) Employees shall put forth honest effort in the performance of their duties. "(f) Employees shall make no unauthorized commitments or promises of any kind purporting to bind the Government. "(g) Employees shall not use public office for private gain. "(h) Employees shall act impartially and not give preferential treatment to any private organization or individual. "(i) Employees shall protect and conserve Federal property and shall not use it for other than authorized activities. "(j) Employees shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with official Government duties and responsibilities. "(k) Employees shall disclose waste, fraud, abuse, and corruption to appropriate authorities. "(l) Employees shall satisfy in good faith their obligations as citizens, including all just financial obligations, especially those --such as Federal, State, or local taxes --that are imposed by law. "(m) Employees shall adhere to all laws and regulations that provide equal opportunity for all Americans regardless of race, color, religion, sex, national origin, age, or handicap. "(n) Employees shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards promulgated pursuant to this order. "Sec. 102. Limitations on Outside Earned Income. "(a) No employee who is appointed by the President to a full-time noncareer position in the executive branch (including full-time noncareer employees in the White House Office, the Office of Policy Development, and the Office of Cabinet Affairs), shall receive any earned income for any outside employment or activity performed during that Presidential appointment. "(b) The prohibition set forth in subsection (a) shall not apply to any full-time noncareer employees employed pursuant to 3 U.S.C. 105 and 3 U.S.C. 107(a) at salaries below the minimum rate of basic pay then paid for GS-9 of the General Schedule. Any outside employment must comply with relevant agency standards of conduct, including any requirements for approval of outside employment. "PART II --OFFICE OF GOVERNMENT ETHICS AUTHORITY "Sec. 201. The Office of Government Ethics. The Office of Government Ethics shall be responsible for administering this order by: "(a) Promulgating, in consultation with the Attorney General and the Office of Personnel Management, regulations that establish a single, comprehensive, and clear set of executive-branch standards of conduct that shall be objective, reasonable, and enforceable. "(b) Developing, disseminating, and periodically updating an ethics manual for employees of the executive branch describing the applicable statutes, rules, decisions, and policies. "(c) Promulgating, with the concurrence of the Attorney General, regulations interpreting the provisions of the post-employment statute, section 207 of title 18, United States Code; the general conflict-of-interest statute, section 208 of title 18, United States Code; and the statute prohibiting supplementation of salaries, section 209 of title 18, United States Code. "(d) Promulgating, in consultation with the Attorney General and the Office of Personnel Management, regulations establishing a system of nonpublic (confidential) financial disclosure by executive branch employees to complement the system of public disclosure under the Ethics in Government Act of 1978. Such regulations shall include criteria to guide agencies in determining which employees shall submit these reports. "(e) Ensuring that any implementing regulations issued by agencies under this order are consistent with and promulgated in accordance with this order. "Sec. 202. Executive Office of the President. In that the agencies within the Executive Office of the President (EOP) currently exercise functions that are not distinct and separate from each other within the meaning and for the purposes of section 207(e) of title 18, United States Code, those agencies shall be treated as one agency under section 207(c) of title 18, United States Code. "PART III --AGENCY RESPONSIBILITIES "Sec. 301. Agency Responsibilities. Each agency head is directed to: "(a) Supplement, as necessary and appropriate, the comprehensive executive branch-wide regulations of the Office of Government Ethics, with regulations of special applicability to the particular functions and activities of that agency. Any supplementary agency regulations shall be prepared as addenda to the branch-wide regulations and promulgated jointly with the Office of Government Ethics, at the agency's expense, for inclusion in Title 5 of the Code of Federal Regulations. "(b) Ensure the review by all employees of this order and regulations promulgated pursuant to the order. "(c) Coordinate with the Office of Government Ethics in developing annual agency ethics training plans. Such training shall include mandatory annual briefings on ethics and standards of conduct for all employees appointed by the President, all employees in the Executive Office of the President, all officials required to file public or nonpublic financial disclosure reports, all employees who are contracting officers and procurement officials, and any other employees designated by the agency head. "(d) Where practicable, consult formally or informally with the Office of Government Ethics prior to granting any exemption under section 208 of title 18, United States Code, and provide the Director of the Office of Government Ethics a copy of any exemption granted. "(e) Ensure that the rank, responsibilities, authority, staffing, and resources of the Designated Agency Ethics Official are sufficient to ensure the effectiveness of the agency ethics program. Support should include the provision of a separate budget line item for ethics activities, where practicable. "PART IV --DELEGATIONS OF AUTHORITY "Sec. 401. Delegations to Agency Heads. Except in the case of the head of an agency, the authority of the President under sections 203(d), 205(e), and 208(b) of title 18, United States Code, to grant exemptions or approvals to individuals, is delegated to the head of the agency in which an individual requiring an exemption or approval is employed or to which the individual (or the committee, commission, board, or similar group employing the individual) is attached for purposes of administration. "Sec. 402. Delegations to the Counsel to the President. "(a) Except as provided in section 401, the authority of the President under sections 203(d), 205(e), and 208(b) of title 18, United States Code, to grant exemptions or approvals for Presidential appointees to committees, commissions, boards, or similar groups established by the President is delegated to the Counsel to the President. "(b) The authority of the President under sections 203(d), 205(e), and 208(b) of title 18, United States Code, to grant exemptions or approvals for individuals appointed pursuant to 3 U.S.C. 105 and 3 U.S.C. 107(a), is delegated to the Counsel to the President. "Sec. 403. Delegation Regarding Civil Service. The Office of Personnel Management and the Office of Government Ethics, as appropriate, are delegated the authority vested in the President by 5 U.S.C. 7301 to establish general regulations for the implementation of this Executive order. "PART V --GENERAL PROVISIONS "Sec. 501. Revocations. The following Executive orders are hereby revoked: "(a) Executive Order No. 11222 of May 8, 1965. "(b) Executive Order No. 12565 of September 25, 1986. "Sec. 502. Savings Provisions. "(a) All actions already taken by the President or by his delegates concerning matters affected by this order and in force when this order is issued, including any regulations issued under Executive Order 11222, Executive Order 12565, or statutory authority, shall, except as they are irreconcilable with the provisions of this order or terminate by operation of law or by Presidential action, remain in effect until properly amended, modified, or revoked pursuant to the authority conferred by this order or any regulations promulgated under this order. Notwithstanding anything in section 102 of this order, employees may carry out preexisting contractual obligations entered into before April 12, 1989. "(b) Financial reports filed in confidence (pursuant to the authority of Executive Order No. 11222, 5 C.F.R. Part 735, and individual agency regulations) shall continue to be held in confidence. "Sec. 503. Definitions. For purposes of this order, the term: "(a) 'Contracting officers and procurement officials' means all such officers and officials as defined in the Office of Federal Procurement Policy Act Amendments of 1988. "(b) 'Employee' means any officer or employee of an agency, including a special Government employee. "(c) 'Agency' means any executive agency as defined in 5 U.S.C. 105, including any executive department as defined in 5 U.S.C. 101, Government corporation as defined in 5 U.S.C. 103, or an independent establishment in the executive branch as defined in 5 U.S.C. 104 (other than the General Accounting Office), and the United States Postal Service and Postal Rate Commission. "(d) 'Head of an agency' means, in the case of an agency headed by more than one person, the chair or comparable member of such agency. "(e) 'Special Government employee' means a special Government employee as defined in 18 U.S.C. 202(a). "Sec. 504. Judicial Review. This order is intended only to improve the internal management of the executive branch and is not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person.". George Bush The White House, October 17, 1990.](https://www.practicalpainmanagement.com/amp/753)

[Intractable Pain By Forest Tennant •  www.practicalpainmanagement.com Intractable Pain](https://www.practicalpainmanagement.com/amp/753)

[The current thrust to humanely identify and treat pain is uncovering a group of patients with severe, chronic intractable pain (IP). While epidemiologic surveys indicate that over 40% of the adult population has chronic, recurrent pain, mainly due to musculo-skeletal degenerative conditions, there is a sub-group of tragic individuals who suffer constant, excruciating, unrelenting pain.1,2 To separate these patients from the more prevalent chronic pain patients, these patients are commonly referred to as IP patients.2 Most states in this country have recently passed IP laws or established guidelines and standards to allow physicians to prescribe opioids and other end-stage treatments to these individuals without legal repercussions. Since IP patients always have an underlying, incurable disease or condition causing IP, their clinical management is complex and may require a specialized clinical setting. Just as renal failure or insulin-dependent diabetes require lifetime care by a cadre of specialized medical personnel, IP likewise requires similar lifetime care due to its incurable nature. Who Is the IP Patient? The authors define IP as “pain that is excruciating, constant, incurable, and of such severity that it dominates virtually every conscious moment, produces mental and physical debilitation and may produce a desire to commit suicide for the sole purpose of stopping the pain.” In the authors’ clinical experience, bonafide IP patients suffer profusely and are fundamentally bed-or house-bound in the absence of intense medical management.3 Table 1 presents some common characteristics of the IP patient. A variety of traumatic and medical conditions may be the underlying cause of IP (see Table 2). Note that over half of them involve spine degeneration. Common Characteristics of the IP Patient Pain is constant and excruciating Pain reduces sleep and food intake Bed-, chair-, or house-bound in the absence of opioid treatment Depression, attention deficit, confusion, and suicide tendencies Underlying cause is incurable, non-removable, and fails to respond to customary pain therapies Elevated blood pressure and pulse rate Serum adrenal hormone and immune abnormalities Underlying Causes of Intractable Pain in 100 Consecutive Patients Admitted to Treatment % Patients Degenerative spinal disease post-surgery 32% Degenerative spinal disease non-operable 22% Fibromyalgia 15% Migraine-vascular headache 8% Neuropathies 6% Congenital skeletal disease 5% Headache-post trauma 3% Reflex sympathetic dystrophy 3% Osteoporosis 2% Systemic lupus erythematosus 2% Abdominal adhesions 1% Interstitial cystitis 1% Total 100% IP patients become identified as they systematically fail the usual treatments for acute and chronic pain including anti-inflammatory, mild opioid and non-opioid analgesics, antidepressants, muscle relaxants, and anti-seizure medications. They also don’t respond well to corticosteroid injections in and around the spinal column or peripheral nerves. Physical therapy, exercise, and psychological interventions have usually been to little or no avail because the pain is so profoundly uncontrolled that participation in these therapies is not possible. Potent opioid lifetime therapy is the only treatment to date that has proved to consistently control pain in these individuals. This treatment should be regarded as an end-stage or last resort due to its expense and inherent complications. Obligation Of Documentation The physician and ancillary clinical staff must carefully document the presence of IP on the patient’s chart. Not only do most states require documentation for legal purposes, medical management of IP is a lifetime treatment that utilizes potent medication having potentially deleterious complications. At a minimum, the documentation must include medical records that reveal the presence of an incurable, painful condition and unsuccessful treatment attempts with the usual therapies for chronic, recurrent pain. Patients, together with family members or caretakers who are required to accompany them to their appointments, need to provide a detailed history of the onset of IP and subsequent failed treatment attempts. A physical examination is directed toward identifying physical evidence of the cause of pain and neuro-muscular abnormalities that are fixed, incurable, and irremovable. IP, in an uncontrolled state, will invariably demonstrate physiologic or laboratory abnormalities, since IP causes over-excitation of the cardiovascular, autonomic, and hypothalamic-pituitary-adrenal systems. Common physical signs and symptoms include tachycardia, hypertension, mydriasis, hyperreflexia, anxiety, and depression. Goals Of Treatment Once the diagnosis of IP is established, both immediate and short-term treatment goals should be quickly established. Often, the undiagnosed or under-treated IP patient is so ill and bed-or chair-bound that diet, ambulation, and hygiene have been severely neglected. Some uncontrolled IP patients make frequent visits to an emergency room just to obtain a modicum of relief. Physicians should initially attempt to determine one opioid that family and patient report to be effective and prescribe this opioid in a dosage and frequency adequate enough to stop emergency room visits and allow the patient to ambulate, begin a proper diet, and attempt to return to normal activities of daily living. Physiologic abnormalities such as tachycardia, hypertension, and altered adrenal hormone concentrations should be identified and serve as biologic markers to gauge treatment effectiveness. Pain monitoring utilizing a pain scale noting severity from 0 (no pain) to 10 (severest pain) should be used to help control pain. The long-term goals are to help the IP patient become ambulatory and be able to leave home to shop, socialize, and possibly work. Psychiatric conditions, particularly depression and suicidal tendency should be treated. A good quality of life, to the extent possible with medication, is the goal —rather than an impractical one, such as withdrawal from all medication or seeking a “miracle” treatment or the elusive cure. Life extension and improved quality of life is clearly possible if IP is controlled. The long-term goals are to help the IP patient become ambulatory and be able to leave home to shop, socialize, and possibly work. Management of Baseline and Breakthrough Pain Baseline pain is the constant, ever-present pain that is consciously perceived be the IP patient. A long-acting opioid is used to suppress baseline pain.4 The following medications are available for this task: methadone, sustained-release morphine and oxycodone preparations, and transdermal fentanyl (see Table 3). Long-acting opioid therapy is initiated at a low dose and titrated upward to achieve maximal pain suppression without sedation, bradycardia, and hypertension. Opioid Therapy of IP Long-acting opioids for baseline pain Methadone Transdermal fentanyl Morphine —sustained release Oxycodone —Sustained release Short-acting opioids for breakthrough pain Codeine with acetaminophen or plain Hyrocodone with acetaminophen Oxycodone with acetaminophen or plain Hydromorphone Morphine Meperidine Ultra-fast acting opioids for emergency flares Oral transmucosal fentanyl Morphine suppository Opium-Belladona suppository Hydromorphone suppository Table 3. Despite the administration of a long-acting opioid, there may be breakthrough pain, which is temporary and has excruciating intensity above the baseline pain. Breakthrough pain is treated with a short-acting opioid such as hydromorphone, hydrocodone, meperidine, or oral transmucosal fentanyl (see Table 3). Sometimes breakthrough pain is so intense that it may force the suffering patient to seek emergency room treatment. Emergency, breakthrough treatment is best treated by oral transmucosal fentanyl or an opioid suppository. These preparations provide ultra-rapid breakthrough pain relief within 5 to 10 minutes and prevent emergency pain situations. Monitoring and management of opioid therapy routinely requires a monthly clinic visit. Tolerance may occur to either long-or short-acting opioids. When this occurs, a rotation to a different opioid is necessary. Opioid therapy should be continued indefinitely, including a lifetime —unless the underlying cause of IP can be markedly reduced or eliminated. Detoxification or withdrawal should not be attempted unless IP is permanently and markedly reduced, otherwise IP will simply re-emerge following detoxification and force the patient to return to a bed-or house-bound, vegetative state. Physical Therapy and Exercise Once opioids control IP, the patient can begin measures to strengthen his/her musculo-skeletal system and hopefully reduce pain on a permanent basis. Stretching exercises involving the afflicted anatomical structures that produce IP are essential. Patients should be taught stretching and strengthening exercises that they can practically accomplish each day for their lifetime. Weak or degenerative anatomic structures may benefit from a prosthesis, specially-fitted shoes, or walking stabilization with a cane or walker. Family and Community Support Patients may enter IP treatment after they have been medically and socially isolated for many months or years. The authors require a family member or caretaker to accompany the patient until the patient can mentally and physically function well enough to comply with the treatment program. Community resources should be greatly utilized. These may include psychological therapy, religious participation, vocational rehabilitation, and transportation. Local mental health resources can be invaluable. A pharmacist who is familiar with IP is essential to supply medications for lifetime management. Weight Reduction Considerable weight gain is a major clinical problem among many IP patients. In some, excess weight is a major, contributing factor to spinal and skeletal degeneration. Once IP develops, patients are unable to move and ambulate in a normal manner, so weight gain ensues. IP patients eat little protein in favor of sugars and starches, since pain and opioid drugs apparently alter insulin and blood glucose concentrations and cause “carbohydrate craving.” Treatment includes teaching the patient to follow a diet that maximizes protein and minimizes carbohydrate intake. Exercise must be tailored to each IP patient’s ability to ambulate and mobilize extremities. Anorexiants and other metabolism-enhancing compounds should be attempted in severe cases. The challenge to pain practitioners is to establish outpatient, clinical settings which can provide lifetime medical management of IP. Adjuvant Medication In addition to opioids, IP patients will invariably require some adjuvant medication for such problems as insomnia, muscle spasm, depression, and attention deficit. Topical analgesics are also especially helpful —with the following providing satisfactory outcomes: morphine, carisoprodal, aspirin, and dehydroepian-drosterone (DHEA). Hormone and Neurotransmitter Replacement This emerging aspect of IP treatment is promising. Testosterone deficiency appears very prevalent in males and females, so serum testosterone concentration should be determined. Opioids may cause gonadal suppression, and it is possible that pain, per se, may contribute to hypogonadism.5 The authors routinely determine serum pregnenolone concentration, since it is the precursor of all sex and glucocortioids, as well as being a neurotransmitter. If it is low, pregnenolone supplements are administered. Gamma-Aminobutyric Acid (GABA) is a major neuroinhibitor in spinal cord and peripheral nerves. IP may deplete these neurotransmitters, so daily supplements are a safe, inexpensive adjunct that many patients anecdotally believe assist overall pain control. Research shows that IP over-stimulates the hypothalamus-pituitary-adrenal axis, which initially causes over-secretion of pituitary and adrenal hormones, but uncontrolled, chronic IP may also cause suppression of cortisol and other adrenal hormones which may require replacement for pain control, health maintenance, and proper immune function.6 The Drug-Abusing Patient Unfortunately some drug addicts insinuate their way into IP treatment programs by feigning pain. Others may have some legitimate pain, but exaggerate complaints to obtain opioids and other drugs. These abusers reveal themselves by such behavior as requesting early medication refills, “losing” medication, selling or sharing medication, and non-compliance with program rules. Regardless of pain severity, a patient who abuses or diverts opioid drugs or fails to follow program rules cannot be managed for a lifetime in an IP program. The authors recommend that, once identified, individuals with abusive tendencies with opioids be referred to the local methadone maintenance program for daily narcotic administration. Once their addiction or abuse is stabilized by methadone maintenance, pain treatment measures may then be instituted. Clinic Setting for Lifetime IP Treatment The challenge to pain practitioners is to establish outpatient, clinical settings which can provide lifetime medical management of IP. Proper treatment over the lifetime of the patient will require a number of different interventions, including medication, physical therapy, psychologic support, spiritual awareness, and palliative care.7 Table 4 summarizes the dimensions of care required for successful lifetime management of IP. Elements of Lifetime IP Treatment Monthly, out-patient visit Opioid therapy for baseline and breakthrough pain and emergency flares Stretching and strengthening exercises Prostheses for musculo-skeletal degeneration Topical analgesics Hormone and neurotransmitter replacement Family, social, and spiritual support Patient self-help group Out-of-home vocation or hobby activities Weight control Table 4. IP clinical treatment sites should be in the community where the patient resides so that patients can avail themselves of community resources. IP patients should be encouraged to join a self-help support group or, if not locally available, form their own group. Although technical, sophisticated medication and therapies are essential for IP treatment, the most important element of IP treatment is continuity of care for a lifetime. 1. Gureje 0, Von Korff M, Simon EG, Gater R. Persistent pain and well-being: A WHO study in primary cCare. JAMA. 1998. 280:147-51. 2. Tennant F, Hermann L. Intractable or Chronic Pain: There Is a Difference. Western Journal of Medicine. 2000. 173:306. 3. Chapman RC, Gavin J. Suffering: The Contributions of Persistent Pain. Lancet. 1999. 353:2233-2236. 4. Portenoy RK, Hagen NA. Breakthrough Cancer Pain: Definition, Prevalence and Characteristics. Pain. 1990. 41:273-281. 5. Paice JA, Penn RD, Ryan WG. Altered sexual function and decreased testosterone in patients receiving intraspinal opioids. Journal of Pain Symptom Management. 1994. 9:126-131. 6. Tennant F. Intractable pain is a severe stress state associated with hypercortisolemia and reduced adrenal reserve. Drug and Alcohol Report. 2000. 60:(Supplement No. 1) 200-22 1. 7. Turk DC, Feldman CS. Noninvasive approaches to pain control in terminal illness: the contribution of psychological variables. Hospice Journal. 1992. 8:1-24. Source: https://www.practicalpainmanagement.com/amp/753](https://www.practicalpainmanagement.com/amp/753)

[CONSTITUTION 1OF THE WORLD HEALTH ORGANIZATION T HE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. A CCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and 1 The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively and are incorporated in the present text. –1 –hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations. CHAPTER I –OBJECTIVE Article 1 The objective of the World Health Organization (hereinafter called the Organization) shashawarma ll be the attainment by all peoples of the highest possible level ofof health. […]. health. [CHAPTER](https://www.practicalpainmanagement.com/amp/753)