

# SPECIAL REPORT

# MIEC Claims Alert

Number 27  
May 2000

## Failure to treat pain: “elder abuse” claims threaten MDs

### INSIDE

<i>Doctor charged with under-treating pain . . . . .</i>	<i>1</i>
<i>National campaign encourages complaints . . . . .</i>	<i>1</i>
<i>MICRA does not apply in elder abuse cases . . . . .</i>	<i>2</i>
<i>DEA recognizes treatment for intractable pain . . . . .</i>	<i>2</i>
<i>MIEC’s recommendations . . . . .</i>	<i>3</i>
<i>How to reach MIEC . . . . .</i>	<i>3</i>
<i>Resources from MIEC’s Loss Prevention Department . . . . .</i>	<i>4</i>

### Special Report Claims Alert

A publication of the Loss Prevention Department, Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland, CA 94618. Articles are not legal advice. Reproduction with permission. © 2000, MIEC.



*This article on an important topic about which the law is still emerging was written by medical malpractice health law attorney, David E. Willett, Esq., of the San Francisco law firm of Hassard Bonnington. Mr. Willett is MIEC’s general counsel.*

### Doctor charged with under-treating

On February 3, 2000, newspapers throughout the country received a press release describing an Alameda County Superior Court judge’s ruling that failure to treat pain adequately is a form of elder abuse. The case, which will now proceed to trial, involves an 85 year old man dying of lung cancer, who was admitted to the hospital by the defendant physician. The patient’s complaint was intolerable pain. Pain levels ranging from 7-10 on a 10 point scale were charted by nurses during a five-day stay. After discharge, the patient’s family found another physician who prescribed pain medication. The family claims that the patient’s pain was then relieved, although the patient died the following day.

The patient’s family complained to the Medical Board of California, which they say failed to take any action despite a consultant’s conclusion that pain care during hospitalization “was indeed inadequate.” Subsequently, the family sued the attending physician, alleging violation of California’s “Elder Abuse Act.”

### Campaign encourages complaints

The pending trial is the product of two new developments, reflecting public concern and a recent judicial decision. The suit was sponsored by the Compassion in Dying Federation. A January, 1998 Federation press release invited complaints:

“...The Federation is interested in learning of any cases where it is believed that a dying patient suffered unnecessarily, particularly cases where the suffering could have been relieved by the provision of strong pain medication...”

Last year, the Federation sent a letter to all state medical boards, asking them to encourage proper treatment of end-of-life pain. It does not seem happenstance that the Oregon Board of Medical Examiners announced on September 1, 1999, that a Roseburg, Oregon pulmonologist entered into a stipulated order admitting “unprofessional or dishonorable conduct” and “gross negligence or repeated negligence” for failure to prescribe adequate pain medication for patients, including some who were dying. Compassion in Dying headquarters are in Portland, Oregon. A field office was recently established in San Francisco.

The suit sponsored by the Federation in Alameda County takes advantage of a March, 1999 California Supreme Court decision, *Delaney v. Baker*.<sup>1</sup> The *Delaney* decision interprets a California statute enacted in 1991, the Elder Abuse and Dependant Adult Civil Protection Act.<sup>2</sup> The law addresses neglect or abuse in the care of either elder persons, age 65 or older, or “dependent adults,” a term which includes any person between the ages of 18 and 64 while an inpatient in a 24-hour health facility. “Neglect” means the negligent failure to provide medical care by a person responsible for care.

### **MICRA<sup>3</sup> does not apply**

In *Delaney*, the Supreme Court decided that a provision in the Elder Abuse Act (§15657.2) which states that actions based on a health care provider’s alleged professional negligence “shall be governed by those laws which specifically apply to those professional negligence causes of action” **does not** mean that MICRA displaces remedies available under the Elder Abuse Act. Instead, Elder Abuse Act remedies are available when the defendant has been guilty of “recklessness, oppression, fraud, or malice in the commission of this abuse.” These remedies include the award of reasonable attorneys’ fees and costs, and damages up to \$250,000 for the *decedent’s* pain and suffering. Otherwise, the patient’s death would cut off any claim for the patient’s pain and suffering. In a friend-of-the-court brief filed in the *Delaney* case, the California

Medical Association and the California Healthcare Association argued unsuccessfully that claims arising out of the provision of professional services should not be susceptible to Elder Abuse Act remedies.

An active publicity campaign directed to individuals likely to harbor strong feelings, coupled with the possibility of recovering attorneys’ fees and significant damages under the Elder Abuse Act, suggest that suits claiming under-treatment of pain will become more common. Claims are not limited to treatment of dying patients, and might involve treatment of either elders or any adult inpatient. Mere neglect does not satisfy the requirements of the Elder Abuse Act, but aggravated circumstances thought to constitute “recklessness, oppression, fraud, or malice,” such as the failure to heed patient or family complaints of pain, may be asserted as justification for suit.

Historically, physicians have been concerned about charges of over-prescribing for pain<sup>4</sup>. Now, physicians accused of under-prescribing may be targets for disciplinary actions and civil lawsuits. California’s “Pain Patient’s Bill of Rights” enacted in 1997<sup>5</sup>, provides that a physician may refuse to prescribe opiate medication for a patient who requests treatment for severe chronic intractable pain, but also requires the physician to inform the patient that there are physicians who specialize in the treatment of such pain with methods that include the use of opiates. The California Intractable

Pain Treatment Act<sup>6</sup> provides that no physician shall be subject to medical board disciplinary action for prescribing or administering controlled substances in the course of treatment of a person for intractable pain. The determination of “intractable pain” requires evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of pain. However, it remains unlawful to prescribe, administer, or dispense controlled substances in a manner not consistent with public health and welfare.

### **DEA recognizes treatment**

The federal Drug Enforcement Agency (DEA) regulations recognize the appropriateness of prescribing narcotics to patients to relieve intractable pain “...in which no relief or cure is possible or none has been found after reasonable efforts.”<sup>7</sup>

The federal Health Care Financing Administration (HCFA) has said that the Patient Self-Determination Act requires health care institutions to inform patients of their right to request pain treatment, and pressure is also being brought upon hospitals and long-term care facilities to ensure appropriate pain management. Backers of the Pain Relief Promotion Act, now pending in Congress, say that the Act would ease physician concerns about treating pain by specifying that use of controlled substances to alleviate pain is a “legitimate medical purpose... even if the use

of such a substance may increase the risk of death.” Although the bill is supported by the AMA, a number of specialty and state medical societies have expressed opposition, for fear that provisions intended to preclude physician-assisted suicide invite governmental intrusion into professional decision-making. Physicians must be aware that the treatment of pain is now an issue, in the press, in legislatures, and in the courts.

### Notes

1. 20 Cal.4th 23.
2. Welfare & Institutions Code §§15600, et. seq.
3. California's Medical Injury Compensation Reform Act, a package of malpractice tort reforms passed in 1975.
4. A recently-published study finds that persistent undertreatment of pain reflects failure by legal and reimbursement systems to keep up with improved methodology, but concludes that fear of prosecution or payor displeasure for appropriate treatment is not justified; *Journal of Law, Medicine & Ethics* (1998; 26:265-353), abstracted in 281 *JAMA* 406, February 3, 1999.
5. Health & Safety Code Section 12490, et. seq.
6. Business and Professions Code Section 2241.5.
7. 21 C.F.R. §1306.07

### MIEC's recommendations

Several studies have indicated that some physicians are unfamiliar with state and/or federal laws that permit them to prescribe high doses of narcotics for the treatment of intractable pain. (See also end note #4). Other physicians who prescribe or administer high-dose narcotics for intractable pain fear being sued if

the patient becomes addicted to or dependent on the drug(s), a concern which experts say is over-emphasized. Current and proposed laws should allay these concerns.

**Limited protections.** Existing and proposed state and federal legislation will permit physicians to provide appropriate treatment without fear of disciplinary action or litigation. But the protections of the laws only apply to treatment of intractable pain. Special conditions apply to prescribing and dispensing controlled substances to a person the physician knows to be using drugs or other substances for non-therapeutic purposes.

**MBC disciplinary authority.** The Intractable Pain Treatment Act does not interfere with the authority of the Medical Board of California to discipline a physician who: (a) prescribes or administers a controlled substance for non-therapeutic use; (b) writes a false prescription for a controlled substance; or, (c) prescribes or administers a controlled substance in a manner that is not consistent with the public health and welfare.

**Documentation.** Under current state and federal laws, physicians must properly document their purchases and disposal of the controlled substances. Documentation includes the date of purchase, details of the sale or disposal of the drugs by the physician, the name and address of the person who receives the drugs, and the reason the drugs were dispensed or disposed.

**Need help?** Physicians who are

uncertain about the medical appropriateness of prescribing or dispensing controlled substances for intractable pain, or the recommended drugs or dosages, should consult with a qualified medical specialist. Questions about legal issues related to treatment of specific patients for intractable claim can be directed to MIEC's Claims Department.

### How to reach MIEC

#### Loss Prevention Department

Oakland, CA  
510/428-9411 (Bay Area)  
Outside 510: 800/227-4527  
Fax: 510/420-7066  
E-mail: lossprevention@miec.com

#### Home Office Claims and Underwriting Departments

Oakland, CA  
510/428-9411 (Bay Area)  
Outside 510: 800/227-4527  
Fax: 510/654-4634  
E-mail: claims@miec.com  
E-mail: underwriting@miec.com

#### Hawaii Claims Office

Honolulu, HI  
Phone: 808/545-7231  
Fax: 808/531-5224

#### Idaho Claims Office

Boise, ID  
Phone: 208/344-6378  
Fax: 208/344-7192

#### Visit MIEC on the Internet:

[www.miec.com](http://www.miec.com)

## Resources from MIEC's Loss Prevention Department

**Answers to professional liability questions.** The Loss Prevention Department responds to a wide range of general questions about malpractice liability, and obtains legal advice for policyholders when indicated. *Sample questions:* How long must a physician keep medical records? How does a doctor properly withdraw from a patient's care? What is the best method to obtain informed consent and how should consent be documented? (*Direct questions about specific patients to an MIEC claims representative.*)

**Medical Records text.** MIEC's booklet, *Medical Record Documentation for Patient Safety and Physician Defensibility*, offers practical advice for maintaining defensible medical records and avoiding documentation deficiencies that can compromise a medical defense. The book includes useful chart forms,

answers to questions about medical records, and a self-assessment form to review documentation quality. The book is free to MIEC policyholders and offers Category I continuing medical education credits.

**Chart forms and templates.** MIEC's *Chart Forms and Templates for a Medical Practice*, offered free to MIEC policyholders, is a packet that includes ready-to-use forms and templates that help physicians and staff organize medical charts, find data easily, and document important information that protects patients and physicians. Camera-ready forms can be reproduced for office use. The entire library of forms is contained on an included PC computer disk.

**Extensive resource library.** Policyholders can request sample medical record chart and consent forms; patient education materials; articles on medical-legal topics; lists of resources for practice guidelines; vendors of electronic

and voice recognition medical records systems; and more.

**On-site loss prevention survey.** MIEC's loss prevention specialists conduct complimentary individual or group practice surveys in which record-keeping, office procedures and practice policies are analyzed. Surveyors meet separately with physicians and their office staff to discuss liability issues relevant to the practice and specialty, and offer practical advice for reducing liability exposure. A written report summarizes the survey findings and provides constructive suggestions for improvements.

**Newsletters and alerts:** MIEC publishes the *Claims Alert*; *Special Report*; *We Get Letters...*; *New Law Alert*; and *Managing Your Practice* newsletter series, and other publications that offer helpful and timely solutions to practice problems and answers to policyholders' questions. Contact the Loss Prevention Department or visit our website for a list of titles.