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A federal watchdog agency issued a report in December finding flaws with the Congressional National Practitioner Data Bank (NPDB). General Accounting Office officials partially blamed the databank's administering agency, says the Health Resources and Services Administration of the Department of Health and Human Services. The report also was critical of hospitals, however, by not following instructions for the databank. 6

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Hospitals get an 'F' on disciplinary report card

Flawed database's reliability questioned

Chances are your hospital doesn't provide timely, accurate reports of malpractice payments and physician disciplinary actions to the government, according to a recent investigation.

The National Practitioner Data Bank (NPDB), the federal government database that contains records of disciplinary actions and malpractice lawsuits filed against physicians and dentists, is not as complete, up to date, or accurate as it should be, charges a recent report by the General Accounting Office (GAO), the investigative arm of Congress.

Despite widespread concern that providers are not reporting all disciplinary actions to the databank as required by law, the agency that maintains the databank, the Health Resources and Services Administration (HRSA), has not included improved enforcement measures in its strategic plan, the report claims. HRSA falls within the Department of Health and Human Services.

In addition, according to GAO analysis of the data bank's records, the disciplinary actions that are reported often contain inaccurate or insufficient information; almost half of the malpractice reports studied by investigators were filed more than 30 days past their due date, and 95% of these reports did not, as required by law, indicate whether the standard of care had been violated. **(For more on missing information, see the chart, p. 6.)**

Investigators also noted that a 13-year-old law expanding the databank to include information on nurses and other providers has not been implemented, and the agency did not have an effective policy for evaluating the suitability of its user fees

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Missing information

The General Accounting Office (GAO) found in its analysis of the National Practitioner Data Bank that malpractice reports often are incomplete. 6

Should patients' biases be tolerated?

✓ *Hospitals get caught in the fray*

A patient, for any number of reasons, requests that he or she receive care by a clinician of only a specific ethnic or racial group or gender. Or, to be more exact, the patient asks not to receive care from a certain caregiver due to that person's gender, race, or ethnicity. 6

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for accessing the bank's information, and did not have a plan for ensuring collection of the fees in a timely manner.

The findings are detailed in the GAO's recent report, *National Practitioner Data Bank: Major Enhancements are Needed to Enhance Data Bank's Reliability*, made public in November of last year. (See editor's note, p. 5, on how to obtain the report.)

Is a state-administered system the answer?

The critical report follows closely in the wake of attempts by some patients' rights groups and Congressional representatives to open the databank to the public. Currently, only hospitals, insurance companies, and state licensing boards have access to the information. (For more facts on the databank, see related story, p. 5.)

A bill introduced in Congress by Thomas Bliley (R-VA) to open the databank to the public has garnered little support by lawmakers, however, and is opposed by groups such as the Chicago-based American Medical Association (AMA), the Physician Insurers Association of America, and the American Academy of Orthopaedic Surgeons in Rosemont, IL.

The new information from the GAO makes clear that the databank is seriously flawed and should not be counted on as a reliable source of information on physician quality for the public, says **Thomas R. Reardon**, MD, immediate past president of the AMA.

Reardon and the AMA are in favor of an effort to link disciplinary information gathered by medical boards in different states rather than the federally overseen separate databank system.

"Information about physician credentials and disciplinary action is available right now through state-based systems already in place," Reardon contends.

The Federation of State Medical Boards is implementing a computer system that would allow the public to access disciplinary information about physicians in every state via the Internet.

State boards traditionally do a better job of maintaining accurate information about physicians practicing in their state and this would be a more reliable information source for the public, says Reardon.

However, the Federation system would not include information about malpractice suits and malpractice payments the NPDB currently does.

"When the [NPDB] was originally conceived,

we supported it. We do think that there should be a national system to track problems with physicians,” Reardon says. “But, then they decided to include malpractice information, and we were not in favor of that.”

The fact that a physician has been sued for malpractice is not in and of itself an indication about whether he or she is a good physician, he notes. “Many physicians are sued several times over the course of their careers. And, those may be the physicians that I would go to or I would send my family to.”

Malpractice lawsuits can be dismissed for lack of evidence, but the fact that a physician was sued remains. Some physicians decide to settle minor malpractice claims in order to avoid a lengthy and expensive trial. And, some carriers of malpractice insurance will agree to settle malpractice claims despite the physician’s desire to fight the case.

All of these situations would still result in a physician being reported to the NPDB — *if* the hospital or insurer were complying with the law.

Information about disciplinary measures taken against a physician, or even information about the number of malpractice suits filed against him in comparison with the average for that specialty are more reliable indicators of physician quality, Reardon believes.

Massachusetts is currently setting up a statewide physician database that will also report malpractice filings, but it will include information about how often someone in that specialty is sued and for what.

“We are not supporting any one, single, state system, but, at least with what they [Massachusetts] are doing, they are attempting to put the malpractice information into some kind of context,” Reardon says.

The AMA is not opposed to the public having information about problem physicians, he says. But, the information should be clear, accurate, and presented in its proper context.

Databank needs repair

One of the biggest problems with the NPDB is that there are a number of different reasons that a practitioner can be reported, but the criteria for reporting and what information should be reported is difficult to understand, says **Jeffrey Oak**, PhD, senior vice president of the Washington, DC-based Council of Ethical Organizations, a group that advises health care organizations on compliance

CME questions

1. According to Thomas R. Reardon, MD, immediate past president of the AMA, the findings in a recent General Accounting Office report on the National Practitioner Data Bank prove:
 - A. The data are flawed
 - B. The data are unreliable
 - C. The data are not timely
 - D. All of the above
2. The biggest problems with the National Practitioner Data Bank, says Jeffrey Oak, PhD, senior vice president of the Washington, DC-based Council of Ethical Organizations, is that:
 - A. Reasons a practitioner can be reported vary
 - B. Criteria for reporting is difficult to understand
 - C. What should be reported is unclear
 - D. All of the above
3. According to John Banja, PhD, a clinical ethicist at the Center for Ethics at Emory University in Atlanta, the issue of patients expressing ethnic or religious bias toward caregivers in the United States is particularly difficult because:
 - A. The Americans with Disabilities Act
 - B. Hospitals have contradictory policies
 - C. Ownership of hospitals dictates appropriate policies
 - D. All of the above
4. Providers can distinguish between a request that might be based in an understandable — though unfounded — concern and a request that is purely rooted in racism, sexism, or ethnic bias, says **Rosalind Ekman Ladd**, PhD, professor of philosophy at Wheaton College in Norton, MA, by:
 - A. Knowing the patient’s reason for the request
 - B. Listening to the patient’s family
 - C. Looking for clues in the medical record
 - D. All of the above

and best-practice issues.

“There a number of different categories of action that are supposed to be reported to the databank,” Oaks notes. “Examples include civil judgments and criminal actions. Criminal actions are pretty easy to verify and understand. Also, actions by government agencies that oversee licensing and certification are reportable. But, states are so very, very different in how that function is administered, that it is less easy to verify that information than it may appear at first glance.”

Other things, such as exclusions from government payer programs, like Medicare and Medicaid, are reportable, but this information also is not easily verifiable and these physicians are not consistently reported, he says. “We work with hospitals and health systems that are doing background checks [on physicians] and a name either doesn’t appear that is actually on the list, or does appear and is there by mistake or confusion.”

What actions will be taken against hospitals, insurance carriers or agencies that do not report physicians also is not clear, and action is not often taken, says **Mark J. Pastin**, PhD, the council’s president.

In his experience, hospitals are wary of reporting for fear of being sued by the physician for damaging his or her career, says Pastin. “They are very concerned about what could happen if they report a physician.”

With the perception that punishment for failing to report is unlikely, evidence that other organizations are not reporting, and fear that the information will be recorded inaccurately make health systems reluctant to take the risk, he adds.

“I don’t think people fear any sanction for failure to report at this time and I don’t think there is an enthusiasm for applying a sanction because a provider can almost always escape through definitional issue of what has to be reported and what does not,” he continues. “The criteria for what gets reported and what does not get reported and what sanctions will apply for failure to report needs to be much clearer.”

No mechanism for comment and correction

One way to address some of the concerns about the accuracy of the information in the database is to have a process by which physicians could add comments of correction to the records about them, Pastin says.

“If you take as a model the Fair Credit Reporting Act, it requires that if somebody drops a negative

about you in your [credit] record, you have the opportunity to respond and correct that record or add a comment that is corrective,” he explains. “In some cases, you have your record cleared if you can substantiate that the claim against you is not valid.”

Appeals would present more accurate picture

If physicians were allowed to add comments explaining the actions that got them reported to the databank, they might feel more comfortable about increased access to that information. And, hospitals and other providers might be less reluctant to report.

“There has been an example in one of the news reports about a physician who was cited in a malpractice settlement because of a defect in an instrument,” he relates. “The settlement relieved him of the responsibility for the instrument failure, but he was nonetheless named in the suit, and it was settled and he ended up in the national databank.”

If that physician were allowed a process to appeal his placement in the bank, or at least add a comment to the record, it would present a more accurate picture of information.

Pastin and Oak doubt that a system administered by the state medical boards would be much more accurate than the current databank.

“A methodology such as [the Federation of State Medical Boards system] takes better account of the differences between states as far as licensing and discipline procedures,” says Oak. “States do a better job of monitoring people in their own state, but it does not really address physicians who go to a different state. A standard, overall model has broader reach, but less ability to ensure consistency.”

The quality and accuracy concerns would remain with a system administered by the state boards, Pastin adds.

“It is a hard thing to say, but it is an issue of the fox guarding the henhouse,” he says. “The state boards are perceived by many patient groups as being dominated by a physician perspective. Whether that perspective is better than a federal perspective is debatable.”

What will happen

What actions will be taken in light of the GAO report is up to the priorities once the new Congress takes office, says Pastin.

SOURCES

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“If you have leadership that is pushing tight federal control of health care, the likelihood is that the report will be viewed as requiring reassessment and review and enhancement of the processes that are in place in the databank,” he says. “If you are inclined to look at government as running amok and destroying health care, then I think the argument will be that we have spent all of this money, and we have a databank that is not very useful, and we should remand it to a lower level.”

In the end, control of the information will not be relegated to state medical boards, however, Pastin predicts. “I just don’t see it going back to the industry on this. I see as more likely there will be mechanisms for recourse, data ombudsmen, or processes where people are going to have the right to contest incorrect data that are entered into databases about them because of the potential harm of incorrect information being circulated about them. That system will be very costly and cumbersome, but I don’t see an alternative.” ■

Facts on the National Practitioner Data Bank

Congress created the National Practitioner Data Bank (NPDB) 10 years ago to establish a central database on information about incompetent or problem physicians to prevent them from moving from state to state without a mechanism to track their performance.

The database, used by hospitals, insurers, and state licensing boards, is controversial in nature because patients cannot access the information. The General Accounting Office (GAO), the Congressional watchdog agency, recently criticized the

NPDB and the inaccurate, delayed information it contains. The findings are detailed in the GAO’s report, *National Practitioner Data Bank: Major Enhancements Are Needed to Enhance Data Bank’s Reliability*, made public in November of last year. **(For information on the GAO findings, see the related story, p. 6.)**

Malpractice information, which constitutes roughly 80% of the information in the databank, is a poor indicator of physician qualifications, critics argue. Highly skilled and experienced physicians may be subject to a lawsuit, argue critics of the NPDB.

State licensing boards, professional societies, hospitals, and managed care organizations are the only entities eligible to access the databank. Hospitals are required to check a physician’s status in the databank when the physician applies for clinical privileges — and then every two years subsequently it must be rechecked.

Agency disagrees with findings

Health Resources and Services Administration deputy administrator **Thomas Morford**, disagrees with the GAO findings. “We think the data are accurate,” he argues.

“We handled 3.5 million queries this year, so the community that it was designed to help is obviously using it,” he adds.

Morford says a system is in place to verify the accuracy of reports. The agency sends incoming reports of action taken against a practitioner back to the organization that reported it and to the subject of the report. “That’s generally regarded as a substantial quality-control mechanism,” he adds.

In regards to underreporting by hospitals, Morford says the agency is acting on the finding. “We’re trying to establish fact on this matter [of underreporting] one way or the other.” As a result, the agency is conducting a nationwide audit of hospitals to ensure the information is being reported accurately and quickly.

(Editor’s note: Physicians may obtain a copy of their own report from the National Practitioner Data Bank for a \$10 fee after completing a request form. Forms can be downloaded from the NPDB site: www.npdb-hipdb.com.

For a copy of the GAO report National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank’s Reliability, go to the GAO Web site: www.gao.gov/new.items/d01130.pdf.) ■

Inaccurate, outdated, and flawed

Government audit: Clearinghouse needs overhaul

A federal watchdog agency issued a report in December finding flaws with the Congressional National Practitioner Data Bank (NPDB). General Accounting Office officials partially blamed the databank's administering agency, the Health Resources and Services Administration of the Department of Health and Human Services. The report also was critical of hospitals, however, by not following instructions for the databank.

The NPDB consists of the following types of reports:

- medical malpractice — 79%;
- state licensure — 15%;
- clinical privilege restrictions — 5%;
- other — 1%.

The report, titled *National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability*, included the following findings:

- malpractice reports constitute 80% of the information in the data bank;
- nearly all medical malpractice records reviewed in the data bank were incomplete (**for a complete breakdown, see the chart, below**);
- about one-third of the reports that contained clinical restrictions taken against physicians held

inaccurate information;

- patient names were included in violation of NPDB reporting instructions;
- the Health Resources and Services Administration has failed to collect information on nurses and other care providers as required by law — about 230,000 reports were primarily against physicians and dentists;
- almost half of malpractice payment reports were filed more than 30 days after they were due;
- 95% of malpractice payments did not notate whether the standard of patient care was considered when the claim was settled or adjudicated. ■

Should patients' biases be tolerated?

Hospitals get caught in the fray

The setting is a swamped public hospital emergency department in a major U.S. city. A busy ER attending is struggling to juggle the care of major traumas and the many acute, but less urgent patients waiting to be seen. He walks into an examining room to see an elderly, African-American woman. She complains that she has been waiting for 45 minutes to be seen. The physician apologizes for the delay and begins to question her about her symptoms.

Before she details the complaint that has brought her to the department, however, the woman gently inquires whether the doctor, also African-American, is indeed a physician. He assures her that he is.

"Your mother must be very proud," she remarks softly. Then she states quietly but firmly that — although she is sure he is a fine physician — she would feel more comfortable with a white doctor. "It's just the way I was raised."

Despite the physician's attempts to reassure her of his training, credentials and standing within the hospital, she will not relent.

"Very well," he sighs, turning to leave. "You can have a white doctor. But, you'll have to wait another 45 minutes."

The scenario described above is fiction; it occurred on a recent episode of the television series *ER*. But, it represents a not-uncommon occurrence in many hospitals and other health care settings.

A patient, for any number of reasons, requests

Missing Information

The General Accounting Office (GAO) found in its analysis of the National Practitioner Data Bank that malpractice reports often are incomplete. Here, for example, is a breakdown of how frequent basic data were missing from the GAO sample of 250 reports:

- Patient age, 134, 53.6%
- Patient gender, 108, 43.2%
- Patient type, 199, 79.6%
- Initial event, 68, 27.2%
- Subsequent event, 37, 14.8%
- Damages, 61, 24.4%
- Standard of care determination, 239, 95.6%

Source: General Accounting Office.

that he or she receive care by a clinician of only a specific ethnic or racial group or gender. Or, to be more exact, the patient asks not to receive care from a certain caregiver due to that person's gender, race or ethnicity.

These situations present difficult ethical challenges, say both medical and ethics experts. And unfortunately, there are no clear answers.

Should the physician, as part of a patient-centered focus on care, attempt to abide by the person's wishes in the interests of ensuring him or her a comfortable experience? Or does the clinician have an ethical responsibility to not permit discriminatory practices against qualified health providers to become part of the practice at his or her institution?

"It's a difficult question because I really think we have contradictory policies in the United States about this kind of stuff," says **John Banja**, PhD, associate professor in the department of rehabilitation medicine, and a clinical ethicist at the Center for Ethics at Emory University in Atlanta. "On one hand, it would certainly seem that no health care institution would want to accommodate patient wishes that could cause the institution to be discriminatory. The law says, on one hand, that the institution should toe the line when it comes to the law [about nondiscrimination on the basis of race, sex, or ethnicity.]"

On the other hand, he notes, ethical standards — and Joint Commission requirements — mandate care that is sensitive to the patient's culture and outlook.

"For example, there are some cultures and religious groups with certain proscriptions about caregivers of the opposite sex," Banja says. "It is not really a personal bias with them, but a deeply held cultural or religious conviction. In essence, a hospital must operate according to two sets of rules that are almost contradictory."

Does the reason make a difference?

Many experts would distinguish between a request that might be based in an understandable — though unfounded — concern and a request that is purely rooted in racism, sexism, or ethnic bias, says **Rosalind Ekman Ladd**, PhD, professor of philosophy at Wheaton College in Norton, MA. Ekman Ladd is a member of the ethics committees at two Rhode Island hospitals where she also teaches.

"I think the reason is important," she notes. "If there are certain reasons that are parts of

someone's cultural or religious identity. That is not really prejudice, particularly the male-female thing."

Health care providers should understand that such a request for a caregiver of some specific race, gender or ethnic background is not necessarily based in racism or sexism, adds **Larry Davis**, the Desmond Lee professor of racial and ethnic diversity at the George Warren Brown School of Social Work at Washington University in St. Louis.

"The field is moving toward recognition that requests of this nature many times are due to [the patient's] desire for a caregiver who is 'like me, who understands me, or who I think will provide the care I need,'" he says. "It is not always motivated by racism, although there are instances where that is certainly the case."

But, for example, a woman who prefers a female physician may not be stating that she feels male physicians are bad or that she does not like them, she simply prefers a female physician because she is more comfortable that way," adds Davis.

Followers of many different religious traditions may have objections to opposite-gender caregivers, or to being touched by certain caregivers in a particular way, Elkman adds.

However, frequently there are patients who demonstrate racist and sexist attitudes in health care settings and, this, Davis says, is a different problem.

"You have what I consider the noble reasons and the ignoble reasons. The ignoble reasons are out there," adds Davis.

Davis has taught educational seminars in a number of hospitals focused on teaching providers how to handle racial, ethnic, or gender-based requests for care.

"I have had many nurses tell me that they have walked into a room and had the patient yell, 'Get that n--- out of here!'" he relates. "So that is out there. It is not a situation that will be unfamiliar to anyone reading this."

Deciding what to do

"I don't think hospitals should accommodate views that are frankly and unabashedly racist," Banja says. "If you have a person point blank state that, 'I do not want an African-American taking care of me,' I think that a hospital ought not to accommodate a wish like that. Yet, there are other instances that we would accommodate

that aren't terribly far away from that."

An archive of a recent Internet discussion on the Bioethics Discussion Pages Web site (www-hsc.usc.edu/~mbernste/index.html), covered the topic of racially or ethnically based patient requests.

Scenarios related by participants included a European-American man about to receive home health services from the hospital's designated provider who demanded that only white nurses be sent to his home. Another post detailed a case of a patient of Korean descent who refused to follow the recommended medical advice provided by his physician, who was of Japanese descent, because the man believed the physician, due to historical prejudice, would be likely to try to harm him. When visited by a doctor not of Japanese ancestry, however, the man accepted treatment and his condition improved.

Many people would be more sympathetic to the second man's situation, Banja says. "In the first case, I would say, absolutely not, I would not honor a request that was solely based in prejudice and dislike," he notes.

But, at their core, are the situations really different?

There was no real reason for the Korean man to believe that the doctor would try to harm him, and by removing the patient from that doctor's care, it essentially reinforced a discriminatory stereotype that had nothing to do with the physician's abilities, he explains.

But, in a crisis situation, it is unlikely that you will be able to change anyone's mind, and arguing with the patient or attempting to influence his or her wishes may be detrimental, notes Ladd. "Another thing to consider, however, is how easy it would be to find someone to comply with the patient's wishes. If you are dealing with a large group of nurses or doctors, that is one thing. But, if you are dealing with very few choices or possibilities, then that is something different."

Adopt a nondiscriminatory approach

If a patient's request is motivated by their real concern for their health care or a desire for a provider who they feel more comfortable with, Davis feels this should be accommodated if such a provider is available.

In a situation where a patient has expressed an unacceptable racial or sexist attitude or behaved abusively toward staff of a particular group, he feels that, first, the staff should express to the

patient that his or her views are unacceptable.

"It is important for a doctor or caregiver in the nondiscriminated-against group to step in immediately and tell the patient, 'We don't agree with what you are saying. We don't support those kinds of attitudes and distinctions here. We do try to accommodate patients' wishes when we can. To the extent that we can accommodate you, we will, but we don't share your attitude and we cannot guarantee that we will always be able to do what you ask.'"

The other staff members also need to immediately go to the health care worker who was slighted by the patient and express their disagreement with the patient's attitude, reiterate that the caregiver will not be allowed to be abused in any way, he adds.

"This attitude needs to come from the top down," Davis adds. "Too many times, we focus on the client and how to deal with that person. But, there is another person — the health care professional — who has been hurt by this. At the end of the day, a white doctor and a black doctor may have both had a long, trying day, but only the black doctor has had to deal with being called a racial slur."

It's also important to state that no member of the staff will be treated with any amount of physical or verbal abuse or disrespect, and the administration should follow that up, notes Davis.

"It may get to the point that if a patient is unable to restrain his or her emotions, you may have to be willing to ask that person to seek care elsewhere," he adds.

As important as it is to keep the patient's best interests in the forefront, it is equally important to the overall institutional ethics of the hospital, that racist, sexist, or ethnic biases not be allowed to be reinforced.

"You can't have doctors in the majority feel that 'Hey, I'm lucky. The patients all like me. I don't have that problem.'" Davis says. "They need to feel a responsibility to support that other doctor or nurse or caregiver and let that person or people know."

Care in the patient's home

As for the home health scenario, Ladd believes more weight should be accorded a patient's wishes in a home health setting than, possibly, than in an acute-care setting, she says.

"If the reason seems to be plain old prejudice, that is a hard one," she notes. "But, it might be a

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little different in a home care situation. There you are on the patient's turf, not on your turf, and I think there may be more reason for the patient to be able to say, 'I want this person and not that person.' It is a more intimate situation, you are dealing with the whole family and with the home."

Talking to the patient

Regardless of whether the request may seem more understandable, or whether it can or will be accommodated, most experts don't recommend allowing the request to go unchallenged completely.

"In some situations, a hospital representative may want to respond and say, 'We recruit and hire and maintain people whose intentions are above board and who are not going to be corrupted by history of political animosity or whatever,' Banja says. "Not addressing that issue, that is the downside of trying to accommodate."

Whenever a hospital decides to accommodate a peculiar or idiosyncratic request for care, they ought to be able to justify or explain it in a way that most people in our society would accept, he adds. "That, to me, takes it one degree closer to acceptability than the other situation."

With the advent of managed care, with its prescribed lists of preferred care providers, patients are left feeling that they have little choice and control over their health care, Ladd believes. "I guess I am more sympathetic to patients wanting to choose when they may not be that comfortable with doctors and nurses anyway."

She feels that diversity training and cultural sensitivity training are essential for providers if they are going to be able to address these types of patient concerns and requests.

"I feel strongly that the people on the health care side need to go through cultural and diversity

training so they can help make people feel comfortable with these kinds of differences. Sometimes the discomfort level comes from both sides." ■

Undertreatment of pain creates new risk

The undertreatment of pain is so common that it represents a huge new liability risk for hospitals and doctors, according to experts who predict that it won't be long before the health care community gets a wake-up call in the form of a major malpractice verdict.

Health care providers routinely neglect or intentionally refuse to treat severe pain, especially the pain of terminally ill patients, says **Kathryn Tucker**, JD, director of legal affairs with the Compassion in Dying Federation in Seattle. Not only is that undertreatment a cause for moral outrage, it also is reason for ethics committees to consider the potential liability, Tucker says.

"Undertreatment of pain is epidemic," she says. "Patients don't get adequate pain care. Elderly patients are at particular risk, and that's a particular concern because of the elder abuse statutes. That is a group known to be at risk for undertreatment, and they have a legal remedy available to them that most groups don't."

Tucker spoke on the topic at the recent meeting of the American Society for Healthcare Risk Management in New Orleans. The problem of undertreatment is not new, she says, but the liability risk has grown from nearly nothing to potentially huge in just the past few years.

Half experienced pain in last three days

In one study, researchers found that 50% of all patients who died during hospitalization "experienced moderate or severe pain at least half of the time during their last three days of life."¹ Another study found that up to 40% of cancer patients in nursing homes are not appropriately treated for pain.² In addition, more than a quarter of those experiencing pain did not receive any pain medication, and 16% were given over-the-counter pain relievers like aspirin or acetaminophen for their pain.

One tragedy of the problem is that nearly all patients in severe pain can be treated successfully.

Very few patients have medical conditions that make it impossible or excessively risky to relieve their pain, Tucker says.

More than 50 million Americans suffer from chronic pain, according to **Russell Portenoy**, MD, chairman of Beth Israel Medical Center's Pain Medicine and Palliative Care Department in New York City. The undertreatment of pain was confirmed recently by the Pain in America survey commissioned by Partners Against Pain, an educational resource for patients and professionals. More than half of all patients surveyed said they have experienced their pain for at least five years, and 52% said their current prescription medication is not completely, or not very, effective.

The underuse of opioids such as morphine and codeine is one reason for the undertreatment, Portenoy says. Physicians fear their patients becoming addicted or that the drugs will hasten death, and they also fear criticism from medical boards and regulatory agencies that may say they are handing out narcotics too freely.

"It is not uncommon for physicians to be investigated for prescribing controlled substances in amounts that regulators perceive as excessive," Tucker says. "Even if the physician's conduct meets relevant guidelines for pain management, the investigations may result in physician discipline, including suspension or revocation of prescribing authority and other limitations on medical practice."

Feds, states urged to revise rules

Some of those fears may be justified, Tucker says. She urges state legislatures and federal agencies to revise rules that discourage physicians from providing adequate pain relief. The other fears regarding addiction and the hastening of death are based on false assumptions, Portenoy says. Even many people with histories of chemical dependency can have chronic pain addressed with drugs and maintain control of their use.

"When prescribed and used appropriately, opioid medications improve quality of life," Portenoy says. "If doctors and others better understood the complex issue of addiction, inappropriate fear of this outcome would not contribute to undertreatment with these drugs."

Undertreatment of pain also is caused by the reluctance of patients to discuss the problem with their physicians, and physicians' lack of skills in pain management. This is due in part to the fact

that there is little training during medical school in either pain management or addiction medicine, Portenoy says. Tucker also notes that physicians should not hold back pain treatment out of fear of hastening a patient's death. Case law has established that, she says.

"Regardless of what you think of the right to die, patients have a right to adequate pain relief," Tucker says. "The highest court in the land has made that clear."

Make providers aware of patient rights

The solution to the undertreatment of pain is not simple, Tucker says, but ethics committees could take a proactive role by alerting clinicians to the risk. Physicians and nurses should understand clearly that patients have a right — legally, not just morally or philosophically — to adequate pain control.

"Make sure your people understand that they have to provide pain relief just as much as they have to take actions to keep the patient alive and safe," Tucker says. "Pain isn't just something you take care of if you want to. The patient has a right to pain control and if that is ignored, then somebody is going to pay a price. And it might be a very big price."

Other solutions involve regulatory reform. The Boston-based American Society of Law Medicine and Ethics undertook an effort at reform recently by launching the Project on Legal Constraints on Access to Effective Pain Management. The project developed a model Pain Relief Act that creates a safe harbor to shelter physicians from both disciplinary and criminal action if the physician can "demonstrate by reference to an accepted guideline that his or her practice substantially complied with that guideline." The physician also must have kept appropriate records, written no false prescriptions, obeyed the Controlled Substances Act, and not diverted medications to personal use.

Tucker says the safe harbor concept also is encompassed in state laws intended to ameliorate the problem. Known as Intractable Pain Treatment Acts (IPTAs), the existing state statutes generally provide shelter from disciplinary action but make no mention of criminal exposure. The Medical Board of California adopted a policy statement in 1994 that encourages aggressive pain care and then adopted another guideline that specifically identifies failure to adequately manage pain as "inappropriate prescribing." By making undertreatment of pain a type of inappropriate prescribing, the board

expressly called it a form of professional misconduct subject to the full range of sanctions.

For the health care industry as a whole, Tucker says it make take a major lawsuit to get everyone's attention and force attention to the problem of undertreatment of pain. She notes that juries can relate well to the story of a loved one dying in terrible pain while medical professionals with the ability to stop it stand by and do nothing. The issue does not involve confusing medical issues, but pain is a topic that may disturb juries enough to prompt major awards.

"I think we're going to see more lawsuits, and it could be that we will see a case in which a provider is held liable for a huge sum of money," Tucker says. "Unfortunately, that may be what it takes to put an end to these egregious cases."

References

1. SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) principal investigators. A controlled trial to improve care for seriously ill patients. *JAMA* 1995; 274:1,591-1,594.
2. Bernabei R. Management of pain in elderly patients with cancer. *JAMA* 1998; 279:1,877-1,879.
3. *Estate of Henry James v. Hillhaven Corp.*, Sup. Ct. Div. 89CVS64, Hertford County, N.C. (1990). ■



Ethics statement slated for revision

For the fourth time in its 153-year history, the Chicago-based American Medical Association began the process last month of revising its Principles of Medical Ethics, citing a need to update the standards for a new era.

The association's House of Delegates will vote on a final revision at its annual meeting in June. The Council on Ethical and Judicial Affairs, the governing body charged with interpreting the

principles, is urging the House of Delegates to revise its principles to keep pace with rapid changes in the medical environment and develop ethical guidelines for areas previously not addressed in the principles.

Among the key passages, a strong statement is included emphasizing the physician's responsibilities to the patient being paramount. Another passage indicates that physicians are dedicated to providing care to all and therefore support access to care for all.

Aside from access for all, the 14 obligations include:

- deliver high quality care;
- implement preventive medical services;
- promote public health;
- do not discriminate;

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- self-regulate and enforce high professional standards;
- advocate for patient interests;
- place patient interests above personal interests. ▼

Hospitals get help with living wills

The U.S. Living Will Registry announced in late December a new Web site for assisting hospitals with advance directive planning.

The unlimited free service from the Westfield, NJ-based organization under the same name, is available to all hospitals to assist patients in determining their health care choices should they become incapacitated. According to the organization's research, between 25% to 30% of Americans actually have an advance directive in place. Conversely, 35% of advance directives cannot be found when they are needed.

Hospital personnel can visit the site (www.uslivingwillregistry.com) and download a free guide offering instructions on how to stage a Living Will Fair to promote community awareness of advance care planning.

For more information about the service, contact the organization. Telephone: (800) 548-9455 or e-mail: admin@uslivingwillregistry.com. Web site: www.uslivingwillregistry.com. ▼

Oregon's marijuana registry gets thumbs up

Officials in Oregon's Department of Human Services Health Division say the state's 1998 Medical Marijuana Act is working just as intended.

To legally qualify to participate, patients must obtain a physician's recommendation and register with the health division to receive an identification card. The \$150 registration fee helps fund the program. The registry's first year resulted in 594 patients participating. Last year, an additional 474 patients joined the registry, according to a report released last October.

"Oregon was the first to implement a statewide registration system for patients," says **Martin Wasserman**, MD, administrator of the Oregon

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Department of Human Services Health Division. "Our first-year review shows the system is working as it was intended. A substantial number of qualified patients and their physicians are using it, and only a very few inquiries from law enforcement officials regarding patients have occurred."

During the first year — May 1, 1999 to April 30, 2000 — statistics of the registry include the following:

- males accounted for 70% of the 594 patients who registered;
- average age of participants was 46, with patient ages ranging from 14 to 87 years old;
- 67% of patients used medical marijuana to control severe and chronic pain;
- 329 physicians provided the required medical documentation for the 594 patients (since April 30, 2000, the number of physicians increased to 438);
- 60% of patients requested a registration card for their primary caregiver, who helps manage their well-being, and may help administer the medical marijuana. ■