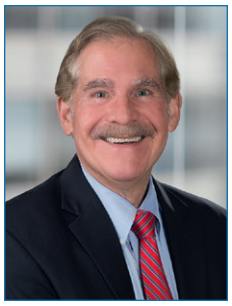

LEGAL ISSUES

By Alan C. Horowitz, Esq., RN

Managing Pain: Legal and Ethical Considerations

"Is there anything you can give me for my pain?" Are there any clinicians who never had a patient utter those words? Treating pain is simple, right? Not exactly. A combination of factors — societal, legal, and ethical — have compounded the challenges for physicians and advanced practice providers (APPs) who earnestly attempt to ameliorate and properly manage their patients' pain. Two examples below illustrate how clinicians sometimes walk a tightrope, balancing between prescribing too much or too little pain medication. But first, let's consider the scope of the problem.

Magnitude of the Problem

Chronic pain is one of the most common chronic conditions people face, with 50.2 million adults (20.5%) in the United States reporting daily or near-daily pain (*Pain* 2022;163:e328–e332). For older adults, chronic pain can be even more common, with as many as 80% of nursing home residents experiencing pain (*J Am Med Dir Assoc* 2020;21:149–163). This can in turn restrict mobility and prevent aging adults from participating in things that keep them active and well.

Clinicians employ a range of non-pharmaceutical approaches to effectively manage patients' pain, but they often need to do so in combination with pharmaceutical approaches, including the use of opioids. However, in an era of intense federal and state government scrutiny and an explosion in opioid-related litigation that does not seem to be abating, how can a clinician appropriately treat severe, intractable chronic pain without fear of legal liability?

A Tale of Two Legal Cases Involving Pain Management

Perhaps geriatric specialists and oncologists have the most significant challenges given their respective patient populations. Further complicating the challenge for physicians and APPs is that either too much or too little of narcotic pain medication can result in litigation, even if there is no factual or legal basis for such an action.

In the case of *Bergman v. Eden Medical Center*, a physician was sued because he allegedly did not prescribe adequate pain medication for his 85-year-old patient who was dying from metastatic lung cancer. Although there are endless lawsuits of this nature, most are couched as negligence or medical malpractice. What made the *Bergman* case noteworthy was that it was the first time an alleged failure to treat pain resulted in a lawsuit alleging a violation of California's Elder Abuse Statute. The case ended in a $1.5 million jury verdict against the physician. The unambiguous takeaway from the *Bergman* case (and similar ones) is that physicians and APPs may be legally liable for not providing adequate pain management not just based on negligence or medical malpractice theories but also based on a state's elder abuse statute.

By contrast, physicians, APPs, nurses, and facilities can also be sued for *allegedly* providing *too much* pain medication. Several years ago, I represented a hospice where its medical director and several nurses were alleged to have prescribed and administered, respectively, "excessive doses of morphine" resulting in the patient's demise. The claim was brought by the patient's adult son and did not have any real basis in fact: there were no excessive doses of morphine, and I argued that the standard of care was not only met but exceeded. Still, the medical director and the nurses who prescribed and administered multiple doses of morphine over two weeks were facing potential disciplinary action by their state boards of medicine and nursing, respectively, as well as other serious legal consequences.

Bolstering the defense of the hospice medical director and the nurses was a medical expert: a hospice medical director, Dr. Dan Haimowitz. Dr. Haimowitz provided credible testimony that was instrumental in having all the allegations dismissed. According to Dr. Haimowitz, "after a careful review of the terminally ill patient's medical record, it became clearly apparent that the hospice medical director prescribed, and the nurses administered, appropriate doses of pain medication." Dr. Haimowitz noted, "Proper pain management can be challenging. The thorough documentation by the physician and nurses supported the clinical decision-making and proved to be essential in this case." The critical fact that saved these caring clinicians from multiple legal actions was their meticulous documentation for every hospice visit and interaction with the patient and his wife, including patient education.

As a result of the opioid epidemic, perhaps the pendulum has swung too far. It is difficult to ignore the staggering statistics regarding overdoses, addiction, and related problems. Virtually every day brings news of a pharmaceutical company, a pharmacy chain, a retail pharmacist, and others named as defendants in multimillion dollar cases. For example, last August, a federal judge ruled that CVS, Walgreens, and Walmart must pay a combined $650.6 million in damages related to the opioid crisis. Teva Pharmaceutical Industries announced it would pay $4.35 billion in a nationwide settlement for its alleged role in the opioid epidemic. Likewise, Purdue Pharma may pay $6 billion for its role in the opioid crisis. And Johnson & Johnson and the three largest U.S. drug distributors — McKesson Corp, Cardinal Health Inc., and AmerisourceBergen Corp — finalized a $26 billion nationwide opioid settlement last February.

Strategies for Risk Mitigation

Given the potential for legal action as well as the legitimate concerns over the possible consequences of even appropriate doses of pain medication (e.g., falls, confusion, addiction, oversedation, impaired function and judgment, etc.), clinicians can arm themselves with strategies to avoid or at least mitigate adverse consequences. A few such strategies are noted below.

- *Guidelines.* Many medical organizations and health systems have developed excellent guidelines regarding pain management. For example, AMDA – The Society for Post-Acute and Long-Term Care Medicine created and published a pain management clinical practice guideline (CPG) and pocket guide (available at https://bit.ly/painCPG). The Society's CPG contains 62 well-reasoned recommendations regarding pain management and notes the importance of reassessing the patient at regular intervals.

According to Dr. Suzanne Gillespie, president of the Society, "chronic pain is prevalent in older adults, including residents of post-acute and long-term care settings." She notes, "Pain is a complex problem, so it is critical that clinicians have clear, evidence-based guidelines to guide them in their efforts to provide safe and effective pain care to their patients."

Interestingly, the Centers for Disease Control and Prevention published guidelines for pain management in 2017, but many clinicians felt those guidelines were too restrictive and unrealistic. Consequently, in 2022, the CDC published its *Clinical Practice Guideline for Prescribing Opioids for Pain* (http://bit.ly/3ZB1hQW). In its revised guideline, the CDC states that "these recommendations do not apply to ... pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care."

- *Informed consent.* As a lawyer, I recommend having patients (or the person designated as their power of attorney, as applicable) sign a dated consent form clearly stating that they have been informed of the risks and benefits of taking opioid pain medication.
- *Documentation.* An essential component of good medical practice as well as prudent risk management is to have thorough, accurate, and complete documentation including, but not limited to, descriptions of discussions with the patient. Those discussions should include items such as the basis for continuing and/or increasing doses, the response to pain management, and any alternatives that have been prescribed or suggested. Such documentation paid off with the hospice case I have described.
- *Patient education.* Patient education, particularly regarding the risks and benefits as well as discussions of all realistic alternatives to opioid medication such as physical therapy, exercise, cognitive behavioral therapy, and interdisciplinary rehabilitation, is another risk management strategy. In some cases, surgery may be an appropriate recommendation, and all alternatives should be discussed and documented with patients.

Conclusion

When dealing with pain management, the ethical components of beneficence, non-malfeasance, and autonomy come into play. The fundamental precept of "first, do no harm" is always a guiding light for clinicians. Proper consideration of the risk management strategies I have noted can go a long way toward allowing clinicians to treat their patients without fear of potential legal consequences.

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