PRF NEWS

Covering Practice and Risk Management Issues for Physicians

Volume 4, Number 3
December 2001

Stephen Scheifele, MD, Executive Editor
Robert D. Nachtigall, MD, Editor

PRF News is produced by Knox Communications

Physicians Reimbursement Fund, Inc.
1409 Sutter Street
San Francisco, CA 94109
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com

June Riley
Executive Director

Soad Kader
Director of Membership

DIRECTORS
George F. Lee, MD
Stephen Scheifele, MD
Damian Augustyn, MD
W. Gordon Peacock, MD
Michael Abel, MD
Andrew Sargeant, ACA, CFA
(Vermont Insurance Management)

Reuben A. Clay, Jr., MD
Chair of Patient Care and Management Committee

Stephen Schiefele, MD
Chair of Risk Management & Education Committee

W. Gordon Peacock, MD
Chair of Peer Review Committee

PRF at a Glance

BY GEORGE F. LEE, MD

More than 26 years ago, this company began as an off-shore captive insurance company. Over the years the company evolved, and today Physicians Reimbursement Fund is an on-shore corporation operating as a fully regulated risk retention group, and one of the few remaining professional liability insurers offering occurrence-based coverage.

The long-standing success of this company can be traced to the continuing participation and support of our physician insureds. The following is a list of PRF committees and their functions, and most importantly, the physicians who serve on these committees – the people who make this company successful.

PRF–RRG BOARD OF DIRECTORS

The PRF–RRG Board of Directors is the policy making body of the company. The board meets monthly to review all matters concerning PRF–RRG insureds, including membership, financial, administrative and regulatory issues. The board also reviews the claims activities report as presented by Reuben A. Clay, Jr., MD, Chair of the Patient Care and Management Committee. Also in attendance at all PRF–RRG Board meetings are corporate counsel, Alan Sparer, and PRF–RRG Executive Director, June Riley.

- George F. Lee, MD, *Chair and President*
- Stephen J. Scheifele, MD, *Secretary*
- Damian Augustyn, MD, *Treasurer*
- W. Gordon Peacock, MD, *Vice President*
- Michael Abel, MD, *Vice President*

PEER REVIEW COMMITTEE

The Peer Review Committee reviews all new applicants for approval. In addition, the committee meets at least once a year to review the renewal applications in order to make recommendations to the Board of Directors for approval/renewal of all insureds.

- W. Gordon Peacock, MD, *Chair*
- Lesley Anderson, MD
- Alan Johnson, MD
- Madelyn Kahn, MD
- Audrey Koh, MD
- Joseph Kushner, MD
- Ziyad Hannon, MD
- Marie Lewandowski, MD
- David Manace, MD
- Frederick Ostermann, MD
- Rachel Shu, MD
- Clare Siu, MD
- Michael Small, MD
- William Wolfenden, MD

PATIENT CARE & MANAGEMENT COMMITTEE

The Patient Care & Management Committee meets monthly to review current claims activities in order to assess the potential financial liability to PRF. Upon review of appropriate medical records, the Committee will make recommendations to the Board for setting reserves as to cost of defense and liability.

- Reuben A. Clay, Jr., MD, *Chair*
- W. Gordon Peacock, MD, *Guest*
- Donald Brown, MD
- Nima Grissom, MD
- William Hagbom, MD
- Holly Holter, MD
- Jordan Horowitz, MD
- Fung Lam, MD
- Margaret Miller, MD
- Peter Volpe, MD
- May Yen Yau, MD
- Counsel: Alan Sparer and Jeff Faucette of Howard, Rice, Nemerovski, *et al.*

EDUCATION & RISK MANAGEMENT COMMITTEE

The Education & Risk Management Committee, in concert with John Knox of Knox Communications, produces the three PRF–RRG newsletters published each year. The committee focuses on a topical theme for each newsletter to assist our insureds in the risk management of their various types of practice.

- Stephen J. Scheifele, MD, *Chair, Exec. Editor*
- Robert Nachtigall, MD, *Editor*
- Nancy Carteron, MD
- Claire Siu, MD
- Maida B. Taylor, MD

PRF–RRG STAFF

The PRF staff serve as a liaison between the Board of Directors, the various committees, legal counsel and all insureds. At least one PRF staff member is present at all company meetings. Please call (415) 921-0498 if you have any questions or concerns regarding anything from your premium to claims made. It is very important that an insured notify the PRF office in the event of a possible suit or arbitration.

- June Riley, *Executive Director*
- Soad Kader, *Director of Membership.* ■

Dr. Lee is president of the PRF-RRG

December 2001

Newsletter of the Physicians Reimbursement Fund, Inc.

PRF NEWS

Volume 4, Number 3

Covering Practice and Risk Management Issues for Physicians

Jurors Tell Physicians to Take Pain Seriously

In a recent groundbreaking legal development, an Alameda County jury awarded a $1.5 million verdict against a physician accused of inadequately treating his patient's pain. Tried under California's elder abuse and neglect law, rather than as alleged medical malpractice, this verdict underscores physicians' vulnerability to accusations of inadequate pain management and raises the possibility that similar cases may follow.

In February 1998 an 85-year-old man was admitted to the hospital for severe back pain caused by spinal compression fractures. The patient's primary care physician did not have hospital privileges, so the patient was admitted under the care of a hospitalist, who ordered 25-50 mg of Demerol IV every 3 hours prn for the pain. After some tests, lung cancer was strongly suspected. The patient requested palliative care only and after five days was discharged home under hospice care.

On the morning of discharge, the patient's pain was assessed by the nursing staff as 10/10 and he was given 25 mg of Demerol. When the patient's daughter came to pick him up, she saw his discharge medications included only Vicodin for pain, so she had the nurse page the hospitalist who ordered another 25 mg of Demerol IV and a 75-mcg fentanyl patch. Two days after discharge a hospice nurse assessed the patient's pain as "out of control" and the primary care physician prescribed liquid morphine and two fentanyl patches, which relieved the pain through the next day when the patient became comatose and died.

The daughter contacted the Medical Board of California (MBC), which agreed that the pain management had been inadequate, but noted a lack of clear and convincing evidence of a violation of the Medical Practice Act. Because California medical malpractice law does not permit recovery for a deceased patient's pain and suffering, the patient's children sued under the elder abuse and neglect law.

At trial, the plaintiff's experts considered the pain management "egregious" and "appalling" and they stressed that the case was about the pain management, not the patient's death. Factors that may have influenced the jury verdict include the following:

- The physician lacked knowledge of modern pain management, having received only one hour of CME on pain management in the past 30 years.
- The physician did not remember the MBC's "Action Report" pain management guidelines that was sent to every California physician in 1994 and 1996.
- The physician was not aware of the Intractable Pain Treatment Act, which protects physicians from MBC discipline for prescribing controlled substances for intractable pain.

As stated in the May/June 2001 issue of the *Professional Liability Newsletter*, "the jurors clearly wanted to send a message to physicians to take pain seriously." The newsletter observed that "many physicians are concerned about being squeezed between liability for undertreatment of pain and liability for excess prescribing of narcotics. But experts believe there is plenty of room between these extremes for good medical practice." ■

Inside PRF News

Medical Management of Pain

BY GEORGE F. SMITH, M.D.

ACUTE PAIN IN AN OUTPATIENT SETTING

Most physicians are used to treating acute pain. This includes sprains, strains, trauma, and the aftermath of outpatient medical or surgical procedures. Pain management in these circumstances is based on a fairly predicable clinical response to injury and takes into account a reasonable variation in an individual patient's response. More extensive injuries may require multiple medications and modalities; for example, an acute severe back sprain may require a combination of anti-inflammatory, opioid, and muscle relaxant medications. It is important that the physician:

- Supply enough medications for the expected treatment duration
- Inform patients of side effects and the contingencies for treating side effects (e.g., nausea and constipation for opioids)
- Arrange for follow up to monitor the effectiveness of treatment.

ACUTE PAIN IN AN INPATIENT SETTING

The treatment of post-operative or post-procedure pain in an inpatient setting requires that the physician take into account the individual's response to pain and use of pain medications prior to the procedure. In general, patients who are taking opioid medication on a regular basis will have developed a degree of tolerance and will require significantly higher doses of opioids post procedure. Postoperative pain **should not** be managed with "prn" orders as this results in poor pain control in the majority of patients. Patient Control Analgesia devices, which administer intravenous or epidural medications, are more effective and safer. There is essentially no risk of addiction in treating patients with opioids after surgery, whereas inadequate pain management can result in complications such as atelectasis, pneumonia, and DVT, as well as prolong the hospitalization.

CHRONIC PAIN

Chronic pain presents a much more challenging problem because the pain is accompanied by significant psychologic dysfunction. Most patients with chronic pain are depressed. The focus of treatment may need to shift from the specific disease entity to the pain and the resultant disability. The physician needs to anticipate a prolonged and even indefinite course of treatment as with other chronic conditions such as diabetes or hypertension. Because the blood levels of administered analgesics need to remain relatively constant throughout the day, short acting opioids such as codeine are usually minimally effective. It is important to consider physical tolerance, dependence and possible addiction. These factors need to be discussed in detail with the patient prior to instituting a long-term treatment plan with opioids, tranquilizers, or antidepressants.

The Medical Board of California has outlined specific guidelines for physicians to follow in treating chronic pain (see list following this article). This was initially outlined in 1994 and updated in the October 2001 Action Report. Six bills have been passed in California in the past ten years that have supported physicians treating chronic pain.

Dr. Smith is an internist in Daly City who specializes in pain management. ■

BRIEFCASE

PAIN CME

AB 487 (Aroner) was recently signed into law by the Governor. This now requires most practicing physicians to obtain 12 continuing education credits within the next four years in pain management and end-of-life care. ■

Medical Board Guidelines for the Treatment of Intractable Pain

1. HISTORY/PHYSICAL EXAMINATION
A thorough medical history and physical examination must be accomplished.

2. TREATMENT PLAN, OBJECTIVES
The treatment plan should state objectives by which treatment success can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. Several treatment modalities or a rehabilitation program may be necessary.

3. INFORMED CONSENT
The physician should discuss the risks and benefits of the use of controlled substances with the patient or guardian.

4. PERIODIC REVIEW
The physician should periodically review the course of opioid treatment of the patient and any new information about the etiology of the pain. Continuation or modification of opioid therapy depends on the physician's evaluation of the progress toward treatment objectives.

5. CONSULTATION
The physician should be willing to refer the patient as necessary for additional evaluation and treatment to achieve treatment objectives. Physicians should give special attention to those pain patients who are at risk for misusing their medications. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with addiction specialists, and may entail the use of agreements between the provider and the patient to specify rules for medication use.

6. RECORDS
The physician should keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews.

7. COMPLIANCE WITH CONTROLLED SUBSTANCES LAWS AND REGULATIONS
To prescribe substances, the physician must be appropriately licensed in California and comply with federal and state regulations for issuing controlled substances prescriptions.

Documented adherence to these guidelines will substantially establish the physician's responsible treatment of patients with intractable pain and will serve to defend that treatment practice in the face of complaints which may be brought. ■

Legal Risks and Responsibilities in Pain Management

BY JEFFREY E. FAUCETTE, JD

Two years ago, the Oregon Medical Board disciplined a physician for not doing enough to mitigate the pain of six terminal cancer patients.

Earlier this year, an Alameda County jury awarded $1.5 million against a physician for failing to give a dying cancer patient sufficient pain medication. And just recently, Governor Gray Davis signed a new law requiring the development of new pain management standards and requiring physicians and surgeons to complete mandatory pain management continuing education courses (see Briefcase item, page 2). Clearly, the treatment of pain now presents risk management as well as medical issues as the Medical Board of California faces increasing pressure from outside organizations and politicians to investigate and *discipline* physicians accused of "undertreating" pain.

Physicians face potential liability over pain management in two ways:

- A patient may include pain claims as part of a conventional medical malpractice suit for treatment alleged to deviate from the standard of care.
- A lawsuit may be brought for elder abuse in cases involving pain management in the treatment of patients 65 and older. Furthermore, pain management claims characterized as "elder abuse" are *not* subject to the $250,000 MICRA limit on non-economic damages, and these claims survive the death of the patient. However, these claims require proof of "reckless" behavior by the physician — a significantly higher standard than the negligence standard applied in an ordinary malpractice claim.

Clearly, the treatment of pain now presents risk management as well as medical issues as the Medical Board of California faces increasing pressure from outside organizations and politicians to investigate and discipline physicians accused of "undertreating" pain.

To avoid legal action for pain management, physicians can:

- Review current resources on pain management and palliative care
- Consider pain and other forms of discomfort as separate medical problems, worthy of their own assessments and plans
- Seek help or consultation for difficult cases
- Make sure that the patient's chart reflects your assessment of the patient's pain, and that your prescription of medications matches that assessment
- Carefully monitor elderly and dependent adult patients for medical problems that can give rise to claims of abuse and neglect, and then aggressively treat those problems
- When dealing with elderly patients, try to make sure that the patient's immediate family members understand your decisions regarding pain management
- Notify the PRF of any potential claims as soon as they are suspected

Jeffrey E. Faucette, JD, is an associate in the law firm Howard, Rice, Nemerovski, Canady, Falk & Rabkin, which represents Physicians Reimbursement Fund and its member physicians.

BRIEFCASE

REQUEST FOR ARTICLE IDEAS

With this issue, Stephen Scheifele, MD assumes the role of executive editor of this newsletter, taking over for Maida B. Taylor, MD, MPH, who served ably in that capacity since 1999. Dr. Scheifele and the Risk Management & Education Committee seek ideas for articles that are timely and deal with issues of concern to PRF insureds. Dr. Scheifele is also looking for insureds who are interested in serving on the committee. Please submit your article ideas or indicate your committee interest by phoning (415) 921-0498 or sending an e-mail message to June@PRFrrg.com. ■