LAW & MEDICINE

Aggressive Treatment of Pain

Question: To relieve intractable pain in a terminally ill patient, the physician administered increasing amounts of morphine. This led to respiratory arrest and hastened the patient's death. The physician's action is:

A. Medical malpractice.
B. Supported by a minority of physicians.
C. The intentional tort of assault and battery.
D. An example of "double effect."
E. Homicide.

BY S.Y. TAN, M.D., J.D.

Answer: D. The "double effect" phenomenon describes situations in which a foreseeable adverse outcome supervenes, even though the intent was to confer a benefit. This doctrine of "secondary, unintended consequences" is commonly invoked to permit the proportionate, albeit aggressive, use of comfort measures such as narcotics in terminally ill patients. Among attending and house staff in a published survey, some 92%-94% agreed that "sometimes it is appropriate to give pain medication to relieve suffering, even if it may hasten a patient's death" (Am. J. Public Health 1993;83:14-23).

The doctor's action in this hypothetical case will therefore not amount to malpractice, as there is no breach of the standard of care and therefore no negligence. This is also not assault and battery, which is an intentional act that involves apprehension of or actual offensive touching without consent. In this clinical setting, consent usually has been explicitly given or implied by the patient or the surrogate decision maker.

The specter of a potential homicide charge may alarm, but no less an authority than the U.S. Supreme Court has reasoned otherwise. In *Vacco v. Quill,* the Court unanimously drew a distinction between aggressive palliation and physician-assisted suicide, clarifying that "in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead" (*Vacco v. Quill,* 117 S. Ct. 2293 [1997]).

Pain management and comfort care become primary treatment goals even if cure is impossible. Dying patients fear that their pain will not be aggressively treated, and studies have repeatedly shown that physicians do not adequately treat pain.

In addition to providing pain relief, physicians should communicate their plans regarding palliative care by using open-ended questions, screening for unaddressed spiritual concerns, and listening actively and with empathy (Ann. Int. Med. 1999;130:744-9).

In a California trial that received widespread media coverage, an Alameda County jury turned in a verdict against an internist charged with elder abuse and reckless negligence because he failed to give enough pain medication to a patient dying of cancer (*Bergman v. Eden Medical Center,* No. H205732-1 [Sup. Ct. Alameda Co., Cal., June 13, 2001]). Under California law, death of a plaintiff extinguishes a claim for pain and suffering. The case was therefore brought under the elder-abuse law, under which the burden of proof was higher, requiring a reckless rather than a simple negligence standard.

The case involved William Bergman, an 85-year-old retired railroad worker with lung cancer, who was admitted to Eden Medical Center in early 1998. The lawsuit alleged that the treating physician was reckless in not prescribing effective medication for Mr. Bergman, who complained of severe back pain. The patient stayed at the hospital for 6 days, and nurses consistently charted his pain in the 7-10 range. On the day of discharge, his pain was at level 10. He died at home shortly thereafter.

After 4 days of deliberation, the jury, in a 9-3 vote, entered a guilty verdict and awarded $1.5 million in general damages. This amount was subsequently reduced to $250,000 because of California's cap on noneconomic damages.

Eight jurors wanted to award punitive damages, as they believed that the doctor had acted with malice or had intentionally caused emotional distress. However, no punitive damages were assessed because nine votes were needed.

The hospital had settled privately with the family before trial. The guilty verdict came despite defense expert testimony that the treatment provided was reasonable and would be the same as that provided by 95% of all internists.

Mr. Bergman's family had earlier filed a complaint with the California Medical Board, which took no action despite a medical consultant's conclusion that the hospital's pain management was inadequate. The medical board felt that it lacked clear and convincing evidence to find a violation of the Medical Practice Act.

The Bergman case is notable for being the first of its kind, and squarely puts physicians on notice regarding their duty to provide adequate pain relief. The closest previous decision finding liability for failure to treat pain involved a nursing home's failure to administer pain medications that had been ordered by the doctor (*Estate of Henry James v. Hillhaven Corp.,* Super Ct. Div. 89 CVS 64 [Hertford Cty, N.C., Jan. 15, 1991]). ■

DR. TAN *is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" (2006). For additional information, readers may contact the author at siang@hawaii.edu.*

Coordinated Care Would Cut Medicare Readmissions

BY JOYCE FRIEDEN

More coordinated care can reduce the rate of hospital readmissions among Medicare beneficiaries by more than 25%, a study has found.

"Policymakers should take notice of this and other studies that demonstrate what's already working in some health care plans," Len Nichols, Ph.D., director of the health policy program at the New America Foundation, a Washington think tank, said in a statement. "It's time to move away from the current fee-for-service payment system toward one that emphasizes value rather than volume, enhances the value of primary care, and holds providers accountable for quality and efficiency."

'If the Medicare fee-for-service program had similar rates of readmissions and preventable hospitalizations, [it] would have saved approximately $10 billion in the year of the study.'

The study involved 13 plans in the Medicare Advantage program, under which private health plans contract with Medicare to care for beneficiaries. The study was sponsored by the Alliance of Community Health Plans (ACHP), an organization of nonprofit, community-based, and regional health plans. All of the plans in the study were members of ACHP.

Gerard Anderson, Ph.D., of Johns Hopkins University, Baltimore, and his colleagues focused their research on two areas: hospital readmissions and preventable hospital admissions/emergency department (ED) visits.

"These measures were chosen for several reasons," they wrote in a report released by ACHP. "First, readmissions and preventable hospitalizations are expensive for the Medicare program. Second, there is an established literature on how to measure readmissions and preventable hospitalizations. Third, they can be used to evaluate if health plans can improve outcomes for Medicare beneficiaries and save money for the Medicare program."

The researchers compared the rates of readmissions and preventable admissions/ED visits in the fee-for-service Medicare program with those of the 13 health plans studied. The study spanned the first 6 months of 2007 and used the third quarter of that year to monitor any readmissions or follow-up care.

The investigators found that the national Medicare fee-for-service readmission rate was 18.6%, while the ACHP plans in the study had an average rate of 13.6%—a rate that was 27% lower. Based on previous readmission cost data, the Medicare fee-for-service plan could have saved nearly $5 billion if it had had the same readmission rate as the ACHP plans in the study, Dr. Anderson and his associates said.

On average, ACHP member plans had preventable inpatient hospitalization rates in 2007 that were 13% of the national average, the researchers noted. Based on an average payment per discharge of nearly $8,400 in 2007, bringing Medicare's fee-for-service preventable hospitalizations down to the same level as the ACHP plans would have saved the program $4.5 billion, according to the study.

As for preventable ED visits, the rate among the Medicare fee-for-service patients was 15.5 visits per 100 beneficiary months, compared with an average of 2.2 visits for the ACHP plans studied (range, 0.5-7.8). The average ACHP plan had 86% fewer preventable emergency department visits than the Medicare fee-for-service program. Based on an average ED visit payment of $510, reducing the Medicare fee-for-service preventable ED visit rate to the rate experienced by the 13 plans studied would have saved Medicare $900 million.

The results suggest that "the approaches adopted by these plans—which include greater focus on primary care, care coordination, transitional planning post-discharge, prevention measures, and active case management—are improving care for their beneficiaries, keeping people out of the hospital, and lowering costs," the authors wrote in the ACHP report. "If the Medicare fee-for-service program had similar rates of readmissions and preventable hospitalizations, then the Medicare program would have saved approximately $10 billion in the year of the study." ■