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OUCH! THAT REALLY HURTS. PAIN MANAGEMENT IN THE ELDERLY AND TERMINALLY ILL: IS THIS A LEGAL OR A MEDICAL PROBLEM?

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Early one Monday morning, you find Dr. A., your friend, somberly waiting in your office. Your secretary comments that Dr. A. is quite upset and has been pacing around the office for a while. As you exchange greetings with Dr. A., Dr. A. relates a horrible story to you. Dr. A. has been treating a patient suffering from extraordinary chronic pain due to cancer. In short, the pain persists, despite the fact that Dr. A. has been medicating the patient with large doses of morphine around the clock. Dr. A. would like to increase her patient's morphine dose in an attempt to alleviate the pain, but she fears both civil liability and possible criminal consequences should anything go wrong with her patient and asks you what she should do. So, how do you advise your friend, Dr. A.?

Introduction

In recent years, society's debate concerning physician-assisted suicide has exposed the problem of inadequate pain management for the elderly and the terminally ill.[1] Specifically, medical studies since the early 1990s have highlighted the problem of under-medication in elderly and terminally ill patients.[2] On one hand, the paradox of a dying patient suffering from excruciating pain despite the latest technology modern medicine offers raises both ethical and legal issues for today's physicians and attorneys. On the other hand, society has spent countless hours and resources rehabilitat-

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1 *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); *see also* Tyche Hendricks, *Skimping on Elderly's Pain Drugs "Like Torture,"* The San Francisco Chronicle, May 4, 2001, at A1.

2 Hyman, *supra* note 1, at 338; *see also* Hendricks, *supra* note 1.

ing narcotic addicts and combating the war on drugs. This dynamic tension between inadequately medicating patients suffering from chronic pain and the need to control narcotic availability to fight addiction has put pain management in the forefront of medicine and law.

Addressing pain management in the elderly and the terminally ill is important to attorneys for two reasons. First, physicians often do not adequately treat the pain of dying patients due to a legitimate fear of state medical board discipline from over-medicating patients with pain symptoms. Second, attorneys think first of medical malpractice remedies and have not often used the concept of elder abuse as a legal theory to hold physicians responsible for the inadequate treatment of pain in elderly and terminally ill patients. Both of these precedents appear to be changing.

The medical community has long indoctrinated its physicians with caution in the use of narcotic therapy for pain relief.[3] As this article will outline, however, the medical community is slowly recognizing its deficiencies in treating patients with chronic pain. In short, medical societies and state licensing boards are slowly adapting their mores, regulations, and policies to allow for adequate pain relief in the elderly and the terminally ill.[4]

Changes in medicine, nevertheless, occur slowly, and it is often only through judicial encouragement that the needed medical changes occur. 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, which has led to the voluntary adoption of more aggressive pain management policies. This article suggests that, at least in some states, a careful use of elder abuse statutes as *quasi*-medical malpractice provisions could help ensure that elderly and terminally ill patients receive adequate pain relief.

Attorneys who understand the historical and current medical concepts involving pain management in the terminally ill may better assist their clients in evaluating any legal rights or remedies they may have when physicians refuse to address the need for pain management in the elderly and terminally ill. To that end, this article

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[3] 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.").

[4] *See infra* Part V.

first will address the medical concept of pain, next it will survey some of the judicial decisions that have influenced the emerging trend of holding physicians responsible for their medical decisions outside of the traditional medical malpractice arena, and finally, the article will describe some of the evolving changes in physician and state medical licensing board attitudes regarding the aggressive treatment of pain in the elderly and terminally ill.

I. Pain Relief: A Crime or a Duty

Physicians often struggle to balance their role in limiting narcotics to patients who suffer with drug addictions and liberally dispensing narcotics to patients with significant chronic pain. These conflicting pain management 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.[5] Additionally, while physicians' ability to manage cancer pain has improved, adequate pain relief continues to elude many dying patients.[6] For instance, a 1998 study performed by the Eastern (U.S.) Cooperative Oncology Group showed that over one-half of the patients receiving pain medication judged their pain relief to be inadequate.[7] Curiously, there is no adequate explanation of why, in the era of modern medicine in which we live today, terminally ill patients must die in excruciating and unrelieved pain.[8]

To better understand the conflicts physicians have regarding the under-medication of patients suffering from painful terminal illnesses, one must recognize the problem of abusing such pre-

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5 Interview with Neil Ellison, M.D., *Overcoming Obstacles to Pain Management*, Pain.com, A World of Information on Pain, *at* http://www.pain.com/cancerpain/cp_int_ellison.cfm (last visited Sept. 23, 2003) (on file with the New York City Law Review). The opioids family of narcotics includes codeine, oxycodone (i.e., oxycontin) and morphine.

6 Neil M. Ellison, M.D. et al., *The Ongoing Challenges of Pain Control*, Pain.com, A World of Information on Pain, *at* http://www.pain.com/articles/onepage.cfm?chapter_id=75 (last visited Sept. 23, 2003) (on file with the New York City Law Review).

7 *Id.*

8 *See id.* (stating that barriers to pain relief include patients' poor compliance with prescribed medication, patients underestimating and mischaracterizing their pain to physicians, patients' and physicians' concerns about narcotic addiction, and poor physician understanding of both the amount of pain their patients are suffering and the best treatment for such pain).

scription drugs in society. Oxycontin provides a recent example of this conflict.[9] On the one hand, oxycontin can be taken orally and provides rapid and highly efficient pain relief, thus negating the need for inconvenient and painful injections.[10] 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.

So, where is the balance? Chronic pain patients need narcotic relief, but narcotics, like oxycontin, have always carried both risks to the patient and adverse consequences to society. Horribly, 117 people in 31 states during the last two years died from the illegal use of oxycontin, graphically illustrating its potential for abuse.[11] Testifying before a House appropriations subcommittee, DEA Administrator Asa Hutchison agreed with several representatives on the subcommittee that the street abuse of oxycontin is a national emergency that needs to be curtailed, but with every curb comes physician hesitance in using narcotics to treat chronic pain in the elderly.[12]

Further efforts to control the abuse of oxycontin are also found in the courts. For instance, in February 2002, a Florida jury convicted a physician of manslaughter in the deaths of four patients for whom he prescribed oxycontin for chronic pain relief.[13] This Florida physician is believed to be the nation's first physician to stand trial on manslaughter or murder charges in the oxycontin

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9 Oxycontin II is an opioid agonist and a Schedule II control substance with an abuse liability similar to morphine. Oxycontin tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycodone can be abused in a manner similar to other opioid agonists, legal or illicit. This should be considered when prescribing or dispensing oxycontin in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse, or diversion. *See, e.g.,* Purdue Pharma, *Thousands of Counterfeit Oxycontin Tablets Seized by U.S. Customs Service* (Dec. 4, 2002), *at* http://www.purduepharma.com/pressroom/news/oxycontinnews/20021204-01.htm (on file with the New York City Law Review).

10 *Id.*

11 *Lawmakers: Oxycontin Maker Failing to Curb Abuse*, USA TODAY, Dec 20, 2001, *at* http://www.usatoday.com/news/health/addiction/2001-12-12-oxycontin.htm (on file with the New York City Law Review).

12 *See id.*

13 *Oxycontin Doctor Convicted in Oxycontin Deaths*, JOIN TOGETHER ONLINE, Feb. 21, 2002, *at* http://www.jointogether.org/sa/news/summaries/reader/0,1854,548406,00.html (on file with the New York City Law Review).

death of a patient.[14] But before concluding that this physician belongs in jail, one must recognize that he worked in two different "pain management" clinics providing care for many patients who could not find relief elsewhere in the medical community.[15] Assuming he is found guilty of illegally and recklessly prescribing oxycontin, what type of chilling effect will this case have on other physicians who legally prescribe pain medication for their terminally ill patients? Many physicians may stop treating terminally ill 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 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?

II. To Medicate, or Not To Medicate: What An Attorney Must Know

A. A Physician's Slant on Narcotics

Physicians are seen as healers, preservers of life and relievers of suffering.[16] In modern life, however, these roles may conflict. Because of the fear of narcotic addiction, pain management in the elderly and the terminally ill presents particular challenges for physicians and society.[17] Although physicians are often very cautious in their use of narcotics, a balance must be forged between the need for adequate pain relief in the elderly and the terminally ill and the concern for patients' misuse of prescribed narcotics.

Two sentinel reports highlight the medical community's concern about prescription drug abuse. First, a 1980 White House Conference on Prescription Drug Abuse extensively chronicled the public's misuse of narcotics.[18] A decade later, the White House Office of National Drug Control Policy quantified the problem by estimating that about one-third of all emergency-room-treated, drug-related deaths were from prescription drugs.[19] In light of these statistics, it is not unreasonable for physicians to be cautious

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14 *Id. See also infra* Part IV for additional descriptions of criminal charges involving physicians and non-oxycontin homicide.

15 *Oxycontin Doctor Convicted in Oxycontin Deaths*, *supra* note 13.

16 *Kansas v. Naramore*, 965 P.2d 211, 213 (Kan. Ct. App. 1998).

17 *See id.* at 214.

18 Bonnie B. Wilford et al., *An Overview of Prescription Drug Misuse and Abuse: Defining the Problem and Seeking Solutions*, 22:3 J. L. Med. & Ethics 197 (1994).

19 *Id.* at 198. One may speculate that the other two-thirds of emergency-room-related drug deaths were from street drugs.

in prescribing narcotics. Attorneys with clients suffering from chronic pain, however, cannot afford to have physicians act so cautiously. Despite the statutory obligations, medical training, medical ethics, and customs that often impose restraints on a physician's ability to prescribe narcotics, attorneys must be able to assure physicians that the legal process will protect them from harm if physicians aggressively treat the pain in their elderly or terminally ill patients.[20] For instance, physicians have been taught to continually assess the severity of their patients' symptoms, the patients' reliability in taking the narcotics as directed, and the possibility that alternative medications may provide equivalent pain relief.[21] The stigma and consequences to a physician for even innocently assisting a patient in becoming addicted to his or her medication may be significant. Further, a physician's aggressive use of narcotics for pain relief may raise issues with state medical licensing boards or hospital peer review committees, may affect the physician's reputation in the community, or may subject the physician to unwanted civil or criminal liability. As a result of these potential consequences, physicians have been trained to be cautious in prescribing narcotics, even when the use of such medication fits soundly within prudent medical judgment.[22] By advocating for clients suffering from chronic pain and encouraging physicians not to fear civil or criminal liability for under-medicating elderly or terminally ill pain patients, attorneys may play a significant role in the solution of their clients' problems of inadequate pain relief.

Attorneys should understand that scientific investigations have negated the myth that the typical abuser of prescription narcotics is a patient whose doctor introduced the drug to him or her during medical treatment.[23] In fact, research finds that persons who abuse prescription narcotics are often also abusing illicit street drugs.[24] Conversely, most medical patients appropriately use prescription narcotics for medical ailments and do not exhibit abusive tendencies.[25] In light of these findings, both attorney and physician education as to the decreased risks of narcotic abuse and the benefits of aggressive pain management in the elderly and the terminally ill becomes important. Attorneys should see that physicians not only provide adequate pain relief to their clients, but also

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[20] *Id.* at 200.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 199.
[24] *Id.*
[25] *Id.*

assess the legal implications of potential claims regarding abuse in their elderly or terminally ill clients who do not receive adequate pain care. But, as will be explained in Part II, on the section on palliative care, the price of pain relief in the elderly and the terminally ill is not without controversy.

B. An Attorney's Slant on the Physician's Slant

Traditionally, physicians divide pain into two main categories:[26] (1) acute pain that may result from surgery, burns, or trauma,[27] and (2) chronic pain from either cancer or non-cancer diseases. The primary cure for cancer pain is the treatment of the underlying malignancy, which is often the source of or a contributing factor to the pain. Secondary treatments for cancer pain include direct symptomatic relief of the pain with medications.[28] Non-cancer pain, however, is often more complex because there may not be adequate therapies to treat the underlying illness. In cases of chronic illness, pain management plays an important role.[29]

The adequate treatment of pain[30] in the terminally ill patient is essential in minimizing or alleviating suffering, yet physicians in the United States have only recently begun to address this issue. For almost 30 years, the medical community has recognized the inadequate and under-treatment of pain in hospitals and long-term care facilities.[31] Throughout this time, the population has continued to age and the need for adequate health care has never been more important. Society and the law are now more aggressively addressing this problem because under-treating pain results in needless suffering by elderly and terminally ill patients.

To better understand this problem, attorneys must recognize the reasons that physicians may be reluctant to aggressively treat

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

27 *Id.*

28 *Id.*

29 *Id.*

30 *Id.* at 43 (Pain is defined as "an unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage."). *See also* CAL. BUS. & PROF. CODE § 2241.5 (2003) (Intractable pain, as seen in the terminally ill and often addressed through the concept of palliative care, may be described as "a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts . . . .").

31 Richard M. Marks, M.D. & Edward J. Sachar, M.D., *Undertreatment of Medical Inpatients with Narcotic Analgesics*, 78:2 ANNALS INTERNAL MED. 173 (1973).

the pain of their patients. For example, most physicians are not adequately educated in medical school about narcotics and proper pain management.[32] Consequently, uncertainty about the use of narcotics breeds physician concerns about civil and criminal liability for the inappropriate use of such pain therapy.[33] In addition, the fear of peer review sanctions affecting a physician's medical license or hospital privileges discourages any aggressive use of narcotics in their medical practice.[34] Finally, physicians have been reluctant to take risks with aggressive pain management in elderly and terminally ill patients because historically there has been less liability for undertreatment of pain.[35]

Attorneys must recognize that, all too often, patients and physicians view pain as a necessary part of an illness. Both patients and physicians may share the attitude that pain should be endured and that medication for pain relief should be used only in the rarest of circumstances.[36] For many young and otherwise healthy patients with acute, short-lived illnesses, this medieval approach to the tolerance of pain may be loosely acceptable. For elderly and terminally ill patients, however, pain management should be aggressive and tailored to their specific illness and situation.

C. What Elderly and Terminally Ill Patients Have to Say to Attorneys and Physicians Alike

Palliative care is medical care whose primary purpose is to alleviate pain and suffering.[37] More specifically, palliative care is the prevention or treatment of pain, shortness of breath, and other symptoms of terminally ill patients.[38] Although the ethical principles of autonomy, beneficence, and non-malfeasance support the concept of palliative care,[39] many have described the practice of palliative care and its aggressive pain management as having a "double effect," reasoning that in its efforts to relieve pain and suffering, the amounts of pain medication used may have the effect of

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32 Furrow, *supra* note 26, at 28.

33 *Id.*

34 *Id.*

35 *Id.*

36 *Id.* at 29.

37 *See* John M. Luce & Ann Alpers, *Legal Aspects of Withholding and Withdrawing Life Support From Critically Ill Patients in the United States and Providing Palliative Care to Them*, 162 AM. J. RESPIR. CRIT. CARE MED. 2029 (2000).

38 *Id.*

39 *Id.*

shortening one's life.[40]

Interestingly, the rule of double effect describes an ethical principal: palliative care would be morally wrong if death was intentionally caused, but it is permissible if death is foreseen but not intended.[41] Many ethicists often use this principle to explain why certain forms of end-of-life-care that result in death are acceptable.[42] Having its roots in the Middle Ages, Roman Catholic moral theologians adopted the rule of double effect in situations where a person must decide whether one potentially harmful action is preferable to another (death versus pain).[43]

Understanding palliative care requires one to recognize the four elements that serve as the rule of double effect's foundation.[44] The first element concerns the nature of the act, which must be beneficial, such as the relief of pain.[45] The second element involves the physician's intention.[46] Specifically, if both a good effect (pain relief) and an evil effect (death) may result from the treatment, only the good effect must be intended.[47] Third, a distinction between the means and the effects must be present, for example, the evil effect (death) must not be a means to the good effect (pain relief).[48] The fourth condition states that the net good effect must outweigh the net evil effect.[49] Obviously, in these instances of the palliative care, the physician's role as healer may conflict with her role as a reliever of suffering when increasing amounts of pain medication are needed to provide the patient comfort care.[50] Balancing these competing issues is often difficult for the physician, the patient, and the patient's family.

In an effort to address the legal issues concerning these end-of-life treatment options, the U.S. Supreme Court in *Washington v. Glucksberg*[51] ruled that, while there is no constitutional right to phy-

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40 *See* Timothy E. Quill et al., *The Rule of the Double Effect – A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768 (1997).

41 *Id.*

42 *Id.*

43 *Id.*

44 *Id.*

45 *Id.* at 1769.

46 *Id.*

47 *Id.*

48 *Id.*

49 *Id.*

50 *Id.*

51 *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997). Justice Souter, in a concurring opinion, described the acceptance of palliative care and noted the following state statutes that authorize 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.

sician-assisted suicide, state statutes allowing palliative care are constitutional.[52] Highlighting the Court's acceptance of palliative care and providing the fifth vote necessary for a majority opinion, Justice O'Connor wrote that "[t]he parties and *amici* agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[53] She also emphasized that "[t]here is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths."[54]

In *New York v. Quill*, the Court further distinguished legal palliative care from illegal physician-assisted suicide.[55] Writing for the majority in *Quill*, Chief Justice Rehnquist reasoned that a doctor who provides aggressive palliative care, even if it hastens a patient's death, has the same intent as a physician who withdraws life-sustaining medical treatment purposefully. Both physicians respect their patients' wishes by not subjecting them to futile and degrading procedures.[56] The Chief Justice continued, "[j]ust as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death."[57]

The *Glucksberg* and *Quill* opinions as well as new state laws permitting palliative care in terminally ill patients with intractable pain have contributed to a growing awareness in the legal and medical communities that patients no longer need to accept the severe pain of their illnesses without relief from medication. As a result, patients and their families have become more aggressive in assert-

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§ 216.304 (Michie 1997); MINN. STAT. ANN. § 609.215 (3) (West Supp. 1997); OHIO REV. CODE ANN. §§ 2133.11 (A)(6), 2133.12 (E)(1) (1994); R.I. GEN. LAWS § 11-60-4 (Supp. 1996); S.D. CODIFIED LAWS § 22-16-37.1 (Supp. 1997); MICH. COMP. LAWS ANN. § 752.1027 (3) (West Supp. 1997); TENN. CODE ANN. § 39-13-216 (b)(2) (1996). *Id.* at 780 n.15 (Souter, J., concurring).

52 This article does not address physician-assisted suicide; however, it is noteworthy that the Court, in *Washington v. Glucksberg*, distinguished and affirmed the concept of palliative care within the context of this constitutional challenge against a state ban on physician-assisted suicide.

53 *See Glucksberg*, 521 U.S. at 737.

54 *Id.* at 737-38.

55 521 U.S. 793, 802 (1997). Note that the opinions in *Glucksberg* and *Quill* were released at the same time. Both cases addressed the constitutionality of state laws prohibiting physician-assisted suicide and had similar holdings.

56 *Id.* at 801-02.

57 *Id.* at 808, n.11.

ing their right to pain relief and have begun to use nontraditional legal theories to litigate their claims against doctors who do not provide adequate pain management. These new techniques include expanding the scope of medical malpractice and charging physicians with elder abuse.

III. Paving the Way for Pain Management Claims: Precedent Cases

The new pain management litigation follows the precedent set by a number of recent cases that clarify and broaden physicians' responsibilities and potential liabilities for their terminally ill patients. In recent years, physicians have become increasingly likely to face criminal charges for errors in treating terminally ill and elderly patients, and the scope of offenses that can constitute neglect has widened.[58] This movement toward increased criminal and civil liability for patient care is paving the way for new types of pain management litigation.

In the 1983 case of *Barber v. Superior Court*, the California Court of Appeals ruled that two physicians did not murder their deeply comatose patient by withdrawing life-support measures.[59] In *Barber*, the deceased underwent successful abdominal surgery, but suffered cardiopulmonary arrest while in the post-operative recovery room.[60] Although he was immediately revived, he remained in a coma for several days.[61] His physicians quickly realized that his coma resulted from severe brain damage that left him in a persistent vegetative state.[62] After discussing the patient's physical condition and his extremely poor prognosis with his family, the family drafted a written request to remove all life-support machines.[63] As a result, the defendant physicians ordered the life-sustaining equipment removed; shortly thereafter, the patient died.[64]

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58 *See* Tanya Albert, *Professional Issues: Malpractice or Murder?,* Am. Med. News, 10 Oct. 22-29, 2001, at 10. The article notes cases where physicians were held criminally liable for their treatment of patients. For example, an Ann Arbor, Mich., surgeon was charged with three counts of second-degree vulnerable adult abuse for care he provided to two nursing home patients, and a Utah psychiatrist was charged with negligent homicide and manslaughter for overmedicating five elderly patients in a way that resulted in their deaths. *See also Kansas v. Naramore*, 965 P.2d 211, 214 (describing the criminal prosecution of a physician for using palliative care methods).

59 195 Cal. Rptr. 484, 494 (Cal. Ct. App. 1983).

60 *Id.* at 486.

61 *Id.*

62 *Id.*

63 *Id.*

64 *Id.*

In a well-reasoned opinion, the California Court of Appeals stated that "a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life-support' equipment."[65] The court further held that the family made an objective, informed decision motivated by "love and concern for the dignity of their husband and father."[66] As such, the court dismissed the murder charges against the physicians.[67]

With the specter of criminal charges removed, the role of families and their physicians in the end-of-life care entered a new era. Certainly an adverse holding in this case would have significantly prolonged the end-of-life vegetative state in many patients, thereby precluding their sense of dignity in death.

After dodging the jail cell in *Barber*, the medical community again confronted criminal allegations in the 1994 New York case of *People v. Einaugler*.[68] This case, however, was very different from *Barber*. Dr. Einaugler was convicted of reckless endangerment and willful violation of health laws arising from his negligent medical treatment of an elderly nursing home patient with renal disease.[69] Unlike the physicians in *Barber*, who had the family's consent to withhold care from a severely comatose patient, Dr. Einaugler's poor medical decisions and subsequent delay in treatment brought about his conviction.[70]

Specifically, after admitting his patient into the nursing home following a hospital stay, Dr. Einaugler "mistook the patient's peritoneal dialysis catheter for a gastrostomy feeding tube and directed that the patient be fed through the peritoneal dialysis catheter."[71] After infusing numerous feedings directly into the patient's abdominal cavity, the patient became severely infected.[72] Although Dr. Einaugler knew this infection could be rapidly fatal if not immediately treated, he delayed the patient's emergency transfer from the nursing home back to the hospital for over 10 hours.[73] The patient died a few days later from complications arising from this infection.[74] Evidence at trial proved substandard medical

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65 *Id.*
66 *Id.* at 493.
67 *Id.*
68 208 A.D.2d 946 (N.Y. App. Div. 1994).
69 *Id.* at 946-47.
70 *Id.* at 947; *see also Barber*, 195 Cal. Rptr. at 486.
71 *Id.*
72 *Id.*
73 *Id.*
74 *Id.*

care.[75] Dr. Einaugler was convicted of reckless endangerment because he "was aware of, and consciously disregarded, a substantial risk of serious physical injury to the patient by delaying her transfer to the hospital . . . ."[76]

When further examined, Dr. Einaugler's conviction for willful violation of health laws revolved around the statutory term of neglect. Neglect, as defined by the regulations of the New York State Department of Health, results from the "failure to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility. . . . "[77] Realizing that it was expanding the traditional concept of medical malpractice into the criminal arena, the court ironically announced that "this case does not support the proposition that medical professionals should fear the prospect of unwarranted criminal prosecutions for honest errors of medical judgment."[78] The accuracy of this court's proclamation is arguable. Certainly, such a decision fuels the growing trend to hold physicians accountable for their medical decisions in both an expanding civil and criminal arena.

Unfortunately, not all cases involving a dispute over "honest errors in medical judgment" will be as clear as the *Einaugler* case. It is likely that *Einaugler* may affect future judicial rulings that extend elder abuse statutes into the realm of traditional medical malpractice.

IV. Count 1: Medical Malpractice; Count 2: Elder Abuse and Neglect

A. Tort v. Tort

While the criminal prosecutions of physicians for medically related decisions have been occasionally successful, the increasing ability of plaintiffs to hold physicians responsible for traditional medical malpractice errors by using nontraditional theories of liability has made the care and treatment of elderly and terminally ill patients increasingly risky. Liability insurance as a shield against poor treatment decisions is no longer foolproof. This trend has both good and bad aspects. As discussed earlier, regulating and

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75 *Id.*

76 *Id.*; *see also Einaugler v. Supreme Court*, 109 F.3d 836, 839 (2d Cir. 1997) (affirming the district court's denial of a writ of *habeas corpus* and noting that Dr. Einaugler was sentenced to 52 weekends of incarceration).

77 *Einaugler*, 208 A.D.2d at 947.

78 *Id.* at 948.

even encouraging physicians to keep abreast of elderly and terminally ill patients' medical needs, specifically regarding pain treatment, is a good thing.[79] The downside, including less access to care for the elderly and terminally ill, must also be addressed, possibly by affording physicians reasonable personal protection from new and inventive torts that may replace traditional medical malpractice claims.[80] The following two cases illustrate the emerging trends in civil liability involving pain management and the care of elderly and terminally ill patients.[81]

In 1990, 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. The jury awarded $7.5 million in compensatory damages and $7.5 million in punitive damages to the estate of Henry James.[82] 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 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 a less powerful painkiller.[83] Unfortunately, Mr. James was in pain caused by his cancer for seven months before he died.[84]

In May 2001, a California jury in *Bergman v. Chin*, awarded $1.5 million (using elder abuse statutes and not the more conventional medical malpractice statutes) to the family of an 85-year-old man whose physician failed to treat him adequately for the pain his cancer caused prior to his death.[85] The Bergman estate claimed that

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79 *See supra* Part II.

80 The balancing of less access to care for the elderly and the terminally ill against liability issues and tort reform is beyond the scope of this article.

81 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) will 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.

82 Tinker Ready, *Family Wins $15 Million in Nursing-Home Suit*, THE NEWS & OBSERVER (Raleigh, N.C.), Nov. 27, 1990, at B2.

83 *Id.*

84 *Id.*

85 Nathalie White, *Failure to Treat Pain, Novel Verdict Could Signal a New Brand of Med-Mal Suit*, LAWYER'S WEEKLY, Aug. 6, 2001, at B1. This 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

Dr. Chin was reckless in not prescribing enough medication to relieve the pain from Mr. Bergman's lung cancer complications.[86] Commenting on the judgment, Dr. Allan Basbaum, a pain researcher at the University of California, stated that the under-treatment of pain is a widespread problem.[87] "Many doctors are afraid of losing their licenses for overprescribing narcotics. Others take a textbook approach rather than listening to what their patients are telling them. In both cases, the patient suffers unnecessarily."[88]

While the *Bergman* case may send chills down the spines of many physicians, three important points need to be made: (1) the awareness of the under-treatment of pain in elderly and terminally ill patients has been extensively chronicled in recent medical literature;[89] (2) in 1994, the California Medical Board issued guidelines encouraging physicians to be more prompt and aggressive in providing medications for pain;[90] and (3) in 1997, the California legislature approved the Pain Patient's Bill of Rights, which grants patients suffering from severe chronic intractable pain the right to request painkillers of their choice.[91] Despite these and similar guidelines and statutes in several states, many physicians are reluctant to use palliative care to treat the terminally ill. The traditional fear of licensure discipline, criminal sanctions, and hospital peer review discipline are the main reasons for this reluctance.[92] Furthermore, this problem appears more prevalent with those physi-

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should have had better palliative care but took no action against the doctor." *Id.* at B12. If the California Medical Board had even sent Dr. Chin a letter of reprimand, this suit may not have been filed. *See id.*

86 Hendricks, *supra* note 1. Notably, a *mens rea* of recklessness, and not the traditional negligence as seen in medical malpractice, is required under the elder abuse statutes. *Id.* at A16. Additionally, unlike the medical malpractice statutes, liability under the elder abuse statutes allows for the recovery of punitive damages. *Id.* The Oregon-based nonprofit organization of the Compassion in Dying Federation assisted 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.*

87 *Id.*

88 *Id.*

89 *See generally* Symposium, *Relieving Unnecessary, Treatable Pain for the Sake of Human Dignity,* 29 J. L. MED. & ETHICS 1 (2001); Symposium, *Legal and Regulatory Issues in Pain Management*, 26 J. L. MED. & ETHICS 265 (1998); Symposium, *Appropriate Management of Pain: Addressing the Clinical, Legal and Regulatory Barriers*, 24 J. L. MED. & ETHICS 285 (1996).

90 Medical Board of California, *Guidelines for Prescribing Controlled Substances for Intractable Pain*, July 29, 1994 *at* http://www.medbd.ca.gov/consumerguidelines.htm (on file with the New York City Law Review).

91 CAL. BUS. & PROF. § 2241.5 (West 2001).

92 Furrow, *supra* note 26, at 28.

cians who may not be as familiar with sophisticated pain management regimens in the terminally ill setting.[93]

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."[94] Many physicians outside of California likely have the same fears and reluctance to address pain management issues in the terminally ill. It will be interesting to see how the national medical community motivates itself to overcome these barriers to pain management; the two most obvious choices of motivation include either voluntary education or the experience and fear of civil liability. As more states adopt pain management guidelines, the standard of care for pain management in the elderly 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 terminally ill patients suffering from intractable pain. During this transition, it will be important for attorneys to understand how elder abuse statutes and other nontraditional remedies may interact with the medical pain management of the dying.

B. Elder Abuse v. Palliative Care: Will State Legislatures Find the Balance?

Many states recognize elder abuse as a significant social problem needing legislative guidance. For instance, the California legislature expressly acknowledged that "elders and dependent adults may be subjected to abuse, neglect, or abandonment and that the state has a responsibility to protect such persons."[95] The legislative mandate that arose from these findings sprang from a 1998 California Senate report highlighting more than 225,000 annual incidents

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93 The author has observed that, generally, anesthesiologists, psychiatrists, and oncologists appear to have more experience and sophistication in advanced pain management, as compared to general internists and family practitioners.

94 Tanya Albert, *California Requires Doctors Take CME in Pain Management*, AM. MED. NEWS, Nov. 19, 2001 at 9. The article notes that 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. The article also points out that 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.*

95 CAL. WELF. & INST. (Elder Abuse and Dependent Adult Civil Protection Act) CODE § 15600(a) (West 2001 & Supp. 2003).

of elder abuse, which reflected a 1,000% increase in reported elder abuse from 1987 to 1997.[96] Admittedly, only 23% of these 225,000 cases in 1997 arose from physical abuse; nevertheless, the rapid rise of elder abuse cases during the previous decade compelled the California legislature to address this crisis with precision.[97] In an effort first to measure the size of this elder abuse crisis and then, in an attempt to manage this crisis, California enacted statutes regarding: (1) the encouragement of health care providers, social service workers, and community members to report suspected cases of elder abuse; (2) the collection of information on the numbers 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.[98] States wishing to protect elderly citizens from abuse will need to recognize similar goals regarding the measurement and the management of this abuse problem when enacting legislation.

Elder abuse is often defined in terms of abuse and 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.[99] 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 assault.[100] Accordingly, in *Mack v. Soung*, the California Court of Appeals provides an example regarding elder abuse liability arising from a physician's willful act that caused

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96 *Id.* § 15610.07 (citing Historical and Statutory Notes accompanying the statute).

97 *Id.* The balance of the report's elder abuse cases include: fiduciary abuse (32%), mental suffering (22%), and sexual abuse (3.8%). *Id.* Although 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.

98 *Id.* § 15601(a)-(c).

99 The statutes of five generally representative states are surveyed in this section. *See generally* ARK. CODE ANN. § 5-28-101 (Michie 2001); CAL. WEL. & INST. CODE § 15610 (West 2001); FLA. STAT. ANN. §§ 415.102(1), (15) (West 2002); N.Y. PENAL LAW §§ 260.25, 260.30 (McKinney 2000); TENN. CODE ANN. § 71-6-117 (1995).

100 TENN. CODE ANN. § 71-6-119 (1995).

physical harm to an elderly citizen.[101] The court, 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, and then not treating, a nursing home patient's bedsore.[102]

Physicians and attorneys alike should note that the liability for elder abuse often involves the acts of a caretaker. As such, 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 the adult person voluntarily, or by contract, or agreement.[103] Thus, it is not inconceivable that, in light of a broad statutory definition of a caretaker, many states might 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 civil elder abuse laws and the criminal statutes of aggravated assault.

A survey of specific state statutes and case law may be helpful, however, prior to initiating an elder abuse action. For example, in Arkansas, abuse of an adult includes "any willful or negligent act which results in neglect . . . unreasonable physical injury . . . and failure to provide necessary medical treatment . . . or medical services."[104] Further, the adult abuse statutes state that it is specifically unlawful for "any person or a caregiver to abuse or neglect" an adult.[105] Conversely, while Tennessee recognizes many of the typical 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

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101 *See Mack v. Soung*, 95 Cal. Rptr. 2d 830, 831 (Cal. Ct. App. 2000). The court in *Mack* said, "recklessness, unlike negligence, involves more than inadvertence, incompetence, unskillfulness, or a failure to take precautions but rather rises to a level of a conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it." *Id.* at 834 (internal quotation marks omitted).

102 *Id.* at 835.

103 *See, e.g., supra* note 99.

104 ARK. CODE ANN. § 5-28-102 (Michie 1997) (codifying the legislative intent regarding the detection and correction of adult abuse).

105 *Id.* § 5-28-103(a) (Michie 2001). 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(2). "Person" is not defined in this statute. *See id.* § 5-28-101. Both criminal and civil penalties apply to such abuse. *See id.* §§ 5-28-103, 106.

traditional medical malpractice claim.[106] 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).[107] 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 will increase in all states.

For the protection of physicians and clients alike, many states have adopted specific palliative care and intractable pain management statutes or regulations.[108] 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. Currently, many states emphasize concerns involving narcotics in both the addiction aspect and in the treatment of pain for the elderly and the terminally ill.[109] Such guidelines would help in establishing a legal standard of care in the treatment of elderly and terminally ill patients suffering from intractable pain.

V. CONCLUSION

A. 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 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

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106 TENN. CODE ANN. § 71-6-120(g) & § 29-26-115.

107 Criminal remedies could include both the potential of a Class A misdemeanor and aggravated assault. *See, e.g.*, TENN. CODE ANN. § 71-6-117 (1995) and TENN. CODE ANN. § 71-6-119 (1995). For an example of a State Board of Medical Examiners' disciplinary process, see TENN. CODE ANN. § 63-6-213-217 (2000).

108 *See Washington v. Glucksberg*, 521 U.S. 702, 780 n.51.

109 Pain & Policy Studies Group, University of Wisconsin Comprehensive Cancer Center, *Annual Review of State Pain Policies 2000*, *available at* http://www.medsch.wisc.edu/painpolicy/publicat/01ppsgar/execsum.htm; *see, e.g.*, TENN. COMP. R. & REGS. 0880-2-.14 (2003).

the terminally ill.[110] Recognizing that quality medical care dictates that patients have access to appropriate and effective pain relief, the Pain & Policy Group highlighted the following issues:

(1) inadequate pain control may result from a physician's lack of sophisticated knowledge or experience in pain management;[111]
(2) fear of investigations by federal, state, or local regulatory agencies inhibit a physician's comfort level in adequately treating patients with intractable pain;[112]
(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;[113] 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 additional evaluation and treatment when necessary, and complied with the control substances laws and regulations.[114]

The adoption of these or similar recommendations by state medical boards, along with physician education and legal enforcement of such recommendations, would allow physicians to better address their patients' pain relief needs.[115] Removing the fear of

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110 Pain & Policy Studies Group, *supra* note 109.

111 *Id.* at App. A § II.

112 *Id.*

113 *Id.* Tennessee's regulation (which is similar to regulations in California, Florida, and New York concerning the "authority of physician[s] to prescribe for the treatment of pain," states that "[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. COMP. R. & REGS. 0880-2-.14 (6) (e) (1) (2003). 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 for 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.

114 *Annual Review of State Pain Policies 2000, supra* note 109 at App. A *2-3.

115 Pain and Policy Studies Group, University of Wisconsin, ACHIEVING BALANCE IN FEDERAL & STATE PAIN POLICY: A GUIDE TO EVALUATION at Executive Summary (Sept. 2003), *available at* http://electra.biostat.wisc.edu/painpolicy/eguide 2003/index/eguide 2003.pdf. Alabama, Florida, Kansas, Kentucky, Missouri, Nebraska, Nevada,

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 of elderly and terminally ill patients. It is only through recognition and enforcement of these and similar recommendations that attorneys will force reluctant physicians to provide relief for patients suffering from chronic pain.

B. Where Do We Go From Here?

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. While it is understandable that society wants to limit the availability of narcotics in our culture of drug abuse, a better understanding of the balance between narcotic addiction and the relief of intractable pain in the elderly and the terminally ill is needed. Organized medicine and several state legislatures have begun to address these issues, 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 as acceptable in terminally ill patients[116] and with the growing use of nontraditional medical malpractice claims where adequate pain relief is not supplied to dying patients, state medical boards in general, and physicians specifically, are on notice of society's expectations in pain management. To defy these expectations, either through ignorance or fear of discipline, will encourage additional legal remedies to ensure that the elderly and the terminally ill have the pain relief they deserve.

As for your friend, Dr. A., physicians practicing pain management are both needed by society and at risk from society. Dr. A. should discuss these pain issues with her patient and her patient's family, expressly document the plan of treatment in the medical record, follow well established pain guidelines, such as the ones cited from the University of Wisconsin, and keep her fingers

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South Carolina, South Dakota and Utah have adopted in full the recommendations of the Pain & Policy Study Group. *Id.* at Table 4. Arizona, Iowa, Maine, New Hampshire, New Mexico, New York, Oklahoma, Pennsylvania, Tennessee, Texas, and West Virginia have adopted the recommendations in part. *Id.* Approximately 20 states have statutes regarding palliative care, and approximately 20 states have regulations concerning palliative care. *Id* at Fig. 1.

116 *See Washington v. Glucksberg,* 521 U.S. 702, 735, 737-38 (1997).

crossed. As organized medicine figures out what the rest of us already know — that pain hurts and that chronic pain really hurts — the medical community will do a better job with pain management. If organized medicine is slow to grasp this concept, however, attorneys will 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 fewer physicians will be criminally prosecuted for the practice of medicine, the possibility of more physicians being held liable for elder abuse and neglect remains a significant possibility.