Voices of Medicine

By Del Meyer, MD

A huge judgment over end-of-life pain is compounded by bad legislation.

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A number of County Medical Society Journals have focused on Assembly Bill 487, the law that went into effect on January 1, 2002, in response to a court judgment in an elder-abuse case for $1.5 million. The amount was reduced by the trial judge to $250,000.

My barrister friends tell me this means that either the judge felt the verdict was so preposterous that he reduced it to the lowest amount that would avoid an appeal, or that he deemed the judgment to be without merit and reduced it as low as he thought sustainable given the emotional situation.

Although there may be issues not recorded in the available reports, Barbara Feiner, the Editor-in-Chief of the *Southern California Physician*, gave the most complete account. It appeared that William Bergman entered the emergency room for chronic excruciating pain caused by four compression fractures. He was a frail, 85-year-old, lifelong smoker with COPD. He was admitted and given morphine, diazepam and promethazine. When his breathing became uneven, with episodes of apnea, his physician switched to 25-50 mg of Demerol IV every three hours PRN. The nurses rated his pain on a 1-10 scale and gave him the prescribed doses two or three times a day, charting by exception.

A chest film and bronchoscopy revealed probable lung cancer, but Bergman declined further testing and returned home for hospice care. His physician added a Fentanyl patch. Due to increasing pain over the next two days, the hospice nurse obtained an order for liquid morphine and more patches from a physician Bergman had seen in the past. His pain was alleviated and he died the next day.

The family filed a complaint with the Medical Board, which felt the pain care was inadequate but took no action. The family then sued the hospital and physician alleging elder abuse. Ben A. Rich, JD, PhD, an associate professor of bioethics at UC Davis School of Medicine, stated that "to prevail in such a claim for elder abuse, the Bergman family would have to persuade a jury by a preponderance of the evidence that the defendants' conduct was not merely negligent but reckless."

When the jury awarded the Bergman family $1.5 million, the California Legislature was not far behind: Assembly Bill 487, signed by the governor on July 4, 2001, requires physicians to complete 12 continuing education hours in pain management and end-of-life care by the end of 2006.

The American Academy of Pain Medicine (AAPM) remains opposed to the final version

of the bill and feels this was a knee-jerk reaction. "This is the first time in California that the Legislature has specified topics of CMEs for licensure," says Executive Medical Director Philipp Lippe, MD. "This can quickly become a slippery slope. What will the Legislature require next year? Bioterrorism CMEs?"

Dr. Lippe also notes, "When a regulatory organization creates a standard, it is written in stone and can't be changed. Given the rapid advances in this area of medicine, we wanted to see more flexible ways to make assessments such as guidelines, protocols or physician parameters. That would have accomplished the same goal without tying the physician's hands to a strict codification."

Feiner and coauthor Andrea Hecht feel the Bergman case will be debated in the medical community for years. At issue:

1. How nurses chart pain and convey information to physicians.

2. Whether a physician's approach to pain control meets board-defined standards of care.

3. How patients describe their pain to their nurses and physicians vs. their complaints to family members.

4. How physicians advise patients and family members about their responsibility to speak up about pain levels.

5. Whether a case like this ultimately proves to be a new strategy for trial attorneys to seek damages beyond the $250,000 MICRA cap on pain and suffering.

Robert McElderry, CMA lobbyist writing in *San Francisco Medicine*, states that not only must pain be relieved, but the law establishes a firm ceiling to deter any physician from prescribing "excessive pain medications" by subjecting them to potential charges of unprofessional conduct.

If we prescribe less than an ill-defined minimum or more than a *firmly* described maximum, or any amount in between which does not relieve pain, does this law make criminals of all who treat patients for pain? It excuses radiologists as non-treating physicians. But many pain complaints come from patients who have been manipulated on hard x-ray tables.

We know there is a lot of pain and hurt in the world. C. S. Lewis, in his book on pain, has two chapters that discuss pain transmitted by neurons. The rest of the book is about the hurts and pains of life that no pain medication will relieve. We have all seen unconscious patients whom the family feels must be suffering. They recoil in horror when a painful stimulus is given to demonstrate there is no pain response. One must remind the family that while they feel the pain of seeing their loved one in this condition, the patient is not experiencing pain.

When a family is told that their loved one has cancer, they feel the pain as much or more than the patient. I made a home visit to a patient recovering from a Whipple procedure, for pancreatic cancer, who stated he was not having any pain, and that the Fentanyl patches were more than adequate. The very next day, I received a call from the hospice nurse requesting a doubling of the strength of the patches. When I mentioned that the patient had told me he had no pain, she asked me if I understood his diagnosis? "He has cancer!" she said, which of course I knew. This nurse was having more pain than the patient.

The big push for physician-suicide laws came about so that patients wouldn't feel severe terminal pain. Reviews of the cases in Oregon regarding patients who chose to be put to death revealed that not one mentioned pain as the primary reason for the decision.

Yes, life is painful. It is painful for the patient, spouse, family, friends, relatives and the doctor treating the patient. And, we are all guilty of not relieving pain. We may be guilty of prescribing too little or prescribing too much; however, in our mortal world, whatever we prescribe will never be "right."

Neither will it be pain free if the legislators play at being the medical school faculty or the doctor in practice. Potentially, we can all be prosecuted and become felons. Yet we struggle with the patient in relieving his or her pain. When the lawmakers who define felonies are hostile to our profession, patients with pain are the primary losers. No longer is it a shared relationship; it has become adversarial.

Our best defense is simply to take that 12-hour course - such a pittance since most of us attend the medical grand rounds in our hospitals or at UCD, take a Medical Letter or *New England Journal of Medicine* or *JAMA* quiz, and attend one or more professional meetings for more than 100 hours per year in CME.

And in all patient-care situations, let us not forget to turn to the spouse, family and friends, tell them we know they're having pain and trouble with their feelings, but that this is okay. It's usually harder on the family than on the patient.

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As this was going to press, I received a copy of Pain Management Principles and Guidelines from a member of the California Assembly. This card also listed types of drugs, drug formulations, their doses, frequency, route of administration, and side effect management. If all items listed were codified by the Legislature, this would give over a hundred causes of actions against almost any physician who treated a patient with pain. Guilt would appear obvious and no expert testimony would seem to be required.
— D.M.

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