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PRECEDENT-SETTING CASE ON INADEQUATE PAIN MANAGEMENT

An Alemeda County, California, jury found a physician guilty of elder abuse and reckless negligence for not providing enough pain medication to a dying patient. In June 2001, the court awarded the patient's family $1.5 million in general damages. As quoted in stories in the *San Francisco Chronicle* (June 14-15, 2001), Barbara Coombs Lee, president of Compassion in Dying, a Portland, Oregon advocacy group that provided legal assistance for the lawsuit, said " . . . This is a precedent-setting case because, to our knowledge, never before has under-treating pain been defined as elder abuse."

The patient, who was hospitalized for six days, had consistent pain charted at 7-10 on a pain scale (where 0 is no pain, and 10 is the worst pain imaginable), and had pain rated at 10 on the day he was discharged so that he could go home to die. Eden Medical Center in Castro Valley, California, was also sued in the case, but settled. Part of the settlement included pain training for the hospital's physicians. Subsequently, another judge reduced the amount of damages to $250,000, but the case is going to be appealed in order to clarify this issue before the courts.

Although the long-term ramifications of this case are not fully known, Russell Portenoy, MD, head of the Pain Management Department of Beth Israel Medical Center in New York, also quoted in the *Chronicle* stories, said "It begins to create the reality of (punishment) . . . for physicians who don't respond to patients who have severe pain."

Robert Arnold, MD, of UPMC's Comprehensive Palliative Care Service, says: "Doctors want to do the right thing. The real challenge is helping them learn more about pain and the various ways it can be treated."

THE PENNSYLVANIA STATE BOARD OF MEDICINE'S GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

The Pennsylvania State Board of Medicine's guidelines (which are reprinted on pages 2 and 3 of this newsletter) make clear that effective pain management is a part of quality medical practice. The Pennsylvania guidelines are adapted from a model developed by the Pain and Policy Studies Group at the University of Wisconsin's Comprehensive Cancer Center (www.medsch.wisc.edu/painpolicy) and are reprinted here with their permission. Eighteen states have adopted all or part of these guidelines. The Pennsylvania guidelines, in conjunction with the JCAHO standards for pain management, provide substantial guidance on pain management for all Pennsylvania physicians.

NATIONAL EXPERT ON END OF LIFE CARE TO SPEAK AT PITT-UPMC

Joanne Lynn, MD, Director of the RAND-Center to Improve Care of the Dying, will be in Pittsburgh January 30-31, 2002, for a series of lectures that should be of great interest to all those who care for dying patients. Dr. Lynn will speak at the Health Policy Institute's Lecture Series in the Graduate School of Public Health auditorium in Crabtree Hall on January 30, at 4:00 p.m. Her topic will be "Management and Policy Aspects of Providing Care at the End of Life." On January 31, at noon, Dr. Lynn will present Bioethics Grand Rounds in Lecture Room 5 of Scaife Hall at the University of Pittsburgh School of Medicine. Her lecture is entitled: "Where to Put the Lever? Autonomy and System Reform." These talks present a great opportunity to meet and listen to a national leader in end of life care.

ADMINISTRATOR NAMED FOR SECTION OF PALLIATIVE CARE AND MEDICAL ETHICS

Nicole Fowler, who holds a master's degree in Health Care Management and Policy, will now be overseeing the administrative responsibilities for the Palliative Care section's research and clinical palliative care consultation service. She is a licensed nursing home administrator, and has worked as a research assistant with the Center to Improve Care of the Dying in Washington, D.C. She is a founding member and current vice-president of the End of Life Partnership of Western Pennsylvania. She may be reached at: fowlernr@msx.upmc.edu

This newsletter may be found online at: www.upmc.edu/palliativecare

PENNSYLVANIA STATE BOARD OF MEDICINE'S GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

Section I: Preamble

The Pennsylvania State Board of Medicine recognizes that principles of quality medical practice dictate that the citizens of the Commonwealth have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain. The board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as legal requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in an inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management. The board has found that these guidelines are consistent with the board's regulations pertaining to prescribing, administering and dispensing controlled substances located at 49 Pa. Code §16.92.

The board recognizes that controlled substances, including opioid analgesics, are essential in the treatment of acute pain due to trauma, surgery and chronic pain due to cancer and other progressive diseases. Physicians are referred to the U.S. Agency for Health Care Policy and Research Clinical Practice Guidelines for a sound approach to the management of acute and cancer-related pain.

The medical management of pain should be based upon current knowledge and research and includes the use of both pharmaceutical and non-pharmaceutical modalities. Pain should be assessed and treated promptly and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The State Board of Medicine is obligated under the law to protect the public health and safety. The board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate and non-medical uses.

Physicians should not fear disciplinary action from the board or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain and in compliance of applicable state or federal law.

The board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to treat the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, physiological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the board considers to be within the boundaries of professional practice.

Section II: Guidelines

The board has found that the following guidelines indicate acceptable standards of practice when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient: A complete medical history and physical examination must be conducted and documented in the medical report. The medical record should document the nature and intensity of the pain, evaluate underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan: The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment: The physician should discuss the risks and benefits of the use of controlled substances with the patient, significant other(s) or guardian. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including (1) urine/serum medication levels screening when requested (2) number and frequency of all prescription refills and (3) reasons for which drug therapy may be discontinued (i.e., violation of agremeent).

4. Periodic Review: At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology of the pain. Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living and quality of social life. If reasonable treatment goals are not being achieved despite medication adjustments, the physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation: The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder require extra care, monitoring, documentation and consultation with a referral to an expert in the management of such patients.

6. Medical Records: The physician should keep accurate and complete records to include (1) the medical history and physical examination; (2) diagnostic, therapeutic and laboratory results; (3) evaluations and consultations; (4) treatment objectives; (5) discussion of risks and benefits; (6) treatments; (7) medications (including date, type, dosage and quantity prescribed); (8) instructions and agreements; and (9) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance with Controlled Substances Laws and Regulations: To prescribe controlled substances, the physician must be licensed in the state, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and the regulations of the board for specific rules governing issuance of controlled substances prescriptions as well as applicable state regulations.

Source: *State Board of Medicine Bulletin*, Winter 1998/99, pp.4-5. Effective date: October 20, 1998. Reprinted by permission.

STAFF NEWS

Tara Lynn Burkholder, CRNP, joined the Chronic Pain Service in July. She holds a BS in Psychology from Pitt, a BS in nursing from Carlow and an MSN from the University of Pittsburgh.

Drs. Robert Arnold of UPMC and Susan Block from Dana Farber Cancer Institute are the co-principal investigators of the project "Survey of Medical Education in End of Life Care," which will study and document end of life training provided to Fellows in sub-specialties. This study will assess the degree to which palliative care is integrated into nationally recognized clinical practice guidelines for chronic, incurable, life-limiting diseases.

FOR HOSPICE REFERRALS: CALL 1-800-535-2273

FOR PALLIATIVE CARE REFERRALS: CALL 412-647-7000

> ***Of all the boons that man asks of the gods, he prays most fervently for an easy death.***
> Poseidippus [fl. 289 B.C.] Fragment from *Myrmex*.

UPMC HEALTH SYSTEM *PALLIATIVE CARE AND HOSPICE NEWSLETTER*
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The newsletter is published twice a year. It is intended to be an educational/informational resource for UPMC physicians. If you have questions/comments about this issue, or suggestions for future issues, email fowlernr@msx.upmc.edu. For consultations, call 412-647-7000 or email: rabob@pitt.edu.

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