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LEGAL AND REGULATORY BARRIERS TO ADEQUATE PAIN CONTROL FOR ELDERS IN LONG-TERM CARE FACILITIES

*Laura D. Seng**

I. INTRODUCTION

Almost one-half of the American population will live out a portion of their lives in a long-term care facility.¹ The combination of shorter hospital stays, extended life spans, and fewer family-member caregivers has led to an increase in the use of long-term care facilities for elder care, especially for care at the end of life.² By 2020, it is estimated that more than 40% of Americans will die in nursing homes.³ Among other things, appropriate care at the end of life includes adequate pain management. Although the majority of elders experience either chronic health conditions (such as arthritis) or painful terminal illnesses (such as cancer) that require proper pharmacological treatment, as many as 83% of nursing home residents experience inadequately treated pain that impairs mobility, impacts psychological well-being, and diminishes quality of life.⁴

The inappropriate pain management of elders in long-term care facilities results from a combination of several factors. Misperceptions about pain, societal attitudes regarding the use of pre-

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¹ LAST ACTS, MEANS TO A BETTER END: A REPORT ON DYING IN AMERICA TODAY 31 (2002) (reporting that 1.6 million people were living in nursing homes as of 1999), available at <http://www.lastacts.org/files/misc/meansfull.pdf>. The terms “nursing home” and “long-term care facility” are used interchangeably throughout this article.

² By 2030, almost 21 million elders will require assistance with daily activities, necessitating either assistance at home or residential care. LAWRENCE A. FROLIK & ALISON McCHRISTAL BARNES, ELDERLAW: CASES AND MATERIALS, 2002 SUPPLEMENT 33 (2d ed. 2002).

³ Joan M. Teno et al., *Persistent Severe Pain in US Nursing Homes*, THE CENTER FOR GERONTOLOGY AND HEALTH CARE RESEARCH AT BROWN UNIVERSITY, available at <http://www.chcr.brown.edu/dying/> (last visited Feb. 13, 2003) (on file with the New York City Law Review).

⁴ *Id.*

scription drugs for pain control, and the unique characteristics of the elderly population itself all contribute to poor pain management.⁵ Furthermore, our current legal and regulatory system creates additional roadblocks to effective pain control. Conflicting legislative policies for drug abuse prevention versus pain control, Medicare/Medicaid reimbursement rules and regulations, the nursing home licensure/accreditation survey process, state medical licensing board policies, and medical staff education norms have all created barriers to effective pain management for the elderly.⁶

This article will explore the legal barriers to appropriate pain control in long-term care facilities. First, an overview of the factors demonstrating the need for improved pain management in long-term care facilities will be provided. Second, the multi-faceted legal barriers to adequate pain control will be examined, beginning with the conflicts between legislative policies for drug abuse prevention and prescription drug control and those promoting pain management. Third, barriers within the medical care system will be explored, including the regulation of physician practice, medical staff education norms, and the effect of state licensing board disciplinary actions. Regulation of long-term care facilities will then be discussed, focusing on the Centers for Medicare & Medicaid Services' (CMS)⁷ nursing home survey process, drug utilization regulations, and hospice access barriers. Lastly, recommendations will be made to improve pain management for the elderly. These recommendations include changes in state physician practice, statutes, as well as changes to CMS survey guidelines and Medicare reimbursement rules, development of state pain management policies, and the promotion of federal legislative action.

II. OVERVIEW OF THE NEED FOR IMPROVED PAIN MANAGEMENT IN LONG-TERM CARE FACILITIES

Unrelieved pain has both physiological and psychological ef-

⁵ Terrie Lewis, *Pain Management for the Elderly*, 29 WM. MITCHELL L. REV. 223, 231 (2002).

⁶ ABA Comm'n on Legal Problems of the Elderly, *Report to the House of Delegates: Proposed ABA Policy on Legal Obstacles to Effective Pain Management* (Apr. 2000) (adopted by the House of Delegates, July 11, 2000), available at <http://www.abanet.org/aging/>. See Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J. L. MED. & ETHICS 28 (2001); Susan Okie, *Doctor's Duty to Ease Pain at Issue in Calif. Lawsuit: Physicians are Wary in Prescribing Narcotics*, WASHINGTON POST, May 7, 2001, at A3.

⁷ The Centers for Medicare & Medicaid Services was formerly known as HCFA – the Health Care Financing Administration. See FEDERAL REGULATORY DIRECTORY 520 (11th ed. 2003).

fects which can negatively impact a person's ability to maintain social relationships, daily routines and activities, and normal sleep patterns.⁸ Pain not only impacts the affected individual, it also affects family members and caregivers who must bear the psychological and emotional burden of watching their loved one suffer.⁹ With the increasing number of elders residing in long-term care facilities, pain management for this segment of the population has become vitally important.¹⁰ Surveys estimate that between 45% and 85% of nursing home residents live in pain.¹¹ For the institutionalized elderly, the combination of chronic health conditions and terminal illnesses will result in 1.27 million persons needlessly suffering from pain each year.¹² While 90% to 95% of all serious pain can be effectively treated, at least half of dying persons report being in pain at the end of their lives.¹³ For the terminally ill, pain is the symptom most often feared.¹⁴

The appropriate treatment of pain has been recognized as both a legal duty and an ethical duty of health care professionals. The Agency for Health Care Research and Quality (formerly the Agency for Health Care Policy and Research of the Department of Health and Human Services) states that "the ethical obligation to manage pain and relieve the patient's suffering is at the core of a health care professional's commitment."¹⁵ Similarly, the American Medical Association Code of Medical Ethics declares that "physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care."¹⁶ Recognizing both the duty to provide adequate pain control and

⁸ Teno, *supra* note 3, at 8.

⁹ LAST ACTS, *supra* note 1, at 34.

¹⁰ Furrow, *supra* note 6, at 42 (estimating that half of Americans age 65 and over will live in a nursing home).

¹¹ Teno, *supra* note 3.

¹² *Id.* (reporting a 1998 study published in the Journal of the American Medical Association that found that 40% of cancer patients discharged from hospitals to nursing homes experienced daily pain, yet 25% of these patients had no analgesic medication prescribed). See also LAST ACTS, *supra* note 1, at 31 (citing another recent study finding that many dying nursing home residents received either inadequate pain treatment or none at all).

¹³ LAST ACTS, *supra* note 1, at 34.

¹⁴ Teno, *supra* note 3.

¹⁵ AGENCY FOR HEALTH CARE POLICY & RESEARCH, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. 94-0592, ACUTE PAIN MANAGEMENT: OPERATIVE OR MEDICAL PROCEDURES AND TRAUMA 4 (1992).

¹⁶ AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS H-140.966 (2001), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-140.966.HTM&st=h-140.966&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&.

the numerous legal and regulatory barriers that impede appropriate prescription drug therapy, the American Bar Association adopted a resolution urging the removal of these barriers in support of the individual's right to receive effective pain management.¹⁷ Likewise, Congress has also recognized the need for appropriate pain management.¹⁸ For example, the Congressional findings in the Pain Relief Promotion Act state, "inadequate treatment of pain . . . is a serious public health problem affecting hundreds of thousands of patients every year"¹⁹ Finally, the U.S. Supreme Court has supported a person's legal right to receive adequate pain relief, even where the administration of appropriate medications may result in unconsciousness or hasten death.²⁰

Pain may be characterized in two ways. Within long-term care facilities, the elderly suffer from both acute and chronic pain.²¹ Acute pain results from an identifiable source and is of limited duration (such as pain following surgery).²² Because acute pain is easily identifiable due to its link with a traumatic event, pain management usually follows a standardized plan tailored toward a short recovery period. Chronic pain, on the other hand, may not be linked to a single traumatic event and is often highly individualized in scope and severity, therefore, it requires specialized assessment and medical treatment plans. Chronic pain arises from either malignant (cancer) or nonmalignant sources (such as arthritis).²³ Because an individual's response to chronic pain is less predictable, medical science has been slower to adopt aggressive standardized

¹⁷ ABA Comm'n on Legal Problems of the Elderly, *supra* note 6.

¹⁸ Controlled Substances Act § 1, 21 U.S.C. § 801(1) (2000) ("Many of the drugs included within this subchapter have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.").

¹⁹ H.R. 5544, 106th Cong. § 2 (2000) ("Congress finds that (1) in the first decade of the new millennium there should be a new emphasis on pain management and palliative care . . . (4) the dispensing or distribution of certain controlled substances for the purpose of relieving pain and discomfort even if it increases the risk of death is a legitimate medical purpose and is permissible under the Controlled Substances Act; (5) inadequate treatment of pain, especially for chronic diseases and conditions, irreversible diseases such as cancer, and end-of-life care, is a serious public health problem affecting hundreds of thousands of patients every year; physicians should not hesitate to dispense or distribute controlled substances when medically indicated for these conditions").

²⁰ *Washington v. Glucksberg*, 521 U.S. 702, 779-780 (1997); *Vacco v. Quill*, 521 U.S. 793, 808 (1997).

²¹ FURROW, *supra* note 6, at 29.

²² SHIRLEY ANN SMITH, HOSPICE CONCEPTS: A GUIDE TO PALLIATIVE CARE IN TERMINAL ILLNESS 108 (2000).

²³ FURROW, *supra* note 6, at 29.

methods of treatment.²⁴ However, pain specialists now generally agree that chronic pain in some patients can be effectively managed with the use of opioid drugs.²⁵

Opioid analgesics are derived from opium and are chemically related to morphine; thus, they serve as effective pain relievers, but are subject to side effects and the potential for abuse.²⁶ Because of confusion over the difference between physical dependence and drug addiction, physicians may be reluctant to prescribe opioids, even though this class of medications provides the most effective relief of chronic pain.²⁷ Although true drug “addiction” to opioids is rare, a common misperception exists that the elderly are more likely to become addicted to pain medications.²⁸ While age-induced metabolic changes may increase the likelihood of drug tolerance or dependence, addiction remains an exceedingly rare outcome during long-term opioid treatment.²⁹ Numerous studies indicate that the use of morphine or other opioids is not only effective as a traditional treatment for cancer pain, but is also the treatment of choice for persons experiencing chronic musculoskeletal pain.³⁰ Although 90% of chronic pain could be controlled through existing legal medications,³¹ chronic nonmalignant pain in the institutionalized elderly remains poorly managed up to 70% of the time.³²

The first step in effective pain management is the appropriate assessment of a person’s pain, including causation, level of discomfort, character and duration of the pain, aggravating factors, and past effective methods for alleviation. The elderly present special problems with regard to accurate pain assessment due to cognitive impairments, memory deficits, and communication barriers, such

²⁴ *Id.*

²⁵ Russell K. Portenoy, *Opioid Therapy for Chronic Nonmalignant Pain: Clinicians’ Perspective*, 24 J. L. MED. & ETHICS 296, 303 (1996).

²⁶ Jacob B. Nist, Note, *Liability for Overprescription of Controlled Substances*, 23 J. LEGAL MED. 85, 86-87 (2002). See also LAST ACTS, *supra* note 1, at 34 (examples of opioids include morphine, codeine, oxycodone, methadone and fentanyl).

²⁷ Portenoy, *supra* note 25, at 298. Drug tolerance refers to the phenomenon where a patient requires an increased dosage to achieve the same medical effect. Physical dependence is defined by the development of withdrawal symptoms following abrupt discontinuation of an opioid. After the withdrawal period is completed, the patient does not “crave” the drug. Drug addiction is characterized as a loss of control over drug use, compulsive use, and continued use of a drug despite physical and psychological harm to the patient and his/her relationships. *Id.* at 300-01.

²⁸ Teno, *supra* note 3.

²⁹ Portenoy, *supra* note 25, at 302.

³⁰ *Id.* at 297.

³¹ See ABA Comm’n on Legal Problems of the Elderly, *supra* note 6.

³² Furrow, *supra* note 6, at 29.

as diminished hearing or difficulty with verbalization following a stroke.³³ Because assessing pain in this population is difficult, pain often goes undetected and severity levels are underreported.³⁴ In addition to physical and neurological barriers that lead to underreported pain, studies indicate that persons suffering from a terminal disease may purposefully underreport pain.³⁵ For example, a dependent elderly person may not report pain because of the distress it causes in his or her caregivers; this is often coupled with the fear that increasing pain is a signal of impending death.³⁶ Thus, one study showed that more than 25% of nursing home residents with cancer who reported daily pain to the surveyor had not reported such pain to their caregivers and therefore had not received *any* pain medication from their caregivers.³⁷

Assuming that the level of pain is accurately assessed, treatment of pain in the elderly also presents unique challenges. Metabolic changes occur with aging, and monitoring the actual effect of medications is critical, as doses may require frequent adjustments.³⁸ While metabolic changes may increase sensitivity to certain medications, drug sensitivity does not equate to medication intolerance.³⁹ Because many caregivers mistakenly presume that the elderly cannot “tolerate” certain medications, ineffective lower doses may be administered rather than substituting a medication that is equally effective without the side-effects.⁴⁰ Additionally, the majority of institutionalized elderly receive multiple medications for concurrent ailments; this increases the likelihood of drug interactions that may hinder the effectiveness of any given medication.⁴¹

³³ Terrie Lewis, *supra* note 5; PAIN IN THE ELDERLY, INT’L. ASS’N. FOR THE STUDY OF PAIN 7 (Betty R. Ferrell & Bruce A. Ferrell eds., 1996) (noting that among nursing home residents, over 50% may have substantial dementia or psychological illnesses resulting in memory deficits, attention deficits, and diminished expressive capacity (aphasia)).

³⁴ Terrie Lewis, *supra* note 5.

³⁵ PAIN IN THE ELDERLY, *supra* note 33, at 6.

³⁶ *Id.*

³⁷ Nist, *supra* note 26, at 88 (citing Roberto Bernabei et al., *Management of Pain in Elderly Patients with Cancer*, 279 J.A.M.A. 1877 (1998)).

³⁸ Terrie Lewis, *supra* note 5, at 230 (noting that the elderly are more sensitive to nonsteroidal anti-inflammatory drugs, which can produce dangerous side effects more often than would be present in the nonelderly adult population, such as stomach ulcers and gastrointestinal bleeding).

³⁹ AGENCY FOR HEALTH CARE POLICY & RESEARCH, U.S. DEP’T OF HEALTH & HUMAN SERVS., PUB. NO. 94-0592, MANAGEMENT OF CANCER PAIN CLINICAL GUIDELINE NUMBER 9 (1994), *available at* <http://hstat.nlm.nih.gov/hq/Hquest/screen/TextBrowse/t/1074708452929/s/59888>.

⁴⁰ *Id.*

⁴¹ PAIN IN THE ELDERLY, *supra* note 33, at 7-8.

The elderly present many challenges to effective pain management based on their physical characteristics, high incidence of cognitive impairments, and differences in response to certain drugs; this necessitates the need for further research on the appropriate use of particular medications for pain control. While further scientific studies are needed to determine the efficacy of particular therapies with the elderly population, this article will focus only on the legal and regulatory barriers to effective pain management.

III. LEGAL BARRIERS TO ADEQUATE PAIN CONTROL

According to Ben A. Rich, J.D., associate professor of bioethics, University of California at Davis Medical School, "Pain patients have been made the noncombatant casualties of the war on drugs Physicians openly and notoriously acknowledge that they underprescribe [narcotic pain medicines] in order to avoid regulatory scrutiny."⁴² This statement graphically illustrates that legislative policies and regulatory agency practices have altered the medical standard of care, and thus, interfered with appropriate pain management. In addition to the barriers arising from the regulation of individual physician practices, the regulatory policies imposed on long-term care facilities also contribute to inadequate pain management through reimbursement disincentives, excessive documentation requirements, and access barriers to hospice services. Underlying these roadblocks is a basic conflict in our nation's legislative policy — whether to support or quell the use of opioids for pain management.

A. *Conflicting Legislative Policies*

Abuse and illegal use of narcotics led to strict laws governing health care providers' ability to order and dispense controlled substances. Regulatory sanctions and criminal prosecution of physicians are unfortunately a necessary evil, as prescription drug abuse of illegally obtained narcotics is a multibillion dollar market, and according to the U.S. Department of Justice, it is "as big [a problem] or bigger than street drugs."⁴³ To combat controlled substance abuse, limitations are placed on physicians' ability to prescribe narcotics; these regulatory hurdles also discourage the use of opioids for pain control.⁴⁴ In addition to policies that discourage prescribing opioids, physicians also face "guidelines" and

⁴² Okie, *supra* note 6.

⁴³ Nist, *supra* note 26, at 86 (citations omitted).

⁴⁴ SMITH, *supra* note 22, at 187 (stating that limitations on the number of doses

encouragement by state licensing boards to be vigilant in reporting suspected drug problems.⁴⁵ For example, the Colorado practice guidelines remind physicians that it is their professional responsibility to guard against abuse and their personal responsibility to protect their “practice from becoming an easy target for drug diversion, which could result in legal actions against you and damage your professional esteem.”⁴⁶ The combination of medical practice restrictions and the threat of disciplinary sanctions and criminal prosecution deter physicians from prescribing opioids for pain control. Physicians are then left with the troublesome task of harmonizing this reluctance to prescribe narcotics with the ethical duty to relieve pain and suffering using the most effective methods of treatment available.⁴⁷ Balancing the ethical and legal duties may be difficult for physicians who have been “conscripted” into service for the war on drugs.⁴⁸

Similar to the conflicts faced by individual physicians, Congress and state legislatures struggle to offset laws fighting substance abuse against those designed to promote pain relief. Legislatures are rightfully concerned with limiting drug abuse and impaired health care providers’ access to controlled substances.⁴⁹ The problems of drug diversion, abuse of prescriptive authority, and Medicare/Medicaid fraud all necessitate a legislative response that includes sanctions and criminal prosecution.⁵⁰ In contrast, these same legislative bodies recognize the need for statutory “approval” of controlled substances for pain management. For example, the Pain Relief Promotion Act (PRPA) was introduced as an amendment to the Controlled Substances Act to reinforce the legitimacy of using opioids for pain management, and to relieve physicians’ fear of disciplinary action arising from the appropriate use of narcotic therapy.⁵¹

that may be prescribed and triplicate-copy prescription programs discourage the use of opioids for pain control).

⁴⁵ See Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1, 57-58 (2000).

⁴⁶ *Id.* (citing COLORADO PRESCRIPTION DRUG ABUSE TASK FORCE, COLORADO GUIDELINES OF PROFESSIONAL PRACTICE FOR CONTROLLED SUBSTANCES FOR HEALTH CARE PROFESSIONALS WHO PRESCRIBE (3d ed. 1997)).

⁴⁷ See FURTOW, *supra* note 6, at 29.

⁴⁸ See Rich, *supra* note 45, at 5.

⁴⁹ See Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J. L. MED. & ETHICS 319, 321 (1996).

⁵⁰ *Id.*

⁵¹ ABA Comm’n on Legal Problems of the Elderly, *supra* note 6, at 8 (citing Pain Relief Promotion Act, H.R. 2260, 106th Cong. (1999)). However, in this author’s opinion, while the goals of the PRPA are laudatory, the Act will never pass Congress

Likewise, several states have enacted “intractable pain treatment” acts, which promote the use of opioid therapy.⁵² Many states developed their statutes by using the Model Pain Relief Act, developed by the American Society of Law, Medicine and Ethics, which creates a “safe harbor” from disciplinary action for a physician who prescribes opioid therapy, provided that the physician complies with the accepted practice guidelines for pain management.⁵³ This type of statute provides physicians with legislative approval for appropriate pain management and protection for their professional judgment and practice. However, the acts of some states characterize opioids as a “last resort” for pain control, which reinforces the misperception that opioids should not be utilized as a standard method of treatment for chronic pain.⁵⁴ In these states, a physician could still be disciplined for prescribing opioids “too early” in the patient’s therapy. Because many of the elderly will not report pain until it is quite severe, requiring these patients to first try other less effective medications before opioids only prolongs the pain and increases medication expenses for the patient. The discrepancies in the approaches of various state acts highlight the continued conflict among legislative policy interests.

B. Regulation of Physician Practice

Although intrusive regulatory policies and the fear of professional disciplinary action hinder appropriate medication prescribing, a more fundamental cause of inadequate pain management may be the lack of education and knowledge on the part of the health care providers.⁵⁵ Before a physician faces the regulatory barriers to effective pain management, he or she must first possess a knowledge base regarding appropriate professional standards for use of opioid therapy.⁵⁶ The majority of physicians receive little formal instruction in medical school related to pain management

because of the controversial section that would displace states’ existing assisted suicide laws. A similar version was reintroduced in 2000 (H.R. 5544), but this bill also never passed out of committee.

⁵² See LAST ACTS, *supra* note 1, at 34-36. Intractable pain is defined as “chronic pain that is difficult or impossible to manage with standard interventions.” TABER’S CYCLOPEDIA MEDICAL DICTIONARY 1555 (19th ed. 2001).

⁵³ Kathryn L. Tucker, *Improving Pain Care: A Safe Harbor is Not Enough, the Seas Outside the Harbor Must Be Rough*, THE ABA HEALTH LAW SECTION: THE HEALTH LAWYER, Vol. 11, No. 4, May 1999, at 15.

⁵⁴ ABA Comm’n on Legal Problems of the Elderly, *supra* note 6, at 10.

⁵⁵ FURROW, *supra* note 6, at 28.

⁵⁶ See Rich, *supra* note 45, at 5-6.

and palliative care;⁵⁷ until relatively recently, the prevailing culture among health care providers was one of “opiophobia.”⁵⁸ The fear of turning patients into addicts, and the societal pressure to reduce drug abuse combined to create this psychosocial impediment to appropriate prescriptive therapy.⁵⁹ In addition to opiophobia, the ongoing confusion among practitioners as to the differences between physical drug dependence and addiction compounds the reluctance to prescribe appropriate medications.⁶⁰

Not only do practitioners generally lack pain management education, physicians specializing in palliative care and pain management are a rarity.⁶¹ For example, in Indiana, out of the 13,461 physicians practicing in the year 2000, only 11 were board certified in palliative medicine.⁶² Without an adequate number of “leaders” in the field, physicians will be slow to accept the newest developments in pain control, including using opioids for chronic pain management of long-term care facility residents. However, this lack of education should be no excuse for breaching the (albeit emerging) standard of care — physicians have an affirmative duty to remain updated on continuing developments in their field of practice.⁶³

The legal duty to adequately manage pain is now emerging as a new area of malpractice and/or elder abuse litigation.⁶⁴ In a landmark elder abuse case, a California jury awarded \$1.5 million to the children of an 85-year-old who was dying of lung cancer and received inadequate pain management.⁶⁵ The jury found that because the standard of care called for continual pain medication,

⁵⁷ *Id.* at 5 and 14-15.

⁵⁸ “[O]piophobia denotes an unreasonable fear of and resultant reluctance to prescribe [or] administer . . . opioid analgesics, even for the relief of severe pain which is unresponsive to other available pain management strategies.” Rich, *supra* note 45, at 43.

⁵⁹ See 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, 336 (1998).

⁶⁰ See Portenoy, *supra* note 25, at 300.

⁶¹ LAST ACTS, *supra* note 1, at 38 (as of March 2002, only 917 doctors in the United States were board certified in palliative care).

⁶² *Id.* at 82-83.

⁶³ See Rich, *supra* note 45, at 35 n.199.

⁶⁴ See Terrie Lewis, *supra* note 5, at 233, 235.

⁶⁵ Despite repeated requests from family members and a visiting nurse, the patient’s physician prescribed inadequate pain medication for control of cancer pain. Following the patient’s death, the family’s medical expert testified that the standard of care required continual pain medication, and that the pain treatment actually received was “appalling.” The jury found the physician liable for reckless conduct and elder abuse under California law. *Doctor Tagged with \$1.5M Verdict in Landmark Elder Abuse Case*, 2 No. 11 ANDREWS NURSING HOME LEG. INSIDER 1, July, 2001, available at

the physician's failure to adequately prescribe rose to a level of reckless conduct.⁶⁶ If plaintiffs continue to pursue cases arising from undermedication of pain, physician incentives may increase for better pain management practices. But presently, undermedication is viewed as cautious and appropriate medical practice, and the existing regulatory systems only reinforce that viewpoint.

Beyond educational inadequacies, physicians encounter regulatory barriers to their daily practice of medicine. With regard to prescribing narcotics, physicians are regulated not only by the Food and Drug Administration and Drug Enforcement Administration, but also by state medical licensing boards, hospital quality assurance committees, Medicare and Medicaid drug utilization review boards, and private health insurers.⁶⁷ This intense level of regulatory scrutiny, coupled with the threat of criminal prosecution for improper use of controlled substances, has resulted in many physicians underprescribing opioids for pain control in order to avoid intrusive oversight of their practice.⁶⁸ Many states place limits on the number of narcotic prescriptions that can be written, the number of medication doses that can be dispensed with one prescription, and the duration of any particular prescription.⁶⁹ State laws trigger investigations of physicians for violating these arbitrary limits, even though the numeric standards have no clinical basis and do not consider an individual patient's pain control requirements.⁷⁰ Investigations may result in charges of unprofessional conduct and carry sanctions ranging from reprimands to suspension of practice or revocation of a physician's prescriptive authority.⁷¹ Even when a physician's prescribed opioid therapy is found to be appropriate, the investigation, disciplinary action, and appellate review process required to exonerate the doctor can be devastating to the professional's practice.⁷²

WESTLAW, ANNHLI Database (noting *Bergman v. Chin*, No. H-205732-1 (Cal. Super. Ct. Alameda County June 13, 2001)).

⁶⁶ *Id.*

⁶⁷ See ABA Comm'n on Legal Problems of the Elderly, *supra* note 6.

⁶⁸ Furrow, *supra* note 6, at 28.

⁶⁹ ABA Comm'n on Legal Problems of the Elderly, *supra* note 6, at 10-11.

⁷⁰ LAST ACTS, *supra* note 1, at 34.

⁷¹ Tucker, *supra* note 53.

⁷² Following the use of opioid treatment for seven chronic pain patients, a Louisiana physician's license was suspended. Upon appellate review, the court found that the doctor had acted in good faith, that the treatment plans were appropriate, and that there was no evidence of diversion or improper use of opioids. However, the vindication of the physician and reinstatement of full licensure consumed nearly four years. Johnson, *supra* note 49, at 320 (noting *In the Matter of Dileo*, 661 So. 2d 162 (La. App. 1995)).

While no medical license has been revoked for the appropriate prescribing of pain medications, the fear of disciplinary action continues to impact prescriptive practice.⁷³ A 1993 study of 897 physicians who were treating patients for cancer pain found that 61% identified physician reluctance to prescribe opioids as a barrier to good pain management.⁷⁴ The sheer volume of drug regulation to which physicians are subject heightens the fear that the state disciplinary board is ever watchful over their daily practice. For example, under “triplicate prescription” laws, physicians are keenly aware that every narcotic prescription they write is tracked for the purpose of identifying over-prescribing.⁷⁵ Every state that has initiated such a program recorded a “greater than 50% reduction in the prescribing of regulated drugs.”⁷⁶ Although a portion of this decrease reflects a lower rate of prescriptive abuse, the heightened scrutiny has greatly reduced the *legitimate* prescribing of most effective pain medications available to the elderly for cancer and chronic pain management.⁷⁷ A nationwide survey of medical licensing boards revealed that a physician may be recommended for investigation solely because the doctor administered opioids to a patient with nonmalignant pain for more than a six-month period.⁷⁸ Recognizing that the elderly commonly suffer from chronic nonmalignant pain, their physicians may be particularly reluctant to prescribe these medications for fear of disciplinary action.

While few licensure sanctions are actually levied against physicians for the over-prescription of opioids to pain patients, the risk of such action, when coupled with the rigor of the investigation process, are an effective deterrent to appropriate therapy.⁷⁹ In addition, physicians may also fear criminal prosecution if a high dose of opioids for pain management contributes to (hastens) a patient’s death from a terminal illness.⁸⁰ Once a disciplinary investi-

⁷³ Laurie Lewis, *Toward a Good Death in the Nursing Home: Pain Management & Hospice are Key*, *Caring for the Ages*, July 2001, at <http://www.amda.com/caring/july2001/gooddeath.htm> (on file with the New York City Law Review).

⁷⁴ ABA Comm’n on Legal Problems of the Elderly, *supra* note 6, at 2.

⁷⁵ SMITH, *supra* note 22, at 108.

⁷⁶ Portenoy, *supra* note 25, at 297.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ Johnson, *supra* note 49, at 321.

⁸⁰ After explaining to a terminally ill 78-year-old’s family that increasing her pain medication could slow respirations, the family members agreed to the medication plan. When her respirations slowed, the patient’s son changed his mind about the medication, and transferred his mother to another facility, where she died. The physician who prescribed the initial medication was found guilty of attempted murder.

gation is opened, the state medical board would rule on the appropriateness of the medication therapy plan. However, medical boards are comprised of physicians who may be “behind the times” with regard to pain management or suffer from opiophobia themselves.⁸¹ In one study of the nation’s state medical board members, 47% of the respondents reported that while prescribing opioids for chronic nonmalignant pain was “legal,” the practice should be discouraged.⁸² In states where medical boards do not recognize the problem of undertreated pain, nor acknowledge the advances in pain management that encourage the use of opioids as the treatment of choice for chronic pain, physicians face a greater risk of disciplinary action, even when the pain management plan is appropriate.⁸³ If a physician is subject to even a minor disciplinary action from the state board, the action is reported to the National Practitioner Data Bank.⁸⁴ Hospitals and insurance companies then use this information when reviewing a physician’s application for admittance to an insurance plan or granting hospital privileges.⁸⁵ The scrutiny of prescription practice may haunt a physician for years to come and the fear of unfounded allegations of over-prescribing deter adequate therapy for pain control.

C. Regulation of Long-Term Care Facilities

Beyond the restrictions placed on individual physicians, regulatory agency and system barriers also negatively impact the long-term care facilities where the elderly reside. The effect on the long-term care facility is similar to the effect on physicians — it is simply easier to not provide adequate pain relief than to jump through the regulatory hoops required to administer the most effective pain management plan.

Like physicians, the nursing staff in long-term care facilities are woefully undereducated with regard to pain management.⁸⁶ The focus of pain management education in nursing schools is on

After spending two years in prison, the doctor’s conviction was reversed, and his license reinstated. However, his reputation and marriage were ruined. Terrie Lewis, *supra* note 5, at 233-34 (citing *Kansas v. Naramore*, 965 P.2d 211 (Kan. Ct. App. 1998)).

⁸¹ Rich, *supra* note 45, at 54.

⁸² *Id.* at 55 (citing a 1991 survey of state medical board members on their knowledge and attitudes toward pain management practice).

⁸³ See Chris Stern Hyman, *Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment*, 24 J. L. MED. & ETHICS 338 (1996).

⁸⁴ Martino, *supra* note 59, at 340 (quoting an investigator for a state medical board).

⁸⁵ *Id.*

⁸⁶ Rich, *supra* note 45, at 8, 10.

the treatment of acute pain and assumes that patients are able to verbally express their need for relief. Because most nursing students' clinical experiences are in acute care hospitals, students may rarely encounter an elderly patient suffering from chronic nonmalignant pain.

Fortunately, in 1999 the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) adopted new standards for pain assessment and management.⁸⁷ As a result, health care entities began to educate their nursing staff about pain assessment with an emphasis on interpreting nonverbal cues, such as changes in vital signs, facial grimacing, and protective body posturing.⁸⁸ However, if a long-term care facility is not accredited by the JCAHO, there are no other agency-imposed pain management continuing-education requirements for nursing staff. While the JCAHO standards encourage better pain assessment protocols, the mere report of an increased level of pain does not ensure that the resident's medication plan will change. Nursing staff work within the confines of the resident's prescriptive orders. Unless the nurse initiates a telephone call to a receptive physician, the resident's medication dosage will not be increased. If the resident's pain appears to be controlled at the time of the next physician visit to the facility, there is no impetus for the doctor to change the medication regime. This can leave residents with inadequate medication to combat sporadic increases in their level of pain.

Similar to the shortage of physicians trained in palliative care, there are few nurses certified in palliative care to serve as role models and educators for their peers.⁸⁹ Of the 38,780 full-time-equivalent registered nurses in Indiana in the year 2000, only 132 were certified by the Hospice and Palliative Nursing Association.⁹⁰ The vast majority of nurses with expertise in pain management are employed by hospice care providers. Hospice services provide palliative medical, psychosocial, and spiritual care to the terminally ill and their families.⁹¹ Hospice services may be received in a client's

⁸⁷ See Rich, *supra* note 45, at 9 n.50.

⁸⁸ This author, a registered nurse with 15 years of acute care hospital experience, assisted hospital administration in the development of formats for pain assessment documentation.

⁸⁹ LAST ACTS, *supra* note 1, at 38.

⁹⁰ *Id.* at 84-85.

⁹¹ Hospice is "an interdisciplinary program of palliative care and supportive services that addresses the physical, spiritual, social, and economic needs of terminally ill patients and their families." *TEBOR'S CYCLOPEDIA MEDICAL DICTIONARY* 1004 (19th ed. 2001). Palliative care is medical and nursing care that "reliev[es] or alleviat[es] without curing." *Id.* at 1559.

home, acute care hospital, nursing home, or freestanding hospice facility. For the elderly with a terminal illness, once the decision is made to focus on palliative care and no longer aggressively treat the disease, the resident can qualify for hospice care and thereby access nursing experts for pain management. However, for those long-term care residents suffering from chronic nonmalignant pain or nonterminal cancer pain, the pain management expertise of hospice nurses is not available.

In addition to educational barriers for nursing staff working within long-term care facilities, the staff members also face regulatory agency policies that discourage adequate pain management. State health departments promulgate licensing and operational standards for pharmacy and nursing services within nursing homes.⁹² These standards, although well intended, may contain language that promotes undermedication of residents, such as “[e]ach resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used . . . in excessive doses (including duplicate drug therapy); [or] for excessive duration”⁹³ These regulations neither promote pain management plans that employ higher medication doses nor allow for a resident to maintain multiple pain medication orders that would provide discretionary choices. For example, a resident’s pain may be best managed by using a routinely scheduled medication for chronic pain, coupled with a second medication to be used when pain becomes more acute, such as following exercise. This type of medication plan could be subject to agency sanctions for duplicate drug therapy. If a state department of health surveyor finds a “deficiency” relating to medication therapy, the facility is likely to be exposed to multiple deficiency ratings because the pharmacy standards are cross-referenced to nursing, administrative services, and resident safety standards.⁹⁴ Thus, current state regulatory schemes serve as a further deterrent to aggressive pain management.

At the federal level, the Centers for Medicare and Medicaid Services’ (CMS) policies likewise do not recognize the importance of pain management for elders in nursing homes. Residents of long-term care facilities are afforded a statutory “bill of rights” that includes rights to autonomy, privacy, confidentiality, information, financial protection, and freedom from abuse and use of restraints

⁹² See IND. ADMIN. CODE tit. 410, r. 16.2-3.1-17-48 (2001).

⁹³ *Id.* 16.2-3.1-48.

⁹⁴ See *id.* 16.2-3.1-25, 31, 35.

without a physician's order.⁹⁵ However, this bill of rights does not include the right to be free from pain or the right to receive a comprehensive pain management program. CMS survey guidelines list 141 "issues of concern" that should be evaluated during a surveyor's inspection of a long-term care facility, but pain management is not included among them.⁹⁶ These policies fail to recognize the importance of pain management for the elderly.

As the problem of pain management is beginning to move into the nation's consciousness, state departments of health, acting as surveyors to ensure compliance with CMS regulations, are independently beginning to focus on pain. While the CMS survey procedure does not specify comfort or pain in the list of "resident needs" that must be assessed, many surveyors review resident records for evidence of pain management plans.⁹⁷ Unfortunately, according to some nursing home administrators, the surveyor's focus is on the documentation of pain medications, rather than an overall evaluation of the resident's comfort level.⁹⁸ For every pain medication administered, the staff must document not only a pre-medication assessment of the resident, but an "effectiveness of medication" assessment 30 minutes after the medication is administered. This documentation process is cumbersome and presents a heavy burden to the nurse who may be administering several pain medications each hour among a group of residents. The process of evaluating and documenting a particular medication's effectiveness is valuable when the medication is a new prescriptive order for a resident or when the resident requires pain relief due to an acute event, such as discomfort following a fall. In these situations, the staff should be documenting after each dose whether the new or short-term medication is effective, so that if needed, changes can be made to the medication plan. But for the elderly resident suffering from chronic yet stable levels of pain, documenting the same evaluation and effectiveness information six to 12 times a day in the resident's chart is a waste of nursing time. Nevertheless, for a surveyor, it is certainly easier to review a chart and "count" the entries, than to interview residents as to the overall effectiveness of

⁹⁵ 42 C.F.R. § 483.10 (1989); 42 U.S.C. 1395i-3(c) (1994).

⁹⁶ Timothy S. Jost, *Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets*, 26 J. L. MED. & ETHICS 290, 293 (1998) (citing 42 C.F.R. § 488.105 (1998)).

⁹⁷ See 42 C.F.R. § 488.110, 754 (2002) (resident needs include items such as hygiene, rehabilitation care and services, and nutrition); Jost, *supra* note 96.

⁹⁸ This statement is based on the author's years of experience in health care administration, personal experiences with state department of health and JCAHO surveyors, and a variety of anecdotal accounts from nursing home administrators over the past eight years.

their pain-management program. This emphasis on documentation penalizes the resident who requires frequent pain medication by creating a disincentive to the nursing staff to administer drugs that require copious charting.

Long-term care facilities face an additional disincentive to providing appropriate pain management. Under the current Medicare reimbursement structure, nursing homes receive no financial gain for referring residents to hospice services.⁹⁹ In the 1980s, hospice care was added as a reimbursable benefit under Medicare and Medicaid.¹⁰⁰ This hospice benefit is limited to the terminally ill, who must agree to receive palliative care rather than curative treatment for their illness.¹⁰¹ Because a Medicare beneficiary cannot simultaneously receive hospice and skilled-nursing facility benefits, nursing homes that refer their residents to hospice lose Medicare reimbursement.¹⁰² This financial conflict presents a disincentive for hospice referrals.¹⁰³

For the eligible residents of long-term care facilities who do elect hospice benefits, a collaborative relationship is intended between hospice and the nursing home.¹⁰⁴ CMS recommends that hospice and the nursing home develop a written contract to address the provision of services for a hospice beneficiary who resides in a long-term care facility.¹⁰⁵ This contract should address issues such as financial responsibility for room and board, which usually falls to the nursing home, development of a comprehensive pain management program, which usually falls to the hospice, and education of nursing staff by hospice.¹⁰⁶ This partnership should provide the resident with appropriate pain management, and raise the educational level of the nursing home staff via the training programs conducted by hospice.¹⁰⁷ In many facilities, this partnership provides a benefit not only to hospice beneficiaries, but by educat-

⁹⁹ Jost, *supra* note 96, at 290.

¹⁰⁰ *Improving Care at the End of Life with Complementary Medicine: Hearing Before the House Comm. on Gov't Reform on Hospice and End-of-Life Care*, 106th Cong. 158, 160 (1999) (testimony of Kathleen A. Buto, deputy director, Center for Health Plans & Providers, Health Care Financing Administration).

¹⁰¹ *Id.*

¹⁰² Jost, *supra* note 96, at 290.

¹⁰³ *Id.*

¹⁰⁴ Memorandum from Steven A. Pelovitz, director of survey and certification group, Center for Medicaid and State Operations, to associate regional administrator of state survey agency director (May 10, 2002) (on file with the New York City Law Review).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

ing nursing staff with regard to pain assessment, every nursing home resident receives the vicarious benefit of a better trained staff. However, CMS recognizes that sometimes this “partnership” philosophy is not implemented, and that poor communication between nursing homes and hospice results in inadequate pain control for the resident.¹⁰⁸ In addition, because of the referral disincentive and hospice benefit limitations (limited to the terminally ill who have given up hope for recovery), few elders will have access to the pain management expertise of hospice providers.¹⁰⁹

IV. RECOMMENDATIONS

In order to improve pain management for elders residing in long-term care facilities, a combination of approaches will be required to address this multifaceted problem.

A. *Legislative Action*

Legislative enactments that promote adequate pain relief while protecting physicians from regulatory sanctions for the appropriate use of opioid therapy would allow physicians to practice an acceptable standard of care without fearing disciplinary action. State or federal acts that set forth a presumption that pain should be aggressively managed and support the use of opioids as an acceptable standard of practice while providing safe harbors for complying physicians would go far in quashing the fears of practitioners.¹¹⁰ Legislative enactments would not only protect physicians from excessive regulatory scrutiny, but would also provide a codified standard of care should a physician come under investigation.¹¹¹ The statutory standard would then serve as the standard of review for disciplinary boards, rather than the individual judgment of potentially opiophobic board members.¹¹² With legislative guidance, physicians and board members would operate from the same standard of care, rather than the existing conflicting “practice guidelines” published by pain specialty groups and

¹⁰⁸ Memorandum from Steven A. Pelovitz, director of survey and certification group, Center for Medicaid and State Operations, to associate regional administrators of Division for Medicaid and State Operations, regions I-X (Apr. 20, 2000) (on file with the New York City Law Review).

¹⁰⁹ Jost, *supra* note 96, at 294.

¹¹⁰ See Martino, *supra* note 59, at 332.

¹¹¹ Johnson, *supra* note 49 at 322.

¹¹² *Id.* (noting that, additionally, a statutory standard could provide the basis for declaratory action by the physician should an investigation be initiated).

the Drug Enforcement Administration or the Department of Justice.

States that have enacted intractable pain treatment acts have made strides in this direction by decreasing real and perceived risks for physicians who treat pain with opioids.¹¹³ However, as discussed above, statutes that focus on “intractable” pain, or declare opioids to be a treatment of “last resort,” do little to support appropriate pain management for elders suffering from chronic nonmalignant pain. Rather, these acts should promote liberal medication dosing, describe with particularity the standard against which dispensing is evaluated, and provide that no disciplinary action will ensue when a physician practices within the act’s defined standard of care.¹¹⁴ In addition, the state legislation should require the continuing education of physicians with regard to advances in pain management.

To provide uniformity in pain policies across the country, passage of the federal Pain Relief Promotion Act of 2000¹¹⁵ would negate the need for individual state pain acts. One objective of the Act is to prevent unnecessary investigations and inappropriate disciplinary actions.¹¹⁶ The Act also requires state medical boards to provide a qualified “clinical expert” to support any cases brought against a health care provider.¹¹⁷ In this way, a physician’s suspected treatment plan would be evaluated by an expert in pain management.¹¹⁸ The Act also defines the standard of care for practitioners by referencing the clinical guidelines published by groups such as the Agency for Health Care Policy and Research, and the American Pain Society.¹¹⁹ A federal statute would set a national standard of care and provide boundaries and guidance, should states desire to adopt their own pain policies.

In the absence of legislative authority, a state’s pain “policies” may provide education and guidance.¹²⁰ While not carrying the force of law, state guidelines would serve to encourage appropriate pain management and provide some reassurance to physicians that they may treat pain using opioids without undue regulatory scru-

¹¹³ Martino, *supra* note 59, at 332.

¹¹⁴ Hyman, *supra* note 83, at 340-341; *see also*, Martino, *supra* note 59, at 332.

¹¹⁵ H.R. 5544, 106th Cong. (2000) (amending the Controlled Substances Act).

¹¹⁶ Johnson, *supra* note 49, at 322.

¹¹⁷ *Id.* at 323.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 324.

¹²⁰ *See* ABA Comm’n on Legal Problems of the Elderly, *supra* note 6, at 2-5.

tiny.¹²¹ State licensing boards should adopt pain policies to emphasize the importance of pain management and to clarify what practices could subject a physician to disciplinary review.¹²²

For any legislative act or policy to be truly effective, it must sanction physicians who underprescribe pain medications, as well as those who over-prescribe.¹²³ If state disciplinary boards allow physicians to practice below the standard of care for pain management, then pain control will continue to be problematic for vulnerable populations like the institutionalized elderly who are without the knowledge or power to advocate for a more aggressive and appropriate treatment. Therefore, legislative acts should include a provision whereby failure to adequately prescribe controlled substances for the relief of chronic pain within approved clinical practice guidelines would subject a physician to disciplinary action.¹²⁴ For example, in 2001, California amended its Medical Practice Act, requiring the state medical board to develop standards for investigation of complaints concerning the undertreatment or undermedication of pain.¹²⁵ Similarly, in Oregon, failure to adequately manage pain is subject to disciplinary action.¹²⁶ To improve the quality of medical care, and to ensure that physicians are not caught unaware by these types of provisions, practitioners should be required to complete an educational program on the subject of pain management that includes the new statutory standard of care.¹²⁷

B. *Education of Health Care Providers*

As a condition of state licensure, health care providers should be required to complete educational programs on pain management and the treatment of the terminally ill and dying patient.¹²⁸ By linking these educational programs to bi-annual licensure renewal, compliance would be assured and health care providers would be able to receive the most up-to-date information on their clinical practice. The educational sessions should be based on the

¹²¹ LAST ACTS, *supra* note 1, at 35.

¹²² *Id.* at 54.

¹²³ Tucker, *supra* note 53, at 16.

¹²⁴ Martino, *supra* note 59, at 343.

¹²⁵ CAL. BUS. & PROF. CODE § 2241.6 (West Supp. 2003).

¹²⁶ In 1999 the Oregon Board of Medical Examiners required a physician to complete an educational program and peer review resulting from a finding of "gross negligence" and "unprofessional conduct" for the inadequate treatment of pain. Nist, *supra* note 26, at 88.

¹²⁷ See CAL. BUS. & PROF. CODE § 2190.5 (West 2003).

¹²⁸ See Hyman, *supra* note 83, at 342; see also CAL. BUS. & PROF. CODE § 2190.5.

Agency for Health Care Research and Quality guidelines and protocols to provide standardization of information across state lines. For those states that have enacted intractable pain treatment acts or pain policies, the educational sessions would provide a forum to promote the new standard of care, as well as an opportunity to reassure physicians regarding prescribing practices and disciplinary review standards.

In addition to the education of practicing physicians, state medical professional board members should also be required to complete specialized training with regard to pain management. Their educational sessions should include not only the standard of care and legislative policies or rules, but also specific training on how to conduct investigations, and how to evaluate the appropriateness of a patient's treatment plan.¹²⁹

Likewise, nurses should be required to complete educational programs that are tailored to their area of practice — acute care, long-term care, rehabilitation services, or hospice care. This way, nurses could receive specialized training on topics such as assessment of the cognitively impaired elder for pain, and on the use of nonpharmacologic strategies for comfort — positioning, exercise, heat therapy, etc.¹³⁰ In addition, nurses working in long-term care facilities could be taught hospice and palliative care concepts, to further improve the quality of resident care.¹³¹

C. *Changes in CMS Standards and Policies*

For nursing home residents, adequate pain control should be a “right” accorded the same status as privacy, confidentiality, and financial protection.¹³² In 1989, CMS added freedom from chemical or physical restraint to the Residents’ Bill of Rights.¹³³ It is now time to add the “right to appropriate pain management” as well. With 83% of nursing home residents experiencing inadequately treated pain, this issue is certainly worthy of being elevated to the status of a resident’s “right.” Furthermore, the adequacy of a long-term care facility’s pain management program should be an express standard for CMS surveys.¹³⁴ Compliance with the prevailing medical standard of care should be required for continued Medi-

¹²⁹ See Hyman, *supra* note 83, at 339.

¹³⁰ See PAIN IN THE ELDERLY, *supra* note 33, at 9.

¹³¹ See Laurie Lewis, *supra* note 72.

¹³² See 42 C.F.R. § 483.10 (1989).

¹³³ 54 Fed. Reg. 5363 (Feb. 2, 1989).

¹³⁴ Jost, *supra* note 96, at 296.

care participation.¹³⁵ The 2001 JCAHO pain management standards could serve as a model for the development of CMS survey standards.¹³⁶ Long-term care facilities that can demonstrate compliance with the current JCAHO standard should be deemed to have met this proposed CMS requirement. In addition, as a further condition of Medicare participation, long-term care facilities should be required to have multidisciplinary palliative care or pain management teams as a resource for patient care.¹³⁷ These teams should be comprised of nursing home staff, hospice nurses and counselors, as well as pastoral care and physical or occupational therapists. Thereby, whenever a resident has a pain control issue, the “team” would meet to create a comprehensive pain management program, and would also meet periodically to monitor the effectiveness of that plan.

These new regulatory requirements must be implemented in a way that focuses on the outcome and not the process. CMS and state department of health surveyors should be trained to evaluate the resident’s overall condition — that the resident is maintained in comfort — rather than focusing on detailed documentation requirements. Long-term care facilities should be encouraged to adopt policies and programs that promote resident comfort, rather than being punished for the failure to document the effectiveness of a single-medication dose.

Finally, to provide the elderly access to the pain management expertise provided by hospice, changes should be implemented in the Medicare/Medicaid benefit system. Because hospice provides the most comprehensive pain management programs, elders who are diagnosed with chronic pain, malignant or nonmalignant in origin, should be eligible to receive pain-management services from hospice providers under standard Medicare Part A coverage.¹³⁸ This way, elders in long-term care facilities would continue to receive Medicare skilled-nursing facility benefits, and could receive consultative pain management services through hospice. Then, long-term care facilities would not encounter the financial

¹³⁵ *Id.* at 300.

¹³⁶ The JCAHO pain management standards include: “(1) the right of patients to appropriate assessment and management of pain . . . (4) determining and assuring staff competency in pain assessment and management, including in the orientation of all new staff; [and] (5) establishing policies and procedures to support appropriate prescription or ordering of effective pain medications . . .”. Furrow, *supra* note 6, at 49 n.160.

¹³⁷ LAST ACTS, *supra* note 1, at 48. See also Laurie Lewis, *supra* note 73.

¹³⁸ See generally LAST ACTS, *supra* note 1, at 48; Jost, *supra* note 96, at 296.

disincentives currently in place, and elders would not have to “give up hope” in order to become eligible for pain management services through a hospice provider.

V. CONCLUSION

With the “graying” of America, adequate pain control for elders in long-term care facilities may soon be the most pervasive health care issue facing our country. Current regulatory restrictions on the use of opioid therapy, conflicting legislative policies, the lack of supportive regulations for long-term care facilities, the lack of pain management education for health care providers, and physicians’ perceptions regarding the risk of sanctions and disciplinary actions, serve as barriers to effective pain management. Development of state pain policies, revisions to physician practice acts, CMS reimbursement and regulatory changes, and federal legislative action are required to correct this multifaceted problem. As stated in the American Bar Association resolution on pain management, “governments must be urged to . . . support fully the right of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management, and ongoing monitoring as part of basic medical care.”¹³⁹ Action must be taken to provide adequate pain relief to an often forgotten and “voiceless” population — elders in long-term facilities — so that we may all look forward to spending our final days in the dignity and comfort we deserve.

¹³⁹ ABA Comm’n on Legal Problems of the Elderly, *supra* note 6.

