IS THE PAIN GETTING ANY BETTER? HOW ELDER ABUSE LITIGATION LED TO A REGULATORY REVOLUTION IN THE DUTY TO PROVIDE PALLIATIVE CARE

Timothy McIntire

Inadequate pain management for the elderly and terminally ill is an obvious social problem. The tension between inadequately medicating patients suffering from chronic pain and the fear of contributing to illegal narcotic availability further frustrates this problem. In this article, Timothy McIntire examines ways an attorney can expect a client to be assessed and examined by a pain management physician. Dr. McIntire argues that a standard of care in the treatment of elderly pain patients can be concluded clearly from current statutes and judicial decisions. As a result, Dr. McIntire theorizes that the future use of such elder abuse suits against physicians will be limited or completely merge into regular negligence medical malpractice claims. Dr. McIntire concludes that through physician liability for negligence, physicians will finally adequately medicate pain.

Timothy McIntire is board certified in Anatomic Pathology, Clinical Pathology, Hematology, and Medical Management. Currently, he is an attorney in the health law section of the Nashville, Tennessee, office of Baker, Donelson, Bearman, Caldwell & Berkowitz. Dr. McIntire received his J.D. from The University of Memphis Cecil C. Humphreys School of Law in 2003, his M.B.A. from Lincoln University in 1991, and his M.D. from Louisiana State University Medical Center in New Orleans in 1983.

I. Introduction

Society's debate concerning physician-assisted suicide has exposed the problem of inadequate pain management for the elderly and the terminally ill.[1] Specifically, studies since the early 1990s have highlighted the problem of undermedication in elderly and terminally ill patients.[2] The dynamic tension between inadequately medicating patients suffering from chronic pain and the need to control illegal narcotic availability has placed pain management at the forefront of medicine and law. Interestingly, confusion defining a pain management standard of care has attorneys wondering whether claims against physicians for the undertreatment of chronic pain should arise in the new theories of elder abuse statutes or should simply be an extension of the more traditional medical malpractice negligence suits.

Although not often discussed in the legal literature, medical quality of care issues often influence the establishment and maintenance of the legal standard of care that physicians owe their patients.[3] Half of the patients who die from cancer suffer similar symptoms, including pain, labored breathing, distress, nausea, confusion, and other physical and psychological conditions that go untreated or undertreated.[4] This is a quality of care issue organized medicine is currently addressing. Attorneys dealing in the undertreatment of pain arena should be able to understand these medical quality of care issues and how they affect the legal standard of care surrounding the treatment of intractable pain in the elderly.

II. Elder Abuse Statutes as a Plaintiff's Sword

A. The Need for Elder Abuse Statutory Protection

Many states recognize that elder abuse is a significant social problem needing legislative guidance. For instance, as a reaction to Senate findings, the California legislature expressly acknowledged

1. Chris Stern Hyman, *Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment*, 24 J.L. MED. & ETHICS 338, 338 (1996).
2. *Id.*
3. *See* discussion *infra* Part III.B.
4. *Executive Summary*, *in* IMPROVING PALLIATIVE CARE FOR CANCER 3, 3 (Kathleen M. Foley & Helen Gelband eds., 2001) [hereinafter IMPROVING PALLIATIVE CARE].

that "elders and dependent adults may be subjected to abuse, neglect, or abandonment and that this state has a responsibility to protect these persons."[5] A 1998 California Senate report highlighting over 50,000 annual incidents of physical abuse of the elderly reflected a 1000% increase in reported elder abuse from 1987 to 1997.[6] This rapid rise of elder abuse cases during the previous decade compelled the California legislature to address this crisis with precision.[7] In an effort to first measure and then manage the size of this elder abuse crisis, California enacted statutes regarding: (1) the requirement of health care providers, social service workers, and community members to report suspected cases of elder abuse; (2) the collection of information on the number of victims, circumstances surrounding the acts, and other pertinent information to help establish adequate services for these elderly victims; and (3) the protection under law for those persons who report suspected cases of elder abuse, so long as the report is without malicious intent.[8]

Elder abuse may be defined in terms of abuse or neglect. As such, a typical state statute concerning elder abuse and neglect may define these terms in two main ways. First, some states characterize elder abuse as either a willful act that is likely to cause physical, mental, or emotional harm to an elderly adult, or as the failure to provide the services necessary, including health care services, which a prudent caregiver would provide to an elderly adult in similar circumstances.[9] Second, states may also define elder abuse as the willful physical abuse or gross neglect of an "impaired adult" with resulting serious mental or physical harm that may be punishable as an aggravated as-

5. CAL. WELF. & INST. CODE § 15600(a) (West 2001) (also known as the Elder Abuse and Dependent Adult Civil Protection Act).

6. *Id.* § 15610.07 historical and statutory notes.

7. *Id.* The balance of the report's elder abuse cases include: fiduciary abuse (32%), mental suffering (22%), and sexual abuse (3.8%). *Id.* While one may think of mental suffering in the elderly as elder abuse, the statute defines mental suffering as a subset of general abuse, describing such mental suffering as "fear, agitation, confusion, severe depression, or other forms of serious emotional distress." *Id.* § 15610.53. Logically, the total reported cases of physical and mental abuse in the elderly include fifty-five percent of the 225,000 reported cases in 1997. *Id.* § 15610.07 historical and statutory notes.

8. *Id.* § 15601(a)–(c) (West Supp. 2003).

9. *E.g.*, ARK. CODE ANN. §§ 5-28-101(1), (10) (Michie Supp. 2003); CAL. WELF. & INST. CODE §§ 15610.07, .57 (West 2001 & Supp. 2003); FLA. STAT. ANN. §§ 415.102(1), (15) (West Supp. 2003); N.Y. PENAL LAW § 260.25 (McKinney 2000); TENN. CODE ANN. § 71-6-102(1) (1995 & Supp. 2002). The statutes of these five generally representative states are surveyed in this section.

sault.[10] For example, the California Court of Appeals, straying from the traditional negligence standard used in medical malpractice claims and using a more complex recklessness standard, found a physician liable for violating the state's elder abuse laws for concealing, then not treating, a nursing home patient's bedsore.[11]

Physicians and attorneys alike should note that the liability for elder abuse often involves the acts of a caretaker.[12] Many statutes define a caretaker as an individual or institution who has the responsibility for the care of an adult as a result of family relationship, or who has assumed the responsibility for the care of an adult person either voluntarily, by contract, or by agreement.[13] Thus, in light of a broad statutory definition of a caretaker, many states could conceivably include physicians as caretakers in the eyes of the law. In this regard, a physician caretaker who provided inadequate pain management to an impaired adult that in turn caused serious physical harm to that adult could be held accountable under both the civil elder abuse laws and the criminal statutes of aggravated assault.

B. Elder Abuse Statutes: Are They All Alike?

Not surprisingly, all elder abuse statutes are not created equally. For example, in Arkansas, abuse of an adult includes "any willful or negligent acts which results in neglect, . . . unreasonable physical injury, . . . and failure to provide necessary treatment . . . or medical services . . . ."[14] Further, the adult abuse statutes specifically declare it unlawful for "any person or a caregiver to abuse [or] neglect" an adult.[15] Conversely, while Tennessee recognizes many of the typical

10. *E.g.*, FLA. STAT. ANN. § 825.102 (West 2000); TENN. CODE ANN. § 71-6-119 (1995).

11. Mack v. Soung, 95 Cal. Rptr. 2d 830, 834 (Cal. Ct. App. 2000). The court in *Mack* defined recklessness as "more than inadvertence, incompetence, unskillfulness, or failure to take precautions, but rather rises to the level of a conscious choice of a course of action with knowledge of the serious danger to others involved in it." *Id.*

12. Sieniarecki v. Florida, 756 So. 2d 68 (Fla. 2000).

13. *E.g.*, ARK. CODE ANN. § 5-28-101(3); CAL. WELF. & INST. CODE § 15610.17; FLA. STAT. ANN. § 415.102(4) (West 1998 & Supp. 2003); N.Y. PENAL LAW § 260.30; TENN. CODE ANN. § 71-6-102 (5) (1995 & Supp. 2002).

14. ARK. CODE ANN. § 5-28-102(b) (Michie 1997) (codifying the legislative intent regarding adult abuse).

15. *Id*. § 5-28-103(a). A caregiver includes "a related or unrelated person . . . that has the responsibility for the protection, care, or custody of an endangered or impaired adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court." *Id*. § 5-28-101(3) (Michie Supp.

elder abuse statutes found in other jurisdictions, a monetary recovery of damages against a physician when a Tennessee elder abuse statute is violated may only be obtained through the use of a traditional medical malpractice claim.[16] This does not, however, preclude the victim of elder abuse from holding her physician responsible for his acts under the elder abuse statutes. For example, other than the civil money damages that can only be obtained via the medical malpractice statutes, there are two important avenues available to Tennessee clients in addressing complaints against their physicians: (1) criminal remedies, and (2) State Board of Medical Examiners remedies (which may limit or revoke the physician's license to practice medicine).[17] As claims arising from the lack of palliative care grounded in elder abuse statutes continue to increase, the likelihood of claims involving traditional elder abuse statutes and criminal sanctions also will increase in all states. Thus, a survey of one's specific state statutes and case law is necessary prior to initiating an elder abuse action.

Many states have adopted specific palliative care and intractable pain management statutes or regulations for the protection of physicians and clients alike.[18] While the need to limit patient narcotic abuse is still present, many states realize that this need must be balanced with guidelines for the treatment of the elderly and the terminally ill suffering from intractable pain.[19] Currently, many states emphasize concerns involving narcotics in both the addiction aspect and the treatment of pain in the elderly and the terminally ill.[20] Logically, it follows that such guidelines would help in establishing a legal stan-

2003). "Person" is not defined in this statute. *See id.* § 5-28-101 (Michie 1997 & Supp. 2003). Both criminal and civil penalties apply to such abuse. *Id*. §§ 5-28-103, -106.

16. TENN. CODE ANN. § 71-6-120(g) (Supp. 2002). "This section shall not apply to a cause of action within the scope of title 29, chapter 26; such cause of action shall be governed solely by title 29, chapter 26." *Id.* Title 29, chapter 26 contains the medical malpractice statutes. *Id*. §§ 29-26-115 to -210 (2000 & Supp. 2002).

17. Criminal remedies could include both the potential of a Class A misdemeanor and aggravated assault. For example, see TENN. CODE ANN. §§ 71-6-117, -119 (1995). For an example of a State Board of Medical Examiners disciplinary remedy, see *id*. §§ 63-6-213 to -217 (1995 & Supp. 2002).

18. *See* PAIN & POLICY STUDIES GROUP, UNIV. OF WIS. COMPREHENSIVE CANCER CTR. ET AL., ANNUAL REVIEW OF STATE PAIN POLICIES 2000 (2001), *available at* http://www.medsch.wisc.edu/painpolicy/publicat/01ppsgar/contents.htm [hereinafter ANNUAL REVIEW OF STATE PAIN POLICIES]; *see also infra* Tbl.1, note 91.

19. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18.

20. *See generally id*.; *see also* TENN. STATE BD. OF MED. EXAM'RS, ch. 0880-2-.14 (2003).

dard of care in the treatment of elderly and terminally ill patients suffering from intractable pain.

III. Claims in the Alternative

A. Negligence, and in the Alternative, Abuse or Neglect

Addressing pain management in the elderly and the terminally ill is important to attorneys for two reasons. First, historically physicians often have not adequately treated intractable chronic pain in patients due to a legitimate fear of state medical board discipline from overmedicating patients with pain symptoms.[21] Second, attorneys have begun to bypass medical malpractice remedies in lieu of the recent trend using elder abuse statutes as the legal theory to hold physicians responsible for the inadequate treatment of pain in elderly and terminally ill patients.[22] Interestingly, both of these precedents appear to be changing.

With respect to the traditional claim regarding physician undertreatment of intractable pain, most state legislatures and medical licensing boards have adopted intractable pain laws and medical protocols to treat patients suffering from debilitating chronic pain.[23] Despite the findings of other legal commentators, the undertreatment of pain is no longer the acceptable "standard of care for physicians."[24]

21. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18.

22. *See, e.g.*, Mack v. Soung, 95 Cal. Rptr. 830 (Cal. Ct. App. 2000).

23. PAIN & POLICY STUDIES GROUP, UNIV. OF WIS. COMPREHENSIVE CANCER CTR. ET AL., DATABASE OF STATE LAWS, REGULATIONS, AND OTHER OFFICIAL GOVERNMENT POLICIES, *at* http://www.medsch.wisc.edu/painpolicy/matrix.htm#Top (last updated Oct. 9, 2003) [hereinafter DATABASE]. The *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* have been adopted by the Federation of State Medical Boards. MODEL GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN (Fed'n of State Med. Bds. 1998), *available at* http://www.cityofhope.org/prc/pdf/model_guidelines_FSMB.pdf [hereinafter MODEL GUIDELINES]. Consequently, most states now have medical guidelines for physicians to treat patients with chronic pain. DATABASE, *supra*. As of October 2003, only Alaska, Connecticut, Delaware, Hawaii, Illinois, Indiana, and the District of Columbia are without either statutes or agency rules and regulations governing controlled substances and the treatment of chronic pain. *Id*.

24. *See* Gilah R. Mayer, Bergman v. Chin*: Why an Elder Abuse Case Is a Stride in the Direction of Civil Culpability for Physicians Who Undertreat Patients Suffering from Terminal Pain*, 37 NEW ENG. L. REV. 313, 316 (2003) (claiming that the standard of care in pain management is to undertreat patients); *see also* Rima J. Oken, *Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917, 1969 (2002) (discussing palliative care in the terminally ill, and secondarily addressing the legal controversies regarding the medical standard of care in pain management negligence cases).

Specifically, the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* outline a standard of care, finding that "[t]he medical management of pain should be based upon current knowledge and research and includes the use of both pharmacologic and nonpharmacologic modalities. Pain should be assessed and treated promptly and the quantity and frequency of [medication] doses should be adjusted according to the intensity and duration of pain."[25] This policy statement, in and of itself, establishes the foundation from which physicians and state licensing agencies can build a medical standard of care. In light of these recent pain management protocols, patients and plaintiff attorneys should rely less and less on elder abuse and neglect claims, most of which require a willful or reckless state of culpability.[26] Consequently, liability in negligence will again be seen as the gold standard in enforcing patients' rights to adequate pain relief from chronic diseases. That is all the more reason for attorneys to sue in negligence and not via the more complicated reckless standard seen in the elder abuse avenue.

As to the attorney's decision whether to bring an elder abuse claim versus the more traditional medical malpractice claim, four main points should be considered. First, expert medical testimony would be needed for both, and an attorney proving a reckless standard allowing for recovery under the elder abuse claim should also be able to prove the lesser negligence regarding a claim of medical malpractice.[27] Second, many state boards of medicine have recently adopted medical protocols for the treatment of patients suffering from chronic pain.[28] Therefore, the claim that there is not a standard of care

25. MODEL GUIDELINES, *supra* note 23, § I.

26. *E.g.*, ARK. CODE ANN. § 5-28-101(2) (Michie 1997 & Supp. 2003); FLA. STAT. ANN. § 415.102(1) (West Supp. 2003).

27. In *Bergman v. Chin*, No. H205732-1 (Cal. Super. Ct. June 13, 2001), to survive the defendant's motion for summary judgment and dispute the defendant's expert testimony, the plaintiffs supplied their own testimony by a physician expert in the field of pain management. Mayer, *supra* note 24, at 331–32. The plaintiff's expert stated that the defendant-physician's conduct was "appalling and fell below the standard of care . . . demonstrating an indifference and deliberate disregard . . . for accepted pain management techniques." *Id*. at 332. For further discussion of *Bergman*, see *infra* notes 76–79 and accompanying text.

28. Some states with locality rules governing the use of medical experts in medical malpractice negligence cases may exclude experts from other geographical regions of the country who would be willing to testify as to the appropriate pain management standard of care. *E.g.*, Hall v. Halburn, 466 So. 2d 856, 869 (Miss. 1985). As such, attorneys may be forced to use the elder abuse statutes to avoid these evidentiary restrictions on medical experts. In time, as pain manage-

in this area can no longer be sustained. Third, if a plaintiff-patient could convince a jury that a defendant-physician is liable for reckless pain management care that actually rose to the level of elder abuse, then the plaintiff-patient should more easily be able to convince that same jury that the defendant-physician also was liable for the lesser culpable standard of negligence. Fourth, as physicians' liability insurance is often seen as a deeper pocket than physicians' personal assets alone, a claim in negligence that is covered by liability insurance is more economically attractive than a reckless claim falling outside of any liability insurance coverage.

Most importantly, though, is the recognition that if a plaintiff can prove the reckless standard needed for liability under the elder abuse laws, then she should also be able to prove the lesser standard of negligence. This recognition correctly infers that future elder abuse claims against physicians may be more effectively brought by the traditional medical malpractice actions. Plaintiff recovery from physician neglect concerning the treatment of intractable pain should be easier under the lesser negligence standard. However, one wonders why physicians would even dream of undermedicating patients suffering from chronic pain.

B. How Quality of Care Can Affect the Standard of Care

The medical community has long indoctrinated its physicians with caution in the use of narcotic therapy for pain relief.[29] As this article outlines, however, the medical community has only recently recognized its deficiencies in treating patients with intractable pain.[30] Part of this recognition has been facilitated by liability physicians have suffered from violating elder abuse statutes.[31] Despite the cause, medical societies and state licensing boards have been slow in adapt-

ment protocols permeate even the most rural areas of medicine, pain management experts testifying on the appropriate standard of care will be available to all.

29. Ann M. Martino, *In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?,* 26 J.L. MED. & ETHICS 332, 337 (1998).

> From the minute I entered medical school to the day I finished my residency, I had it drilled into my head that narcotics should be used sparingly (if ever). We spent hours listening to professors describe how patients will do anything to get their doctors to prescribe narcotics and not more than a minute or two discussing their therapeutic uses.

Id.

30. *See* MODEL GUIDELINES, *supra* note 23 (not adopted until 1998).

31. *See, e.g.*, Mack v. Soung, 95 Cal. Rptr. 2d 830 (Cal. Ct. App. 2000).

ing their mores, regulations, and policies to allow for adequate pain relief in the elderly and the terminally ill.[32] Nevertheless, the recent changes in pain management, reflected by the many medical protocols established for the treatment of those suffering from chronic pain, will assist in defining a national and local standard of care.[33] For example, the National Foundation for the Treatment of Pain recommends some essential considerations in the treatment of chronic, intractable pain by highlighting pharmacological methods of treatment.[34] The Foundation's protocols call for the correct medicine and dose to be selected, and that the pharmacologic risks, including side-effects, be carefully monitored and weighed against the benefits.[35] The most serious considerations are excessive sedation, severe constipation, and underdosage.[36] If the patient is not fully and adequately relieved of the pain, then the treatment is inadequate.[37] Physicians must, therefore, choose a medicine strong enough so that excessive numbers of pills are not required to accomplish pain relief.[38]

Similarly, physicians and attorneys are beginning to recognize that health care quality indicators are needed to help define the appropriate standard of care in patients suffering from chronic pain.[39] These quality indicators serve two distinct purposes: (1) to measure accountability by regulators, health care purchasers, and consumers; and (2) to perform the monitoring and continuous surveillance needed for quality improvement.[40] Criteria that should also be considered in defining standard of care boundaries include pain symptom management, patient satisfaction, shared decision making among the patient, her family, and the treating physicians, coordination of

32. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18 (highlighting progress being made as an increasing number of states adopt pain regulations and policies).

33. *See generally id.*

34. NAT'L FOUND. FOR THE TREATMENT OF PAIN, ESSENTIAL CONSIDERATIONS IN THE TREATMENT OF INTRACTABLE PAIN, *at* http://www.paincare.org/pain_management/essential/adequate.html (last visited Sept. 29, 2003).

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *See* Joan M. Teno, *Quality of Care and Quality Indicators for End-of-Life Cancer Care: Hope for the Best, Yet Prepare for the Worst*, *in* IMPROVING PALLIATIVE CARE, *supra* note 4, at 96, 96–97.

40. *Id.* at 97.

pain care with other medical and social issues, and the guarantee of continuity of care throughout the chronic pain illness.[41]

Pain is common among dying cancer patients, and this pain increases as death approaches.[42] Unsurprisingly, pain assessment and management are important public concerns. However, what is surprising to physicians and attorneys alike is that almost forty percent of patients dying of colon or lung cancer have severe pain during the last three days of life.[43] As physicians study pain more extensively, they recognize that many chronic pain sufferers believe their pain is undermedicated and their mobility and quality of life is significantly impaired due to this undermedication.[44]

Recently, many medical societies and organizations have developed medical guidelines addressing the treatment of intractable chronic pain in elderly and terminally ill patients.[45] When followed, these guidelines establish an appropriate standard of care for the treatment of such patients. Unfortunately, there is strong evidence that chronic pain is still too often undertreated, despite these clearly established guidelines.[46] Many believe that if the pain management guidelines were followed, pain could be relieved in the great majority of patients.[47] Because the inappropriate treatment of such chronic pain is now recognized and found unacceptable, the medical guidelines for the treatment of this pain should define the standard of care for treatment in chronic pain patients. In fact, many physicians now recommend that pain and its control should become an outcome measure used to judge the quality of end-of-life care for purposes of public accountability.[48]

C. Model Recommendations for Physicians: A Checklist for Attorneys

In achieving the balance between limiting narcotic addiction and adequately treating terminally ill patients, many state legislatures and

41. *Id*.
42. *Id*. at 106.
43. *Id*. at 106–07.
44. *Id*. at 107.
45. *See, e.g.,* MODEL GUIDELINES, *supra* note 23.
46. Teno, *supra* note 39, at 107.
47. *Id*.
48. *Id*. Specifically, Ms. Teno recommends research into and demonstration projects involving efforts to implement accountability measures for pain management. *Id*.

medical licensing boards have turned to the Pain & Policy Studies Group at the University of Wisconsin Comprehensive Cancer Center (Pain & Policy Group) for recommendations on specific policies relating to the treatment of pain in the elderly and the terminally ill.[49] The Pain & Policy Group highlighted the following issues, recognizing that quality medical care dictates that patients have access to appropriate and effective pain relief:

> (1) inadequate pain control may result from a physician's lack of sophisticated knowledge or experience in pain management;[50]
>
> (2) fears of investigations by federal, state, or local regulatory agencies inhibit a physician's comfort level in adequately treating patients with intractable pain;[51]
>
> (3) state medical boards have a responsibility to develop guidelines and policies which would allow physicians who treat intractable pain to be adequately educated on current issues in pain management, and not to fear discipline when using such pain management appropriately;[52] and
>
> (4) in each case of pain management concerning intractable pain, a physician should have fully evaluated the patient, developed a written treatment plan, obtained the patient's informed consent and agreement for treatment, conducted periodic reviews of the treatment at responsible intervals to assess the ongoing need of the narcotics, kept complete medical records, obtained specialty consultation for addi-

49. ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18; *see also* MODEL GUIDELINES, *supra* note 23.

50. ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18, at 23 app. A. Appendix A *infra* provides the text of the MODEL GUIDELINES, *supra* note 23.

51. *Id.*

52. *Id.* Tennessee's regulation, which is similar to regulations in California, Florida, and New York, concerning the authority of physicians to prescribe for the treatment of pain includes "[t]he treatment of pain, including intractable pain, with dangerous drugs and controlled substances is a legitimate medical purpose when done in the usual course of professional practice." TENN. STATE BD. OF MED. EXAM'RS, ch. 0880-2-.14(6)(e)(1) (2003), *available at* http://www.state.tn.us/sos/rules/0880/0880-02.pdf. Notably, this rule should eliminate any physician concern for discipline when providing adequate palliative care. Potentially this rule could be used to establish that a medical treatment plan fell below the standard of care in patients needing palliative care when their physicians do not provide such care. States without such rules or similar statutes do a disservice to their citizens who could benefit from palliative care in that: (1) physicians may fear discipline for such aggressive pain management in elderly patients; and (2) a legal standard for end-of-life pain management may be hard to measure.

tional evaluation and treatment when necessary, and complied with the control substances laws and regulations.[53]

The adoption of these or similar recommendations by state medical boards, along with physician education and legal enforcement of such recommendations, often allows physicians to better address their patients' pain relief needs.[54] Removing the fear of physician discipline is paramount in allowing for more appropriate palliative care. Additionally, such recommendations may reduce the total number of legal claims for elder abuse and neglect, and allow for a more consistent and accepted standard of care in the pain management for elderly and terminally ill patients. Through recognition and enforcement of these and similar recommendations, attorneys will force reluctant physicians to afford relief for patients suffering from chronic pain.

As a consequence of the foregoing discussion, attorneys should be aware that there are many exams and tests used to assess patients suffering from chronic pain in order to determine which medical treatment protocol would best suit them. An initial assessment includes:

- A detailed medical history, including a description of the pain, previous pain episodes, how they were treated, and whether treatment was successful. Patients should keep a "pain diary" that documents what the patient was doing when she noticed the pain, how the physician treated it, and whether the pain was relieved.
- A general physical exam to assess the patient's physical well-being and to help the physician precisely identify areas of pain. Pain affecting the body's ability to move properly may be assessed with range-of-motion exercises. A physical exam may uncover conditions that may be contributing to the chronic pain.

53. ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18, at 23 app. A.

54. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18. Alabama, Florida, Kansas, Nebraska, Nevada, Pennsylvania, South Carolina, and Utah have adopted in full the recommendations of the Pain & Policy Study Group. *Id.* at 1 tbl.2. Arizona, Louisiana, Maine, New Hampshire, New York, Oklahoma, and Tennessee have adopted the recommendations in part. *Id.* As of October 2003, only Alaska, Connecticut, Delaware, Hawaii, Illinois, Indiana, and the District of Columbia are without either statutes or agency rules and regulations governing controlled substances and the treatment of chronic pain. DATABASE, *supra* note 23.

- A neurologic exam to identify possible nervous system problems. This exam involves simple tests to assess mental ability, emotional condition, and language functions. For instance, the patient may be asked to repeat a series of numbers or to answer questions about dates, places, and current events. By checking reflexes and the patient's ability to feel light touch, the exam can help judge whether the patient has a nerve problem.
- A mental health assessment to determine whether such conditions as depression, insomnia, or stress are contributing to or occurring as a result of the patient's chronic pain. These conditions may often occur with chronic pain.
- Diagnostic tests, including blood tests or other laboratory tests, X-rays or other imaging tests (such as CT scans or MRIs), electromyography and nerve conduction studies or other nerve tests, angiography or other vascular studies, and diagnostic nerve blocks (such as injection of a local anesthetic to see whether a nerve is causing the pain). All of these medical examination tests build the foundation needed to establish a legal standard of care.[55]

D. In the Alternative

Changes in medicine, nevertheless, occur slowly and often only through judicial encouragement. For instance, an increasing number of elderly and terminally ill patients are afforded more effective pain relief as a result of the medical community's fear of legal liability.[56] This fear has led to the voluntary adoption of more consistent and aggressive pain management policies, thereby cementing a previously elusive standard of care regarding the treatment of the elderly suffering from intractable chronic pain.[57] Some states with locality rules

55. *See* WEBMD, CHRONIC PAIN: EXAMS AND TESTS, *at* http://www.my.webmd.com/content/healthwise/21/5292.htm (last visited Oct. 12, 2003).

56. *See* Mary E. Baluss & K. Francis Lee, *Legal Considerations for Palliative Care in Surgical Practice*, 197 J. AM. C. SURGEONS 323, 326–29 (2003), http://www.promotingexcellence.org/downloads/jacs_0803.pdf.

57. *See* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18. The study of improving pain care in the chronically ill continues to evolve. Many advocate additional studies funded by governmental organizations such as the National Cancer Institute. *Executive Summary*, *supra* note 4, at 5. Specifically, the studies advocated would have the National Cancer Institute designate cancer centers to play a central role as agents of national policy in advancing palliative care research and

governing the use of medical experts in medical malpractice negligence cases, however, may exclude experts from other geographical regions of the country who would be willing to testify as to the appropriate pain management standard of care.[58] Therefore, attorneys may be forced to continue their use of elder abuse statutes to avoid these evidentiary restrictions on medical experts. In time, as pain management protocols permeate even the most rural areas of medicine, pain management experts testifying on the appropriate standard of care will be available to all. Consequently, at least in some states, a careful use of elder abuse statutes as quasi-medical malpractice provisions has helped, and may continue to help ensure that elderly and terminally ill patients receive adequate pain relief.[59] Nonetheless, in time, as pain management awareness and medical protocols continue to evolve, plaintiffs' use of the elder abuse statutes as relief from the undermedication of chronically ill patients should lessen, folding back

clinical practice, with initiatives that address many of the barriers identified in this report. *Id.*

> NCI should designate certain cancer centers, as well as some community cancer centers, as centers of excellence in symptom control and palliative care for both adults and children. The centers would deliver the best available care as well as carry out research, training, and treatment aimed at developing model programs that can be adopted by other cancer centers and hospitals. Activities should include, but not be limited to the following:
> • formal testing and evaluation of new and existing practice guidelines for palliative and end-of-life care;
> • pilot testing "quality indicators" for assessing end-of-life care at the level of the patient and the institution;
> • incorporating the best palliative care into NCI-sponsored clinical trials;
> • innovating in the delivery of palliative and end-of-life care, including collaboration with local hospice organizations;
> • disseminating information about how to improve end-of-life care to other cancer centers and hospitals through a variety of media;
> • uncovering the determinants of disparities in access to care by minority populations that should be served by the center, and developing specific programs and initiatives to increase access; these might include educational activities for health care providers and the community, setting up outreach programs, etc.;
> • providing clinical and research training fellowships in medical and surgical oncology in end-of-life care for adult and pediatric patients;
> • creating faculty development programs in oncology, nursing, and social work; and
> • providing in-service training for local hospice staff in new palliative care techniques.

Id. at 5–6.

58. *E.g.*, Hall v. Halburn, 466 So. 2d 856, 869 (Miss. 1985).

59. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18.

into the more traditional negligence actions against offending physicians. So, why would a physician ever undermedicate a patient suffering from intractable chronic pain?

IV. Pain Relief: A Crime or a Duty

A. Crime: The Oxycontin Paradox

Physicians often struggle to balance their role in prescribing narcotics to patients suffering from intractable chronic pain and withholding such medication from patients with drug addictions.[60] Naturally, these conflicting situations provide a constant source of turmoil and legal liability for physicians. In addressing this turmoil, attorneys should recognize the opportunities and liabilities physicians face when prescribing narcotics for pain. For example, one-half of patients suffering from chronic pain syndromes have extreme difficulty performing the normal activities of life and cannot control their pain with any medication other than narcotics.[61] Additionally, while physicians' ability to manage cancer pain has improved, adequate pain relief continues to elude many dying patients.[62] Curiously, there does not appear to be an adequate explanation of why, in an era of modern medicine such as the one we live in today, terminally ill patients must die in excruciating and unrelieved pain.

To better understand the conflicts physicians have regarding the undermedication of patients suffering from painful terminal illnesses,

60. *See generally* PAIN & POLICIES STUDIES GROUP, UNIV. OF WIS. COMPREHENSIVE CANCER CTR. ET AL., PROMOTING RELIEF AND PREVENTING ABUSE OF PAIN MEDICATION: A CRITICAL BALANCING ACT, *at* http://www.medsch.wisc.edu/painpolicy/consensus2.pdf (last visited Oct. 6, 2003).

61. *See* Richard L. Brown, *The Management of Chronic Pain, Symposium on the Legal and Ethical Issues Affecting Pain Management* (Sept. 2000) *at* http://www.familypractice.com/lectures/pain/lecture_brown_text_frame.htm (explaining that sixty-two percent of survey participants had pain greater than five on a scale of one to ten, which meant a significant dysfunction in their lives). The opioid family of narcotics includes codeine, oxycodone (e.g., oxycontin), and morphine. Neil Ellison, *The Role of Opioids in Pain Management, Symposium on the Legal and Ethical Issues Affecting Pain Management* (Sept. 2000) *at* http://www.familypractice.com/lectures/pain/lecture_ellison_text_frame.htm.

62. *See* Tanya Albert, *Doctor Guilty of Elder Abuse for Undertreating Pain*, AM. MED. NEWS, July 23, 2001, *at* http://www.ama-assn.org/amednews/2001/07/23/prl20723.htm. Barriers to pain relief include patients' poor compliance with prescribed medication, patients' underestimating, thus mischaracterizing their pain to their physicians, concerns about narcotic addiction by both patients and physicians, and poor physician understanding of both the amount of pain their patients are suffering and the best treatment for such pain. Ellison, *supra* note 61.

one must recognize the abuse such prescription drugs play in today's society. Oxycontin provides a recent example of this conflict.[63] On one hand, oxycontin is taken orally and provides rapid and highly efficient pain relief, thus negating the need for inconvenient and painful injections.[64] Physicians underprescribing oxycontin may be accused of not being sensitive to their patients' pain conditions. On the other hand, oxycontin has a tremendous potential for abuse as an illegal street drug, and physicians overprescribing oxycontin run the risk of both civil and criminal liability, as well as state licensure sanctions.[65] So, where is the balance? Chronic pain patients need narcotic relief, but narcotics, like oxycontin, have always carried risks to patients and adverse consequences to society.

The following two examples compound physicians' anxiety surrounding the treatment of patients suffering from chronic pain. First, in 1999, the Oregon Medical Board disciplined a physician for prescribing insufficient pain medication to a terminally ill patient.[66] Second, in 2002, a Florida jury convicted a physician of manslaughter in the deaths of four patients in which he prescribed oxycontin for chronic pain relief.[67] This Florida physician is believed to be the nation's first physician to stand trial on manslaughter or murder charges for the oxycontin death of a patient.[68] Both examples illustrate the no-win situations a physician must decide between. Unfortunately, without adequate medical protocols to define a standard of care that physicians can find shelter under, many physicians may stop treating elderly and terminally ill pain patients, finding the risk of potential investigation and prosecution too great to assume. So, how does one counsel a physician who treats elderly or terminally ill patients? Will

63. Oxycontin is the generic name of a controlled release form of oxycodone, an opioid narcotic available by prescription only. *See* WHOLE HEALTH MD, OXYCODONE HYDROCHLORIDE, *at* http://www.wholehealthmd.com/refshelf/drugs_view/1,1524,470,00.html (last visited Oct. 6, 2003). Oxycontin allows for both immediate and sustained pain relief and has the added convenience of being able to be taken by mouth (not by injection) twice per day (not four to six times per day as with other oral pain medications). *See id.*

64. *Id.*

65. *See* Mark A. Ford, *Another Use of Oxycontin: The Case for Enhancing Liability for Off-Label Drug Marketing*, 83 B.U. L. REV. 429, 437, 453–56 (2003); Martino, *supra* note 29, at 340.

66. Ellen Goodman, *From Oregon, A Call for Compassionate Care*, BOSTON GLOBE, Sept. 9, 1999, at A19.

67. *Oxycontin Prescriber Guilty*, ORLANDO SENTINEL, Feb. 20, 2002, at B2, *available at* 2002 WL 3031547.

68. *Id.*

traditional concerns of narcotic addiction, medical licensure discipline, and illegal street narcotics be the greatest barrier to real-time and adequate pain relief for elderly or terminally ill patients?

B. Duty: What the Private and Government Sectors Have Done

Physicians, attorneys, and regulatory personnel share responsibility for ensuring a balance between the availability of narcotics for the treatment of chronic pain and the enforcement of drug laws. A consensus joint statement from the Drug Enforcement Administration and twenty-one health organizations proclaims the following:

> - Undertreatment of pain is a serious problem in the United States, including pain among patients with chronic conditions and those who are critically ill or near death. Effective pain management is an integral and important aspect of quality medical care, and pain should be treated aggressively.
> - For many patients, opioid analgesics—when used as recommended by established pain management guidelines—are the most effective way to treat their pain, and often the only treatment option that provides significant relief. . . .
> - In spite of regulatory controls, drug abusers obtain these and other prescription medications by diverting them from legitimate channels in several ways, including fraud, theft, forged prescriptions, and via unscrupulous health professionals.
> - Drug abuse is a serious problem. Those who legally manufacture, distribute, prescribe and dispense controlled substances must be mindful of and have respect for their inherent abuse potential. . . .
> - Helping doctors, nurses, pharmacists, and other healthcare professionals, law enforcement personnel and the general public become more aware of both the use and abuse of pain medications will enable all of us to make proper and wise decisions regarding the treatment of pain.[69]

This consensus statement lends additional support to this author's assertion that the current standard of care in pain management is not that of undertreatment. Consensus statements, such as this one, have removed the ambiguous standard of care barrier attorneys previously fought in pain management—medical malpractice actions, thereby allowing patients once again to effectively make a prima facie

69. PAIN & POLICIES STUDIES GROUP, *supra* note 60.

case in negligence against physicians who continue to undertreat chronic pain conditions. Further, as a consequence of similar consensus statements, elder abuse claims recently used to compensate patients for the pain of undertreatment should continue to decrease—or disappear, being replaced by the more traditional negligence medical malpractice claims.

V. Elder Abuse Cloaked in Medical Malpractice: The Birth of a New Cause of Action

While the criminal prosecutions of physicians for medically related decisions are occasionally successful, the increasing ability of plaintiffs to hold physicians responsible for traditional medical malpractice errors by using nontraditional theories of liability makes the caring and treatment of elderly and terminally ill pain patients increasingly risky. Malpractice liability insurance is no longer a foolproof shield from poor treatment decisions. The following two cases are illustrative of these emerging trends in civil liability involving pain management and the care of elderly and terminally ill patients.[70] As one reads these case summaries, ponder whether a client would be afforded better legal relief through a new tort in elder abuse or through the traditional negligence torts of medical malpractice.

A. Illustrative Cases

In 1990, the estate of Henry James sued the Guardian Care nursing home in North Carolina for the inadequate pain control of the decedent Henry James, a terminally ill cancer patient.[71] In this case, although the physicians had ordered adequate doses of morphine to be given every three hours for Mr. James' pain control, the nursing home's staff regularly substituted less powerful narcotics.[72] Unfortu-

70. Physicians are not unlike others who will avoid professional risk. The fear of a physician risking criminal punishment (which also brings with it licensure revocation) or personal liability for nontraditional civil judgments (because malpractice liability policies may not cover intentional, reckless, or willful torts) may drive many physicians to limit their medical practice to "low-risk" patients. Factoring in the often lower than market reimbursement for nursing home and eldercare, the legal risk of caring for the elderly and the terminally ill may come to outweigh the financial and professional rewards of such care.

71. Tinker Ready, *Nursing Home Is Fined*, NEWS & OBSERVER (Raleigh, N.C.), Nov. 27, 1990, at 1B.

72. *Id*.

nately, Mr. James was in pain caused by his cancer for seven months before he died.[73] Quietly and ahead of its time, a North Carolina jury found the Guardian Care nursing home liable for violations of state Division of Facility Services regulations concerning the inadequate pain control of a terminally ill cancer patient.[74] The jury awarded $7.5 million in compensatory damages and $7.5 million in punitive damages to the estate of Henry James.[75] While suits against nursing homes for poor care are not unique, this case may be the first of its kind where a nursing home was held liable for inadequate pain control.

In *Bergman v. Chin*,[76] the family of an eighty-five-year-old man sued the physician who failed to treat him adequately for the pain his cancer caused prior to his death, using elder abuse statutes and not the more conventional medical malpractice statutes.[77] The Bergman estate claimed that Dr. Chin was reckless in not prescribing enough medication to relieve the pain from Mr. Bergman's lung cancer complications.[78] In May 2001, a California jury awarded $1.5 million to the Bergman estate.[79]

73. *Id.*
74. *See id*.
75. *Id*.
76. No. H205732-1 (Cal. Super. Ct. June 13, 2001).
77. Natalie White, *Failure to Treat Pain, Novel Verdict Could Signal a New Brand of Med-Mal Suit*, LAWYER'S WKLY. USA, Aug. 6, 2001, http://www.lawyersweeklyusa.com/subscriber/archives.cfm?page=/archives/usa/01/806011.htm. Despite the fact that this case involved elder abuse laws, and not medical malpractice statutes, the trial judge reduced this $1.5 million award to $250,000 applying California's $250,000 medical malpractice damage "cap." Marino, *supra* note 29, at 341–42 (citing CAL. CIV. CODE § 3333 (West 1995)). This author suggests that the verdict and the precedent it establishes may be a "self-inflicted wound" by organized medicine. The *Bergman* case began as a complaint to the California Medical Board, "which agreed the patient should have had better palliative care but took no action against the doctor." White, *supra*. If the California Medical Board had even sent Dr. Chin a letter of reprimand, this suit may not have been filed. *See id.*
78. Tyche Hendricks, *Skimping on Elderly's Pain Drugs "Like Torture,"* S.F. CHRON., May 4, 2001, at A1. Notably, a mens rea of recklessness, and not the traditional negligence as seen in medical malpractice, is required under the elder abuse statutes. *Id.* Additionally, unlike the medical malpractice statutes, liability under the elder abuse statutes allows for the recovery of punitive damages. *Id.* Importantly, while many attorneys were reluctant to assist the Bergman family in their novel claim for fear of not being able to establish adequate damages, the Oregon-based nonprofit organization of The Compassion in Dying Federation was glad to assist in both the filing of the complaint with the California Medical Board and the suit in Alameda County. *Id.* The Compassion in Dying Federation is an advocacy group for physician-assisted suicide and palliative care and may be an effective resource for legal and research assistance. *See id.*
79. White, *supra* note 77.

B. Have Physicians Opened the Door to These Elder Abuse Claims?

While the *Bergman* case may send a chill down the spine of many physicians, three important points need to be made: (1) the awareness of the undertreatment of pain in elderly and terminally ill patients has been extensively chronicled in recent medical literature;[80] (2) in 1994, the California Medical Board issued guidelines encouraging physicians to be more prompt and aggressive in providing medications for pain;[81] and (3) in 1997, the California legislature approved the Pain Patients Bill of Rights, which grants patients the right to request painkillers of their choice.[82] These three points should establish beyond a

80. Symposium, *Appropriate Management of Pain: Addressing the Clinical, Legal, and Regulatory Barriers*, 24 J.L. MED. & ETHICS 285 (1996); Symposium, *Legal and Regulatory Issues in Pain Management*, 26 J.L. MED. & ETHICS 265 (1998); Symposium, *The Undertreatment of Pain—Legal, Regulatory, and Research Perspectives and Solutions,* 29 J.L. MED. & ETHICS 11 (2001).

81. MED. BD. OF CAL., GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR INTRACTABLE PAIN, http://www.medbd.ca.gov/consumerguidelines.htm (last visited Oct. 6, 2003).

82. CAL. HEALTH & SAFETY CODE § 124961 (West Supp. 2003). The California Legislature found and declared all of the following:

> (a) The state has a right and duty to control the illegal use of opiate drugs; (b) Inadequate treatment of acute and chronic pain originating from cancer or non-cancerous conditions is a significant health problem; (c) For some patients, pain management is the single most important treatment a physician can provide; (d) A patient suffering from severe chronic intractable pain should have access to proper treatment of his or her pain; (e) Due to the complexity of their problems, many patients suffering from severe chronic intractable pain may require referral to a physician with expertise in the treatment of severe chronic intractable pain. In some cases, severe chronic intractable pain is best treated by a team of clinicians in order to address the associated physical, psychological, social, and vocational issues; (f) In the hands of knowledgeable, ethical, and experienced pain management practitioners, opiates administered for severe acute and severe chronic intractable pain can be safe; (g) Opiates can be an accepted treatment for patients in severe chronic intractable pain who have not obtained relief from any other means of treatment; (h) A patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities to relieve his or her severe chronic intractable pain; (i) A physician treating a patient who suffers from severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain as long as the prescribing is in conformance with the provisions of the California Intractable Pain Treatment Act, Section 2241.5 of the Business and Professions Code; (j) A patient who suffers from severe chronic intractable pain has the option to choose opiate medication for the treatment of the severe chronic intractable pain as long as the prescribing is in conformance with the provisions of the California Intractable Pain Treatment Act, Section 2241.5 of the Business and Pro-

doubt that the undertreatment of pain in chronically ill patients falls below the standard of care in California. Why the plaintiff in *Bergman* could not find an expert to testify to this standard of care is puzzling.[83] Despite these and similar guidelines and statutes in most states, many physicians are still reluctant to use palliative care to treat the terminally ill. The traditional fear of licensure discipline, criminal sanctions, and hospital peer review discipline, however, are the main reasons for this reluctance.[84] Furthermore, this problem appears to be more prevalent with physicians who are less familiar with sophisticated pain management regimens in the terminally ill setting.[85]

As a consequence of the *Bergman* decision, and in recognition of the reluctance of many physicians to aggressively treat pain in the terminally ill, California recently enacted legislation requiring physicians "who could encounter pain management and end-of-life care issues to take 12 hours of continuing medical education classes on the topic to renew their medical licenses."[86] Many physicians outside of California likely have the same fears and reluctance to pain management in the terminally ill. Observing how the national medical community motivates itself to overcome these barriers to pain management will be interesting; the two most obvious choices of motivation

> fessions Code; and (k) The patient's physician may refuse to prescribe opiate medication for a patient who requests the treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

Id. § 124960.

83. *See* Mayer, *supra* note 24, at 316. One would presume, absent an evidentiary technicality, that a physician expert testifying as to the defendant's reckless treatment of the plaintiff-patient would also suffice for a negligent breach of duty and fall below the accepted standard of care.

84. Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J.L. MED. & ETHICS 28, 28 (2001).

85. This is a personal observation. Generally, anesthesiologists, physiatrists, and oncologists appear to have more experience and sophistication in advanced pain management, as compared to general internists and family practitioners. *Id.* Dr. Chin, the defendant in *Bergman*, was a general internist. Hendricks, *supra* note 78.

86. Tanya Albert, *California Requires Doctors Take CME in Pain Management*, AM. MED. NEWS, Nov. 19, 2001, *at* http://www.ama-assn.org/amednews/2001/11/19/prsb1119.htm. While many states mandate continuing medical education to renew one's medical license, California is the first state to require specific classes in pain management. *Id.* Interestingly, the California Academy of Family Physicians met the mandatory classes with skepticism, while the American Academy of Pain Management said the bill was "well intended" and supported the training. *Id.*

include either voluntary education or the experience and fear of civil liability. Fortunately, in 1988, the Federation of State Medical Boards developed the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*.[87] As more states adopted the pain management guidelines, the standard of care for pain management in the elderly became firmly established on a national level.[88] Soon, the standard established by these model guidelines will become consistent throughout both urban and rural America, all but forcing even the most reluctant of physicians to offer aggressive pain management to their elderly and terminally ill patients suffering from intractable pain. During this transition, however, attorneys must understand the role elder abuse statutes play in the dynamics arising from the medical pain management of the elderly.

VI. Conclusion

The practice of medicine may, at times, be both conservative and technologically complex. In the backdrop of organ transplantation, gene therapy, and biomedical sophistication, patients dying in pain occurs too frequently. In the current culture of drug abuse, society understandably wants to limit the availability of narcotics. However, a better understanding of the balance between narcotic addiction and the relief of intractable pain in the elderly and the terminally ill has led to the adoption of many medical protocols specifically addressing pain relief. On their own, most state legislatures and organized medicine have begun to solve these issues,[89] but grass-roots physician education and acceptance has been slow to ensure nationwide compliance in palliative care. With the U.S. Supreme Court's acknowledgement and approval of palliative care for terminally ill patients[90] and with

87. MODEL GUIDELINES, *supra* note 23. For the model guidelines recommended for by state medical boards in addressing pain care by physicians, see *infra* Appendix.

88. *See generally* ANNUAL REVIEW OF STATE PAIN POLICIES, *supra* note 18.

89. *See infra* Tbl.1, note 91.

90. New York v. Quill, 521 U.S. 793 (1997); Washington v. Glucksberg, 521 U.S. 702, 735 (1997). In *Glucksberg*, the Court upheld a Washington State statute prohibiting physician-assisted suicide (WASH. REV. CODE § 9A.36.060(1) (1994)). *Id.* Justice Souter, in a concurring opinion, described the acceptance of palliative care and noted the following state statutes as examples that authorized such end-of-life pain management: IND. CODE § 35-42-1-2.5(a)(1) (Supp. 1996); IOWA CODE ANN. § 707A.3.1 (West Supp. 1997); KY. REV. STAT. ANN. § 216.304 (Michie 1997); MICH. COMP. LAWS ANN. § 752.1027(3) (West Supp. 1997); MINN. STAT. ANN. § 609.215(3) (West Supp. 1997); OHIO REV. CODE ANN. §§ 2133.11(A)(6), .12(E)(1)

the growing use of the nontraditional, elder abuse claims against physicians when adequate pain relief is not supplied to dying patients, physicians failing to keep current with recent trends in pain management are on notice of society's expectations regarding pain treatment. To further ignore these expectations, either through ignorance or fear of discipline, is to encourage the continued evolution of additional legal remedies to ensure that the elderly and the terminally ill have the pain relief they deserve. The use of elder abuse statutes as a tool to hold physicians liable for medical malpractice, when a standard of care concerning the treatment of chronically ill patients appears elusive, was only the first of many creative avenues attorneys will use to gain respect and adequate pain relief for their clients. Now that the standard of care for the treatment of chronically ill pain patients is well established through accepted medical protocols, the enforcement of a patient's right to pain relief again may be seen most efficiently through traditional medical malpractice actions.

Physicians should discuss pain issues with their patients and their patients' families, expressly document the plan of treatment in the medical record, and follow well-established pain management guidelines. As the rest of organized medicine figures out what many elderly patients already know—that pain hurts and that chronic pain really hurts—physicians will do a better job with pain management. If organized medicine is slow to grasp this concept, however, attorneys will continue to reinforce their clients' right to adequate pain relief through the courts. Both the legal and medical systems should be charged with finding the balance between fighting illegal drug users and guarding against the negligence of undertreating a patient's pain—not an enviable task. Although it seems as though medical protocols regarding pain management will keep fewer physicians from being criminally prosecuted, the possibility of more physicians being held liable for elder abuse and neglect through traditional medical malpractice negligence suits remains significant. Certainly, as the medical protocols for the treatment of chronic pain become more widespread, noncompliant physicians will find themselves unable to hide in the shelter of an ambiguous standard of care that protected them in the past from negligence actions.

(West 1994); R.I. GEN. LAWS § 11-60-4 (Supp. 1996); S.D. CODIFIED LAWS § 22-16-37.1 (Michie Supp. 1997); TENN. CODE ANN. § 39-13-216(b)(2) (1996). *Glucksberg*, 521 U.S. at 780 (Souter, J., concurring).

Table 1

State Medical Board Polices[91]

STATE	POLICY TYPE ADOPTED	YEAR	TITLE OR REFERENCE NUMBER
Alabama	Regulation	2000	Ala. Admin. Code r. 540-X-4-.08
Arizona	Guideline	1997	Guidelines for Prescribing Controlled Substances
Arizona	Guideline	1999	Use of Controlled Substances for the Treatment of Chronic Pain
Arkansas	Regulation	1998	Regulation 2(6)
California	Guideline	1985	Guidelines for Prescribing Controlled Substances for Chronic Conditions
California	Guideline	1994	Guidelines for Prescribing Controlled Substances for Intractable Pain
California	Policy	1994	A Statement by the Medical Board
Colorado	Guideline	1996	Guidelines for Prescribing Controlled Substances for Intractable Pain
Florida	Guideline	1996	Management of Pain Using Dangerous Drugs and Controlled Substances
Florida	Regulation	1999	Fla. Admin. Code Ann. r. 64B8-9.013
Georgia	Guideline	1991	Management of Prescribing with Emphasis on Addictive or Dependence-Producing Drugs
Idaho	Guideline	1995	Prescribing Opioids for Chronic Pain
Iowa	Regulation	1997	653 Iowa Admin. Code 13.2 (148, 150, 150A, 272C)
Kansas	Guideline	1998	Guidelines for the Use of Controlled Substances for the Treatment of Pain
Kentucky	Guideline	1996	Guidelines for Prescribing Controlled Substances

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91. Aaron M. Gilson et al., *Improving State Medical Board Policies: Influence of a Model*, 31 J.L. MED. & ETHICS 119, 123 (2003).

Table 1—*Continued*

STATE	POLICY TYPE ADOPTED	YEAR	TITLE OR REFERENCE NUMBER
Kentucky	Guideline	2001	Model Guidelines for the Use of Controlled Substances in Pain Treatment
Louisiana	Regulation	2000	La. Admin. Code 46:XLV.6915 (et seq.)
Maine	Regulation	1999	Code Me. R. 02-373-011
Maryland	Guideline	1996	Prescribing Controlled Substances
Massachusetts	Guideline	1989	General Guidelines for the Use of Narcotic Analgesics in Chronic Pain
Massachusetts	Guideline	2001	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (adopted by reference)
Minnesota	Guideline	1988	Cancer Pain Management Information
Minnesota	Guideline	1995	The Common Denominator and Common Sense
Minnesota	Policy Statement	2000	Pain Management: A Patient's Right to Adequate Pain Control
Mississippi	Policy Statement	1997	Pain, Pain Management and Mississippi Medical Board of State Licensure Scrutiny
Mississippi	Regulation	1999	Miss. Code Ann. § 50-013-022
Missouri	Guideline	2001	Palliative Care Guidelines
Missouri	Guideline	2001	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Montana	Guideline	1996	Statement on the Use of Controlled Substances in the Treatment of Intractable Pain, Guidelines for Prescribing Opioid Analgesics for Chronic Pain
Nebraska	Guideline	1999	Guidelines for the Use of Controlled Substances for the Treatment of Pain
Nevada	Regulation	1996	Nev. Admin. Code 630.255
Nevada	Regulation	1999	Nev. Admin. Code 630.020
Nevada	Regulation	1999	Nev. Admin. Code 630.193

(*Continued on next page*)

Table 1—*Continued*

STATE	POLICY TYPE ADOPTED	YEAR	TITLE OR REFERENCE NUMBER
Nevada	Regulation	1999	Nev. Admin. Code 630.195
Nevada	Regulation	1999	Nev. Admin. Code 630.197
Nevada	Regulation	1999	Nev. Admin. Code 630.230
Nevada	Regulation	2000	Nev. Admin. Code 630.187
Nevada	Regulation	2000	Nev. Admin. Code 630.230
New Hampshire	Guideline	2000	Guidelines for the Use of Controlled Substances in the Management of Chronic Pain
New Jersey	Regulation	1997	N.J. Admin. Code § 13:35-7.6
New Mexico	Guideline	1996	Guidelines on Prescribing for Pain
New York	Guideline	2000	Policy Statement for the Use of Controlled Substances for the Treatment of Pain
North Carolina	Policy Statement	1996	Management of Chronic Non-Malignant Pain
North Carolina	Policy Statement	1999	End-of-Life Responsibilities and Palliative Care
North Carolina	Policy Statement	1999	Joint Statement on Pain Management in End-of-Life Care
North Dakota	Regulation	1995	N.D. Cent. Code §§ 19-03.3-01 to -06.
Ohio	Regulation	1998	Ohio Admin. Code Ann. 4731-21-01-06
Oklahoma	Guideline	1994	Guidelines for Prescribing Controlled Substances for Intractable Pain
Oklahoma	Regulation	1999	Okla. Admin. Code 435:10-7-11
Oregon	Policy Statement	1991	Statement of Philosophy: Appropriate Prescribing of Controlled Substances
Oregon	Policy Statement	1995	Pain Management on Acute Conditions and Statement Terminal Illness
Oregon	Regulation	1996	Or. Admin. R. 847-015-0030
Oregon	Policy Statement	1999	Current Philosophy on Pain Management
Pennsylvania	Regulation	1985	49 Pa. Code § 16.92
Pennsylvania	Guideline	1998	Guidelines for the Use of Controlled Substances in the Treatment of Pain

(*Continued on next page*)

Table 1—*Continued*

STATE	POLICY TYPE ADOPTED	YEAR	TITLE OR REFERENCE NUMBER
Rhode Island	Guideline	1995	Guidelines for Long Term Pain Management
South Carolina	Guideline	1999	Guidelines for the Use of Controlled Substances for the Treatment of Pain
South Dakota	Guideline	1999	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Tennessee	Policy Statement	1995	Management of Prescribing with Emphasis on Addictive or Dependence-Producing Drugs
Tennessee	Regulation	1999	Tenn. Comp. R. & Regs. R. 0880-2-.14
Texas	Policy Statement	1993	Pain Control and the Texas State Board of Medical Examiners
Texas	Regulation	1995	22 Tex. Admin. Code § 170.1-170.3
Utah	Policy Statement	1992	Prescribing Controlled Substances for Cancer Pain: Position Paper of the Utah Division of Occupational and Professional Licensing
Utah	Guideline	1999	Model Guidelines for the Use of Controlled Substances for the Treatment of Pain
Vermont	Guideline	1996	Report of the Prescribing Practices Committee
Virginia	Guideline	1998	Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain
Washington	Policy Statement	1987	Bulletin to Physicians Issued by the Medical Disciplinary Board
Washington	Policy Statement	1989	Policy Statement on Chronic Pain Issued by the Medical Disciplinary Board
Washington	Policy Statement	1992	Guidelines on Opiate Usage
Washington	Policy Statement	1996	Guidelines for the Management of Pain

(*Continued on next page*)

Table 1—*Continued*

STATE	POLICY TYPE ADOPTED	YEAR	TITLE OR REFERENCE NUMBER
Washington	Regulation	1999	Wash. Admin. Code § 246-919-800
West Virginia	Policy Statement	1997	Positive Statement on the Use of Opioids in the Treatment of Chronic Non-Malignant Pain
West Virginia	Policy Statement	2001	Joint Policy Statement on Pain Management at the End of Life
Wyoming	Policy Statement	1996	Letter to Wyoming Physicians

Appendix

Model Guidelines for the Use of Controlled Substances for the Treatment of Pain[92]

Section I: Preamble

The (name of board) recognizes that principles of quality medical practice dictate that the people of the State of (name of state) 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 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 statutory 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 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 recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the *U.S. Agency for Health Care and Research Clinical Practice Guidelines* for a sound approach to the management of acute[1] and cancer-related pain.[2] The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic 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 (name of board) is obligated under the laws of the State of (name of state) to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion

92. MODEL GUIDELINES, *supra* note 23.

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 purposes.

> 1. Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. *Clinical Practice Guideline.* AHCPR Publication No. 92-0032. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. February 1992.
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> 2. Jacox A., Carr D.B., Payne R., et al. Management of Cancer Pain. *Clinical Practice Guideline No. 9.* AHCPR Publication No. 94-0592. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. March 1994.

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 or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

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 control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, 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 adopted the following guidelines 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 record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should 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, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. 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:

   - urine/serum medication levels screening when requested;
   - number and frequency of all prescription refills; and
   - reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

   At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of 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, i.e., ability to work, need of health care resources, activities of daily living and quality of social life.

If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. 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 pose 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 may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records

The physician should keep accurate and complete records to include:

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- evaluations and consultations;
- treatment objectives;
- discussion of risks and benefits;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements; and
- 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, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to *the Physicians Manual of the U.S. Drug Enforcement Administration* and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.