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A Proposal to Recognize a Legal Obligation on Physicians to Provide Adequate Medication to Alleviate Pain

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A PROPOSAL TO RECOGNIZE A LEGAL OBLIGATION ON
PHYSICIANS TO PROVIDE ADEQUATE MEDICATION TO
ALLEVIATE PAIN

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I. INTRODUCTION

Eileen, age 57, has just returned home from visiting her family doctor to discuss the results of her yearly, routine examination. The doctor just informed her she has terminal cancer. She has twelve to eighteen months to live.

It is now one year later, and Eileen's cancer has begun to spread throughout her body. She is suffering from excruciating pain, and her family can no longer adequately care for her in her debilitating state. She enters a hospital. Like many others in her situation, she is unfamiliar with the option of hospice care.

Despite her remaining under the care of physicians and nurses in a hospital setting, Eileen still suffers intolerable pain. She tells her doctor that she is in constant, agonizing pain, but he refuses to increase her dosage of morphine. In addition to her own physical and emotional pain, she watches her husband

and two children helplessly experience her long, painful death with her. She does not want to be remembered this way. She would rather die now than endure possibly weeks or months of this inhumanity. But suicide is not an option. Her doctor will not even increase her pain medication. Eileen has no alternative but to suffer a slow, unbearably painful death.

The above scenario is agreeably a sad, unfortunate chain of events. However, to many of its readers, the story may not seem like anything out of the ordinary. That is because it is not. Due to physicians' practice of undermedicating for cancer and other types of pain, we as a society have been forced to accept the prospect of a slow, painful death from cancer or other terminal diseases. What is unfortunate about the scenario is that it does not have to be this way. Physicians themselves have admitted that patients are currently being undermedicated for their pain. More adequate pain management is available for patients today.

The problem does not only exist in physicians' undermedicating terminally ill patients who are suffering from unnecessary pain. Many individuals suffering from acute pain are also undermedicated, often because their physicians adhere to the unfounded myth that pain medication is highly addictive.

If adequate pain management is available, why are so many individuals still subjected to needless pain and suffering? I propose that the time has come for patient autonomy to be recognized, especially when the choice is to be relieved of unbearable pain. I also propose that in order to effectuate patient autonomy, a medical malpractice action for a physician's failure to adequately medicate for pain should be recognized by American courts. Only then will individuals like Eileen be comforted not only during their final days, but from the time of their diagnosis, in knowing they will retain their dignity during their ultimate journey on this earth.

This note seeks to show how the current practice among medical practitioners in the United States, by treating pain retroactively after it begins, is inadequate. Administering narcotics to patients on an "as needed" basis unnecessarily prolongs pain and suffering. A more effective approach, which is advocated by the Agency for Health Care Policy & Research (AHCPR), is to treat pain preventatively rather than retroactively. The myth that pain medication is addictive, and that physicians should therefore prescribe as little pain medication as possible, is just that, a myth. Patients are suffering pain in today's hospitals and at home unnecessarily. Given today's advanced medical technology and expertise, physicians should be responsible for administering adequate pain relief. If physician-assisted suicide remains unavailable to a majority of patients to relieve them from excruciating pain, then physicians should be held legally bound to provide adequate pain relief.

This note also seeks to reveal that American health care systems are lacking in critical pain management techniques. Part II explores the basic principles of pain, including the pain experience, the differences between subjective and objective pain, and the differences between chronic and acute pain. This section also discusses the fear of addiction to pain medication as well as the inadequacies in today's management of pain. Part III analyzes various alternatives to the current pain management philosophy, including the AHCPR's guideline recommendations for the treatment of pain, hospice care,

and physician-assisted suicide. Finally, Part IV analyzes the recognition of legal liability on medical personnel for the failure to adequately medicate for pain, beginning with a discussion of the factors to take into consideration in recognizing a legal obligation to render adequate pain relief medication.

II. BACKGROUND

A. *The Basic Principles of Pain*

In order to fully understand the fundamentals of pain management, one must first become familiar with the basic principles of pain. This section provides an introduction to the pain experience, discusses the differences between subjective and objective pain, and addresses the distinctions between chronic and acute pain.

1. The Pain Experience

Pain is defined as, "a more or less localized sensation of discomfort, distress, or agony, resulting from the stimulation of specialized nerve endings."¹ Pain typically begins with the body's receipt of noxious stimuli, or "nociceptive input."² However, the intensity of the pain and the individual's reaction to the pain are not defined solely by the nociceptive input.³ Rather, in addition to the nociceptive input, a person's pain experience depends largely on psychological and social factors.⁴

"Pain behavior," which is the action or language attributable to the pain experience, is typically a function of a person's pain experience.⁵ Pain behavior includes such action or inaction as the inability to lift, bend or concentrate as the result of pain.⁶ Just as nociceptive input is determined largely by psychological and social factors, an individual's pain behavior is also defined by psychological and social factors that influence an individual's response to pain.⁷ For example, when two individuals receive a similar level of nociceptive input, they both experience genuine pain even though one may experience a heightened level of pain and exhibit more severe pain behaviors.⁸

¹DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1212 (27th ed. 1988).

²Ellen Smith Pryor, *Compensation and the Ineradicable Problems of Pain*, 59 GEO. WASH. L. REV. 239, 246 (1991).

³*Id.*

⁴*Id.*

⁵*Id.* at 247.

⁶*Id.*

⁷*Id.*

⁸*Id.* at 248.

2. Subjective v. Objective Pain

While the above depiction of pain tends to indicate that an individual's pain experience is highly subjective, studies have shown that certain types of pain are not merely subjective.⁹ One example is cancer pain. A study found that "more than three-fourths of cancer patients experience chronic pain during the course of the disease."¹⁰ In a survey of pharmacists who were familiar with the undertreatment of cancer pain, eighty percent of those surveyed stated that most cancer patients experience pain at some time during their illness, and eighty-five percent stated that since the patient is the best judge of the intensity of the pain, nurses should believe the patient's report of pain.¹¹ Another less subjective type of pain is pain resulting from burns, since most burn patients have been found to suffer from severe pain.¹² Pain from dental work such as root canal surgery has also resulted in a high incidence of pain when undermedicated.¹³ Similarly, physical trauma (bullet wounds, lacerations, etc.) and surgery or other invasive procedures of the body invariably result in pain.

The Texas Second District Court of Appeals delineated nine examples of objective evidence of injury which would support an award of damages for pain and suffering.¹⁴ In *Hammett v. Zimmerman*, the plaintiffs were injured when their car was struck from behind by a car driven by the defendant.¹⁵ The jury in the lower court failed to award the plaintiffs any damages for their claims of physical pain and mental anguish.¹⁶ The Second District stated that if the plaintiffs offered "uncontroverted evidence of an objective injury, a jury finding that the plaintiffs suffered no past physical pain would be against the great weight and preponderance of the evidence."¹⁷ The nine examples of objective evidence of injury that would support an award of damages for pain and suffering listed by the court included the following: 1) Scull and facial

⁹See E.T. Yeh & H.M. Chang, *Pathophysiology and Principles of Pain Management in Rheumatic Diseases*, 4 CURR. OPIN. RHEUMATOL. 332 (June 1992). In this article, the authors suggest that there are both objective and subjective components to the experience of pain.

¹⁰R.K. Portenoy, *Pharmacologic Management of Cancer Pain*, 22 SEMIN. ONCOL. 112 (Apr. 1995).

¹¹S.E. Krick, C.M. Lindley & M. Bennett, *Pharmacy-Perceived Barriers to Cancer Pain Control: Results of the North Carolina Cancer Pain Initiative Pharmacist Survey*, 28 ANN. PHARMACOTHER. 857 (July-Aug. 1994).

¹²A. Jonsson, J. Cassuto & B. Hanson, *Inhibition of Burn Pain by Intravenous Lignocaine Infusion*, 338 LANCET 151 (July 20, 1991).

¹³Mohd Sulong, *The Incidence of Postoperative Pain After Canal Preparation of Open Teeth Using Two Irrigation Regimes*, 22 INT. ENDOD. J. 248 (Sept. 1989).

¹⁴*Hammett v. Zimmerman*, 804 S.W.2d 663 (S.D. Tex. 1991).

¹⁵*Id.* at 664.

¹⁶*Id.*

¹⁷*Id.*

fractures (accompanied by the dripping of spinal fluid from the nose); 2) Organic brain syndrome and nerve damage; 3) Severe electrical burns; 4) Broken hip; 5) Linear fracture of the foot; 6) Cut; 7) Lacerations, tendinitis, and torn muscles requiring surgery; 8) Reverse curvature of the spine, concussion, and lumbar sprains; and 9) Broken ankle requiring full cast.¹⁸

The court in *Hammett* held that since one of the plaintiffs, Nan Hammett, had presented objective evidence of an injury, "a conclusion that some degree of pain, suffering and mental anguish resulted was inescapable." The court reversed the trial court's decision and remanded the case for a new trial as to Nan Hammett only.¹⁹

Therefore, in instances such as those listed above, pain cannot be seen as merely subjective. When a patient presents injuries such as the ones listed by the *Hammett* court, the patient displays objective evidence of pain which should not be discounted. In discussing a physician's legal obligation to adequately relieve pain, objective pain should be treated differently from purely subjective pain, such as headaches and backaches. In cases of subjective pain, the patient's report of the pain is the only evidence of pain. Affirmative proof that the pain actually exists is lacking. In those instances, a physician should not be held liable for failing to relieve pain, since there is no confirmatory proof that the pain is present.

However, in instances of objective pain, such as those listed above, the doctor is provided with affirmative proof that pain must be present. The doctor does not have to rely on the patient's report of pain, as the injury itself is confirmatory proof of the pain. In those instances, a doctor should treat the pain with the appropriate level and dosage of medication. The doctor has no reason to discredit or question the pain when there is objective evidence that the pain exists. In those cases, when the dosage and strength of the medication is inadequate, the doctor should be liable for malpractice.

3. Chronic v. Acute Pain

Another important concept to consider in a discussion of pain is discerning the difference between chronic and acute pain. Chronic pain is typically pain which persists for a long period of time and is void of any conclusive physical findings or single modality of treatment to provide relief.²⁰ Psychosocial factors may reinforce pain behaviors in individuals experiencing chronic pain.²¹ Most pain experts agree that ongoing nociceptive input plays a minor role in

¹⁸*Id.* at 666.

¹⁹*Id.* at 668.

²⁰Eric L. Diamond & Ken Grauer, *The Physician's Reactions to Patients with Chronic Pain*, 34 AM. FAM. PHYSICIAN 117 (Sept. 1986).

²¹*Id.*

individuals experiencing chronic pain, while the psychological, social, and behavioral factors of the individual play a much greater role.²²

In contrast to chronic pain, acute pain is typically temporary,²³ and tends to subside once proper treatment for the pain is rendered.²⁴ As opposed to chronic pain, acute pain is considerably a function of nociceptive input, while social and psychological factors are less important.²⁵

The treatment of acute pain poses little controversy in the medical profession since it comports with the traditional "medical model" of treatment: fixing or correcting the underlying pathology in order to eliminate the effects of the injury.²⁶ On the other hand, chronic pain has generated a great deal of controversy.²⁷ This is because chronic pain is a predominant form of suffering, and patients often become hostile with physicians who fail to relieve their pain.²⁸ Physicians, too, become frustrated with patients who continue to complain about persistent pain, and sometimes resort to telling the patient that the pain is "all in your head."²⁹ In addition, some medical professionals feel that chronic pain is actually reinforced by the use or overuse of analgesic medications which actually contribute to the patient's pain behaviors.³⁰

B. Fear Of Addiction

Research has proven that once an individual experiences pain, the pain is harder to control.³¹ The current retroactive approach to relieving pain, in treating it only after it has begun, is suggested partly to be the result of an age-old myth of our western culture: that patients will become addicted to pain relief medication.³²

²²Pryor, *supra* note 2, at 255. See also Brett A. Stacey, *Effective Management of Chronic Pain*, 100 POST GRADUATE MEDICINE 281 (Sept. 1996). In his article, Stacey states that although the definition of chronic pain implies that it is subjective, the pain is in fact real.

²³Pryor, *supra* note 2, at 253-54.

²⁴Diamond & Grauer, *supra* note 20, at 117.

²⁵Pryor, *supra* note 2, at 253-54.

²⁶*Id.* at 254.

²⁷*Id.* at 281.

²⁸Diamond & Grauer, *supra* note 20, at 117.

²⁹*Id.*

³⁰*Id.*

³¹Drug Research Reports, 27 THE BLUE SHEET 12 (March 14, 1984).

³²Patricia C. Crowley, *No Pain, No Gain? The Agency for Health Care Policy & Research's Attempt to Change Inefficient Health Care Practice of Withholding Medication from Patients in Pain*, 10 J. CONTEMP. HEALTH L. & POL'Y 383, 383 (1993).

Aside from the medical community, there exists generally in today's society a major concern about narcotic addiction.³³ This understandable cultural concern is unfortunately also reflected in the medical community's approach to treating patients suffering with pain.³⁴ Many medical practitioners have justified their refusal to administer analgesics to patients in pain by adhering to their fear that the patient will become addicted to the medication.³⁵ Likewise, patients sometimes refuse medication despite their persistent pain due to the concern of addiction.³⁶ This cultural concern about drug addiction in general has consequently caused physicians to consistently undermedicate for pain, and has resulted in needless pain and suffering for many patients.³⁷

Contrary to the prevailing belief among both medical practitioners and laypersons, numerous studies have indicated that narcotics which are given to control pain are not addictive.³⁸ While the concern about addiction to "street" drugs such as marijuana and crack cocaine is a justifiable concern, studies have shown that morphine, a drug often administered for severe pain, is not addictive.³⁹ A physician with fifteen years of oncologic experience reported that he has treated approximately three thousand cancer patients, of which about one-half have suffered severe acute or chronic pain problems.⁴⁰ "Only two patients displayed drug use which may be considered abusive, and only one experienced an abstinence syndrome."⁴¹ In fact, studies indicate that drug use by itself is not the determinative element of developing a pattern of drug abuse; rather, medical, social, and economic conditions are significant factors.⁴²

June Dahl, Ph.D., of the University of Wisconsin Medical School and chair of the Wisconsin Cancer Pain Initiative, has voiced her concern about physicians' failure to prescribe medication for cancer patients in pain.⁴³ She indicated that while effective drugs for cancer pain are available, physicians are reluctant to use the drugs at the appropriate dosage and frequency to

³³Marcus M. Reidenberg, *Barriers to Controlling Pain in Patients with Cancer*, 347 LANCET 1278 (May 11, 1996).

³⁴*Id.*

³⁵*Id.*

³⁶*Id.*

³⁷Rex Greene, *Towards a Policy of Mercy: Addiction in the 1990s*, 3 STAN. L. & POLY REV. 227, 228 (1991).

³⁸Julie A. Steele, *Cancer Pain: Its Management Emerges as Public Health Issue*, 82 J. NAT'L CANCER INST. 646-47 (1990).

³⁹Greene, *supra* note 37, at 228.

⁴⁰*Id.*

⁴¹*Id.*

⁴²*Id.*

⁴³Steele, *supra* note 38, at 646.

effectively manage pain due to an unjustified fear of addiction.⁴⁴ She discussed the existence of an "opioid phobia," or exaggerated concern about the addictiveness and side effects of narcotics.⁴⁵ Dahl suggested that the fear of creating addicts is unfounded, since research indicates that narcotics administered to control pain are not addictive.⁴⁶ Others in the medical profession agree with Dahl that physicians are unjustifiably concerned about the addictiveness of pain medication. Dr. Monica Winefryde Furlong in her book, *GOING UNDER: PREPARING YOURSELF FOR ANESTHESIA*, discusses the continuing problem in hospitals of undermedicating severe pain following surgery.⁴⁷ She links the problem to physicians' unrealistic fear of causing addiction to narcotics, and states that unless a patient already has a problem with drug abuse prior to surgery, he or she will rarely become addicted to pain relief medication from short-term use after surgery.⁴⁸

Therefore, since numerous studies have found that the fear of addiction to pain medication among members of the medical community is groundless, it is apparent that the unfounded fear is merely a myth. As such, it should not be used by physicians as an excuse to withhold medication from individuals in pain. If a patient is in pain and requests medication for relief, the myth that the patient will become addicted to the pain medication should not justify a doctor's withholding of ample medication, for to do so unnecessarily and unjustifiably prolongs the pain and suffering.

C. Inadequacies in Today's Management of Pain

The problem with the current method of treating pain, in treating it retroactively and inadequately, is that it leaves many patients suffering from unwarranted pain. The problem is not often litigated, however, because the law does not currently recognize a legal obligation on the part of physicians to adequately treat pain. This is because pain, by itself, is not compensable.⁴⁹

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶*Id.*

⁴⁷ See *Management of Pain*, 34 AM. FAM. PHYSICIAN 290 (Sept. 1986). This article states that patients hospitalized with acute pain are often given inadequate amounts of narcotic analgesics due to physicians being overly concerned about the possibility of addiction. See also P. Cooney, *BRN Adopts Pain Management Policy*, 14 SUM CAL. REG. L. REP. 102, 103 (Spring/Summer 1994). This report discusses the RN's role in educating hospital staff, patients and families about the low risk of addiction from long-term use and/or high dosages of opiates to relieve pain. See also Crowley, *supra* note 25, at 393. In this section, Crowley discusses the AHCPR's findings that morphine or demerol addiction is extremely rare when given for less than ten days for post-operative and injury-related pain.

⁴⁸ *Going Under: Preparing Yourself for Anesthesia* (book review), 19 HEALTHFACTS 1 (Apr. 1994).

⁴⁹ See IRVING J. SLOAN, *PROFESSIONAL MALPRACTICE* 35 (1992).

Absent some physical manifestation of an injury or a worsening of the patient's condition, an individual cannot recover in a medical malpractice action.⁵⁰

1. Comparison to Awards for Emotional Distress

Some people may be skeptical about the idea of holding a doctor liable for malpractice because he or she failed to adequately relieve a patient's pain. This skepticism may result from the belief that this kind of medical malpractice action will open the floodgates to many unfounded claims for relief, and may be the reason that currently there is no such medical malpractice action. The prevailing belief may be that the possibility of fraud would be great because it is difficult to determine if pain is actually present. However, in the instances of objective pain discussed above, studies have shown that pain *must* be present. In those situations, there is no danger of fraud, because the type of injury itself is affirmative proof that pain is present. The danger of fraud would occur in instances of wholly subjective pain, such as headaches and backaches, and therefore no medical malpractice action should be allowed in those cases.

While the law currently does not recognize a medical malpractice action for the undermedication of pain, the law does allow recovery for emotional distress as long as physical injury accompanies the emotional distress or if the victim was in the zone of danger. Commentators have stated that the reason for the physical injury or zone of danger requirement is that allowing recovery for injuries resulting from purely emotional distress would cause a slippery slope for fictitious or speculative claims.⁵¹ Additionally, the requirement of physical impact gives the court a guarantee that the emotional injury to the plaintiff is genuine.⁵²

Similar to recovery for emotional distress injuries, physical pain has also been held recoverable when a physical injury is present. Consistent with the reasoning for allowing emotional distress damages when physical injury is present, allowing recovery for physical pain when a physical injury is present allows courts more certainty in ascertaining whether there is physical pain. When pain is accompanied by a physical injury, the court does not have to speculate about whether or not the pain is present.

Consistent with this analysis, when an individual presents objective evidence of pain, that pain should be recoverable when the physician fails to render adequate pain relief. For example, when an individual suffers from cancer pain, burn pain, or pain from dental work, studies have shown that pain is definitely present. The doctor should provide an adequate dosage and strength of pain medication to relieve the individual's pain. If the doctor fails to do so, the doctor should be held liable for medical malpractice. The court would not have to speculate on whether or not pain really exists, since the

⁵⁰*Id.*

⁵¹1 THOMAS M. COOLEY, COOLEY ON TORTS 97 (3d ed. 1906).

⁵²W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 54, at 363 (5th ed. 1984).

objective evidence of pain confirms the patient's report of undertreated pain. This is consistent with the reasoning for allowing recovery for emotional distress when a physical injury is present, since the physical injury provides the affirmative proof of the injury. Objective evidence of pain is the affirmative proof that is needed in order to allow recovery for a doctor's failure to provide adequate pain relief, since the objective evidence confirms the presence of pain.

2. Evidence in the Medical Field

Although the law does not currently recognize a medical malpractice action for the failure to treat pain, there is strong indication in the medical field itself that the problem does exist in fact and practice. A recent study performed by the Eastern Cooperative Oncology Group (ECOG) revealed that one out of four cancer patients dies without adequate pain relief.⁵³ The survey also revealed that out of the 897 physicians who were surveyed,

eighty-six percent thought that most patients do not receive adequate medication for pain, while sixty-seven percent believed that at least half of their patients had experienced pain during their illness, and forty-eight percent estimated that about one-half of their patients had pain that lasted for more than one month.⁵⁴

The physicians were also asked "at what point in a patient's illness they would recommend maximum tolerated narcotic analgesic therapy for the patient's pain."⁵⁵ "Thirty-one percent said that they would wait until the patient's prognosis was less than six months, while fifty-four percent would only recommend the maximum tolerated dosage if the prognosis was less than twenty-four months."⁵⁶

The ECOG's study revealed further evidence of the lack of pain management in today's hospitals. When asked about their educational experience in pain management during medical school, "only twelve percent said that it was excellent or good, while thirty-six percent responded that it was fair and fifty-two percent said that it was poor."⁵⁷ "The response regarding pain management experience during residency programs was slightly better, as twenty-seven percent said that training was excellent or good, forty-six percent reported that it was fair, and twenty-seven percent said that it was poor."⁵⁸ The authors of the study concluded that "[i]f physicians requested pain assessment scores as often as they requested vital signs they would receive an essential

⁵³Survey: *Physicians Undermedicate for Cancer Pain*, 12 THE BROWN UNIV. DIGEST OF ADDICTION THEORY AND APPLICATION 6 (Nov. 1993).

⁵⁴*Id.*

⁵⁵*Id.*

⁵⁶*Id.*

⁵⁷Survey: *Physicians Undermedicate for Cancer Pain*, *supra* note 53, at 6.

⁵⁸*Id.*

lesson in pain management and would give this problem the attention it deserves."⁵⁹

Terminally ill patients are not the only patients suffering unnecessarily. Evidence exists which shows that patients suffering from acute pain are also undermedicated. As discussed above, a major reason for physicians' failure to adequately administer pain medication is the unfounded fear that patients will become addicted to the medication. While this phenomena has also not been litigated due to the absence of the requisite physical manifestation of injury, at least one court has indicated that the failure to provide adequate pain relief may be compensable.⁶⁰ In *Ladish v. Gordon*, Heather Ladish was treated by her physician, Dr. Gordon, for condyloma, which is commonly known as genital warts.⁶¹ The severity of Ladish's condition required Dr. Gordon to perform laser surgery to remove the warts.⁶² Following the surgery, Ladish experienced a great deal of pain and suffering as well as a significant amount of swelling.⁶³ As a result, Ladish went to the emergency room, where Dr. Gordon observed an adherence of the labial lips which required separation.⁶⁴ Dr. Gordon separated the lips with his finger without giving her any pain medication.⁶⁵ Ladish testified that the pain she experienced during the procedure was the "worst pain she had ever experienced in her life."⁶⁶ Ladish filed suit against Dr. Gordon for the negligent treatment of her condition, alleging, among other things, that he was negligent in "failing to administer pain medication prior to separating her labia."⁶⁷

The jury awarded Ladish \$75,000.00 for her pain and suffering, but the trial court entered an order granting Dr. Gordon's motion for judgment notwithstanding the verdict.⁶⁸ The court of appeals affirmed the decision of the trial court because the court found that the plaintiff did not establish that Dr. Gordon had a legal duty to do anything other than what he did.⁶⁹ In doing so, however, the court indicated the potentiality of recognizing liability for the failure to administer pain medication. "[A]ssuming without deciding that a claim based on failure to give pain medication may in some circumstances be legally

⁵⁹*Id.*

⁶⁰*Ladish v. Gordon*, 879 S.W.2d 623 (Mo. Ct. App. 1994).

⁶¹*Id.* at 626.

⁶²*Id.*

⁶³*Id.* at 626-27.

⁶⁴*Id.*

⁶⁵*Id.*

⁶⁶*Id.*

⁶⁷*Id.*

⁶⁸*Id.*

⁶⁹*Id.* at 629.

cognizable, plaintiff has not in this case shown that there was a legal duty to administer pain medication."⁷⁰

The language used by the court indicates that there may be a legally cognizable action for the failure to administer pain medication in a situation where pain is likely to follow or accompany a certain medical procedure. The fact that the jury awarded *Ladish* \$75,000.00 also reflects society's belief that a cause of action for inadequate pain relief should be recognized. If undermedication in the *Ladish* situation, where the pain has not even occurred yet, may be a cognizable action, then it only follows that where a patient is already experiencing pain which continues to be undermedicated by a physician, a legally cognizable action should be recognized.

Another problem relating to physicians' reluctance to adequately administer pain relief medication is connected to the issue of physician-assisted suicide. This issue will be discussed in greater detail in Section III. Suffice it to say now that many physicians are deterred from administering adequate pain relief due to a concern about the legal ramifications or sanctions by licensing boards as a result of possibly overmedicating for the patient's pain. However, "it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression."⁷¹

Based on the inadequacies in today's health care system in treating patients suffering from severe pain, the time has come for courts to recognize a legal duty on the part of physicians to provide adequate pain relief. Before discussing the particulars of recognizing such a duty, I would like to explore a few alternative approaches to pain management which exist today and provide further foundation to support the existence of the pain management problem.

III. ALTERNATIVE APPROACHES TO PAIN MANAGEMENT

The approach by physicians to the treatment of pain today fails to reach an acceptable level of effectiveness, as research has shown that pain is harder to manage after it begins.⁷² Alternative approaches to today's ineffective management of pain, such as the Agency for Health Care Policy & Research's Guideline Recommendations for pain treatment and the hospice philosophy, offer more appropriate methods for treating pain. Furthermore, if inadequate pain relief continues to prevail, more patients may wish to resort to physician-assisted suicide rather than having to endure prolonged, excruciating pain.

⁷⁰*Id.*

⁷¹John Glasson, *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES L. & MED. 91, 95 (1994).

⁷²THE BLUE SHEET, *supra* note 31, at 12.

*A. The Agency For Health Care Policy & Research's Guideline Recommendations
For The Treatment Of Pain*

The Agency for Health Care Policy & Research (AHCPR) recently developed a set of guidelines relating to the treatment of pain. The guidelines were issued by Louis W. Sullivan, the Secretary of Human Health Services, who recognized that "it is unthinkable that patients suffer needlessly when we have the medical know-how to prevent more than half the cases of unrelieved pain."⁷³ As opposed to the "as needed" approach to the treatment of pain, the AHCPR recommends preventative drug therapy since physiological studies have confirmed that established pain is harder to suppress.⁷⁴ The guidelines criticize the "as needed" approach to pain management because it often results in unnecessary delays while nurses retrieve and prepare the drugs for administration.⁷⁵ Instead of the burdensome "as needed" approach, the guideline recommends that initially, pain medication should be given on a regular basis, but should later be adjusted to prevent the pain from returning.⁷⁶ Furthermore, the guideline advocates "on-demand" dosing, in which the patient controls the amount of analgesia administered for pain, as a safe method for postoperative pain which is preferred by many patients over intermittent injections.⁷⁷

Clifton Gaus, Administrator of the AHCPR, stated that the guideline was a result of the way pain was being managed in hospitals.⁷⁸ "We found that pain was being undermanaged in hospitals, and that in fact, hospitals doing more aggressive, effective pain management have reduced their costs in this area."⁷⁹ Gaus stated that the AHCPR seeks to show that "better quality often costs less."⁸⁰ Sullivan stated that inadequate pain management actually inflates hospital costs because it often inhibits recovery and prolongs hospitalization.⁸¹ Postoperative pain is no longer deemed an inevitable occurrence, and improperly treated pain has the potential to not only inhibit recovery, but also may provoke complications such as pneumonia, heart attacks, or blood clots.⁸²

⁷³Crowley, *supra* note 32, at 389.

⁷⁴*Id.* at 392.

⁷⁵Robert T. Angarola & Brian L. Pendleton, *The Agency for Health Care Policy and Research and the Pharmaceutical Industry*, 48 FOOD & DRUG L.J. 511, 517 (1993).

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸Interview with Clifton Gaus, Administrator of the Agency for Health Care Policy & Research, 69 HOSPITALS 43 (July 20, 1995).

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹Julie A. Steele & Ellen Taylor, *Guidelines Released on Acute Pain Management*, 84 J. NAT'L CANCER INST. 481 (Apr. 1992).

⁸²*Id.*

The AHCPR guideline on pain treatment also confronts the addiction myth discussed previously. The guideline reiterates what numerous studies have indicated; namely, that addiction to pain medication such as morphine and demerol is extremely rare when used for less than ten days for post-operative and injury-related pain.⁸³ In addition, the guideline cites morphine as the most effective drug for treating acute pain, and suggests that physicians should rely on it more often to control pain instead of employing the most commonly used post-operative pain control, meperidine.⁸⁴

Based upon the underlying reasoning behind the AHCPR's guideline recommendation for the treatment of pain, as well as the guideline recommendation itself, it is apparent that the guideline is a preferred alternative to the current method of treating pain. The "as needed" approach no longer suffices to alleviate post-operative and injury-related pain. Thus, physicians should follow the guideline and begin to implement a preventative approach to the treatment of pain.

B. The Hospice Philosophy

The National Hospice Organization (NHO) defines hospice as "a centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons and their families."⁸⁵ The model hospice, St. Christopher's, was established in London in 1967 by Cicely Saunders, M.D.⁸⁶ Saunders realized that central to the care of the terminally ill was controlling pain, and she soon started to experiment with alternative approaches to pain relief.⁸⁷ Central to her discovery was that she could work more effectively with patients on their personal and emotional problems "when drugs were administered to prevent pain from occurring rather than using drugs to relieve pain after the pain began."⁸⁸ Saunders is credited with developing the "total pain" concept; "total pain meaning physical, psychological, social, and spiritual."⁸⁹

In the United States in 1973, two significant events in the area of pain management occurred.⁹⁰ First, R.M. Marks and E.J. Sachar published a ground breaking study which revealed that seventy-three percent of medical patients

⁸³Crowley, *supra* note 32, at 393.

⁸⁴Angarola & Pendleton, *supra* note 75, at 517.

⁸⁵Robert M. Cunningham, Jr., *The Evolution of Hospice*, 59 HOSPITALS 124 (April 16, 1985).

⁸⁶*Id.*

⁸⁷*Id.*

⁸⁸*Id.*

⁸⁹Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 OHIO N.U. L. REV. 755, 756 (1994).

⁹⁰*Id.*

in hospitals treated for pain with narcotics analgesics were undermedicated for their pain and consequently suffered constant discomfort.⁹¹ Second, Connecticut Hospice, the first hospice in the United States, was opened as an alternative to the way pain was being undermanaged in conventional settings.⁹²

Since the opening of the first hospice in 1973, the idea of hospice care has spread rapidly throughout the United States. As of 1989, an estimated 1,400 hospices were operating in the United States, with a large percentage of those located in the Northeast and California.⁹³ To be eligible for hospice care, a patient must meet certain criteria. First, the patient must have a disease for which disease-oriented, life-prolonging therapies have ceased to become effective.⁹⁴ Second, the patient must have a predicted life expectancy of six months or less.⁹⁵

Today's hospice implements a team approach to managing pain and symptoms without an intent to cure the patient.⁹⁶ Rather, the emphasis is on alleviating the physical pain while also addressing the pain that is emotional or spiritual in nature.⁹⁷ The goal of hospice is to support not only the patient, but also the patient's family, during the patient's ultimate life journey.⁹⁸

Unfortunately, several barriers to adequate hospice care exist today. One barrier is education.⁹⁹ That is, by definition, a terminal disease is incapable of being cured; thus, there is no possibility of success in medical terms for caring for terminally ill patients.¹⁰⁰ Consequently, very few, if any, medical schools in the United States teach the philosophy of hospice or palliative care.¹⁰¹ Another barrier to adequate hospice care is the overall unfamiliarity with hospice among the American public.¹⁰² A study in 1984 found that nationwide, nearly fifty-three percent of respondents aged fifty-five and above were unfamiliar

⁹¹*Id.*

⁹²*Id.*

⁹³Vincent Mor, Gerry Hendershot & Cynthia Cryan, *Awareness of Hospice Services: Results of a National Survey*, 104 PUBLIC HEALTH REP. 176 (1989).

⁹⁴Michael H. Levy, *Living With Cancer: Hospice/Palliative Care*, 85 J. NAT'L CANCER INST. 1283 (Aug. 1993).

⁹⁵*Id.*

⁹⁶Wheeler, *supra* note 89, at 755.

⁹⁷Marilyn H. Cromer, *Hospice Care: A Proven Alternative*, 68 HOSPITALS 6 (Mar. 5, 1994).

⁹⁸*Id.*

⁹⁹Wheeler, *supra* note 89, at 757.

¹⁰⁰*Id.*

¹⁰¹*Id.*

¹⁰²Mor, Hendershot & Cryan, *supra* note 93, at 176.

with hospice.¹⁰³ Surprisingly, respondents with cancer, those with the greatest possibility of entering a hospice, were only somewhat more likely to be familiar with hospice than those who did not have the disease.¹⁰⁴ Obviously, in order for an individual to exercise his or her choice between alternative systems of care, one must first become familiar with the alternatives. Unfortunately, familiarity with hospice is lacking.¹⁰⁵

Although hospice deals only with terminally ill patients, the underlying philosophy of hospice care should be implemented by conventional health care systems to more adequately treat patients in pain. The hospice movement predicated the AHCPR's guideline recommendation for preventative pain control.¹⁰⁶ Preventing pain from occurring should be the goal of effective pain management in conventional hospitals, and should not be reserved only for those who have less than six months to live.

C. Physician-Assisted Suicide as a Means for Patients to Escape Pain

Closely related to the issue of adequate pain relief is the topic of physician-assisted suicide. A common fear among many Americans is the prospect of dying in an impersonal hospital setting surrounded by strangers.¹⁰⁷ Most people say that when they die, they want it to be a quick, painless process, and they want to be surrounded by their families and friends.¹⁰⁸ Unfortunately, however, most people end up dying a slow, painful death in a hospital while surrounded by strangers.¹⁰⁹

Another common fear among individuals is the fear of pain itself. For example, one study found that fifty percent of the families surveyed reported that their loved ones experienced moderate or severe pain at least half of the time during the last three days of their lives.¹¹⁰ In order to avoid a prolonged, painful natural death, many patients may wish to die now, painlessly, with the help of a physician, rather than continuing to suffer in pain.

Those in the medical field justify the illegality of physician-assisted suicide by asserting that physicians are able to alleviate the pain. However, as the above studies indicate, physicians do *not* adequately alleviate patient's pain, especially in the patient's final days of life. Therefore, it only follows that if

¹⁰³*Id.*

¹⁰⁴*Id.*

¹⁰⁵*Id.*

¹⁰⁶Crowley, *supra* note 32, at 394.

¹⁰⁷George J. Annas, *Physician-Assisted Suicide—Michigan's Temporary Solution*, 20 OHIO N.U. L. REV. 561, 561 (1994).

¹⁰⁸*Id.*

¹⁰⁹*Id.*

¹¹⁰Carl. H. Coleman & Tracy E. Miller, *Stemming the Tide: Assisted Suicide and the Constitution*, 12 ISSUES L. & MED. 211, 217 (1995).

doctors are not using adequate dosages and strengths of pain medication available to them and are consequently allowing their patients to suffer continued pain, then the patient ought to have the ability to die sooner and avoid the pain when death is inevitable.

The prospect of suffering a slow, painful death in an impersonal setting often results in many patients considering the alternative of physician-assisted suicide. Dr. Timothy E. Quill advocates the use of physician-assisted suicide and believes that physicians have a duty to help their patients achieve a "good death."¹¹¹ During remarks he made at Albany Law School, Dr. Quill stated:

In my view, it is malpractice for physicians caring for severely ill patients not to know how to use pain medicine, and not to use it aggressively when a patient is dying in pain. But I also know that sometimes death can provide the only escape from intolerable suffering, and that under such circumstances it can be legitimate and rational to want death.¹¹²

Dr. Quill also discussed the unfortunate fact that the places where people often end up dying, hospitals, are dangerous places to be if you wish to die with comfort and dignity.¹¹³ The disturbing truth is that people die in acute health care facilities often tied down, with tubes protruding from every orifice.¹¹⁴ Probably very few Americans would choose this type of medically invasive death.¹¹⁵

The status of the law today in the area of the right to die is that a competent individual has the right to terminate treatment, i.e., terminate the use of a feeding tube or respirator, even if the termination of the treatment will hasten the patient's death.¹¹⁶ An individual does not have a right to physician-assisted suicide, although the Ninth and Second Circuit Courts of Appeal have upheld such a right.¹¹⁷

¹¹¹Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas* (November 5, 1993) in 57 ALB. L. REV. 693, 694 (1994).

¹¹²*Id.*

¹¹³*Id.* at 697.

¹¹⁴*Id.*

¹¹⁵Quill, *supra* note 111, at 697.

¹¹⁶*See* *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990). In *Cruzan*, the Supreme Court found that Ms. Cruzan's Fourteenth Amendment rights were not violated by Missouri's continuation of life-sustaining procedures. However, the Court focused on the fact that Ms. Cruzan was incompetent and could not provide clear and convincing evidence of her wish to terminate such procedures. Significantly, the Court held that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. . . ." *Id.* at 278.

¹¹⁷*See* *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

A great deal of debate surrounds the issue of physician-assisted suicide, as those in favor believe in the patient's right to choose whether to live in constant pain or die a quick and painless death, while others oppose physician-assisted suicide and argue that it is inconsistent with the physician's role as healer.¹¹⁸ However, an important fact which is often overlooked is that unless you have experienced the right to die, you cannot truly understand such a right.¹¹⁹

An example of someone who has experienced such a right is Dax Cowart. When Cowart was twenty-seven years old, he was severely burned and his father killed when their car exploded near a leaking propane gas pipe line.¹²⁰ Cowart had burns covering sixty percent of his body, was blinded, and his ears were mostly destroyed.¹²¹ He endured terribly painful cleaning of his wounds and bathing in a special tub to change his dressings.¹²² He decided that because of the painful treatments, and because he did not want to live as a blinded and crippled person, the "end result [was] not worth the pain involved," and he wished to die.¹²³ He was denied his wish to leave the hospital and kill himself. Twenty years later Cowart spoke at a meeting of the Academy of Psychosomatic Medicine in Phoenix.¹²⁴ He said that after he left the hospital, he tried twice to commit suicide, he had great difficulty sleeping, but that ultimately a psychiatric hospitalization helped him a great deal.¹²⁵ Since then, he has graduated from law school and has passed the Texas bar exam.¹²⁶ He is now an advocate of patients' rights, particularly of the patient's right to refuse treatment.¹²⁷ Although Cowart said he is glad to be alive now, he believes that he should have been allowed to die.¹²⁸ He also indicated that if he had not been undermedicated for his pain, he may not have wished to die in the first place.¹²⁹

The debate over physician-assisted suicide will continue until the right is more clearly defined. Committing suicide is legal, but over two-thirds of the

¹¹⁸Glasson, *supra* note 71, at 93.

¹¹⁹Scott I. Davidson, *But, Why do We Shoot Horses?: An Analysis of the Right to Die and Euthanasia*, 12 N.Y.L. SCH. J. HUM. RTS. 115, 116 (1994).

¹²⁰Dr. Michael Blumenfield, *Psychiatry Today*, GANNETT NEWS SERVICE, Jan. 10, 1995.

¹²¹*Id.*

¹²²*Id.*

¹²³*Id.*

¹²⁴Dr. Michael Blumenfield, *Psychiatry Today*, GANNETT NEWS SERVICE, Jan. 10, 1995.

¹²⁵*Id.*

¹²⁶*Id.*

¹²⁷*Id.*

¹²⁸Dr. Michael Blumenfield, *Psychiatry Today*, GANNETT NEWS SERVICE, Jan. 10, 1995.

¹²⁹*Id.*

states make assisting suicide a crime.¹³⁰ A physician terminating the use of a respirator or feeding tube at a competent patient's request is legal,¹³¹ but prescribing or administering a high dose of narcotics to bring death is not.¹³² However, administering pain medication with the intent to relieve a patient's pain is allowed, even if the dosage may result in hastening the patient's death.¹³³

The line between cutting off the use of a respirator and prescribing lethal doses of medication is unclear, since both are ways for a physician to "assist" in causing the death of a patient. Nevertheless, if physician-assisted suicide remains unpracticed, either because it is illegal or because it cuts against a doctor's moral beliefs, patients will continue to be left in pain due to undermedication. If Dax Cowart had been adequately medicated for his pain, he would not have wanted to die in the first place. If suicide is not an option, as it was not in his case, then doctors should be liable for failing to provide adequate pain relief.

IV. THE NEXT STEP: RECOGNIZING LEGAL LIABILITY FOR FAILURE TO ADEQUATELY MEDICATE FOR PAIN

A. Factors To Consider In Recognizing A Legal Obligation To Render Adequate Pain Relief

Obviously, a physician cannot possibly relieve every patient's pain all of the time. Therefore, this section discusses under what circumstances a physician should be held legally responsible to provide adequate pain relief.

Certain circumstances may exist in which it is preferable to refrain from relieving a patient's pain right away; for example, when the underlying cause of the injury or illness has yet to be discovered. In those situations, a physician is justified to withhold pain medication until the origin of the pain is revealed. As discussed previously, certain individuals, based on past experiences with narcotics, may be particularly prone to addiction to pain medication. In those

¹³⁰David M. English, *Issue of Physician-Assisted Suicide Confronted by Courts and Legislatures*, 23 EST. PLAN. 230, 230 (June 1996).

¹³¹See *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990). In *Cruzan*, the Supreme Court found that Ms. Cruzan's Fourteenth Amendment rights were not violated by Missouri's continuation of life-sustaining procedures. However, the Court focused on the fact that Ms. Cruzan was incompetent and could not provide clear and convincing evidence of her wish to terminate such procedures. Significantly, the Court held that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. . . ." *Id.* at 278.

¹³²*But see* *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996). In that case, the court held that an outright ban on physician-assisted suicide is violative of a terminally ill patient's substantive due process, as such a patient has a "liberty interest in controlling the time and manner of [his or her] death. . . ." *Id.* at 813.

¹³³See James K. Rogers, *Punishing Assisted Suicide: Where Legislators Should Fear to Tread*, 20 OHIO N.U. L. REV. 647, 657 (1994).

instances, a doctor may justifiably withhold highly addictive medication, such as morphine. However, this still begs the question of whether it is really better to remain in pain than to be addicted to pain medication. Some patients may wish to risk becoming addicted rather than continue experiencing severe pain. The patient should be the one to decide whether he or she will risk addiction in order to be relieved from severe pain, since it is the patient who is confronted with the choice of addiction versus suffering severe pain.

Another set of factors a physician must take into consideration are the drug's possible side effects. For example, the *Physician's Desk Reference* indicates that demerol and other narcotic analgesics contain major hazards, including respiratory and circulatory depression, respiratory arrest, shock and cardiac arrest.¹³⁴ More frequently experienced side effects include lightheadedness, dizziness, nausea, vomiting and sweating.¹³⁵ These side effects occur more often in ambulatory patients and those who are not in severe pain.¹³⁶ Risk of drug interaction is another factor that must be taken into account by the physician.

A physician should also consider whether or not the particular patient is terminally ill. If the patient is terminally ill, the doctor should have no concern about the patient becoming addicted. The doctor should also strive to alleviate the pain of the terminally ill patient so that the process of dying is as comfortable and painless as possible.

A final consideration is the actual type of pain of which the patient is complaining. As previously discussed, cancer pain, pain from burns, and dental pain are among the types of pain which are established without necessarily relying on the patient's subjective response to the pain. In situations such as cancer pain, a doctor or nurse should take into consideration the fact that the pain reported by the patient is probably genuine, and he or she should administer more pain relief medication whenever medically feasible. In cases where objective evidence of pain exists, the doctor should believe the patient's report of pain, because the objective evidence of pain confirms that the pain is present. In those situations, the physician should administer pain medication when the patient reports pain.

The factors discussed above are among a few of the factors a physician must take into consideration when determining whether or not to administer a certain type of pain medication. Additionally, these considerations are also factors for a finder of fact to take into consideration when deciding whether a particular physician has breached his or her duty of care. Certainly, there are some circumstances in which a physician is justified in withholding narcotics to a certain degree; however, absent a valid justification for doing so, pain medication should be administered to patients in pain.

¹³⁴PHYSICIAN'S DESK REFERENCE 2308 (50th ed. 1996).

¹³⁵*Id.*

¹³⁶*Id.*

B. Establishing Liability for the Undermedication of Pain

The above discussion illustrates that far too many patients are unnecessarily undermedicated for their pain, and are consequently living and dying in severe pain. In order to deal with this problem, the failure to adequately medicate for pain must be recognized as a cause of action for medical malpractice.

At least one time in the past, in *Helling v. Carey*, a court imposed a standard of care on an entire branch of medicine.¹³⁷ In that case, the plaintiff alleged that the defendants were negligent in failing to administer a pressure test for glaucoma to her at an earlier time which, if given then, would have detected her condition and would have avoided the resulting loss in her vision.¹³⁸ The standard of the profession at that time did not require performing the routine pressure test on persons under age forty because the risk of glaucoma was very rare in that age group.¹³⁹ The defendants argued that the standard of care thus insulated them from liability.¹⁴⁰ However, the court recognized that it is the court's duty to determine what is required in order to protect patients in that age group from the damaging effects of glaucoma.¹⁴¹ The court held that reasonable prudence required the timely administration of the pressure test to the plaintiff. "[T]he reasonable standard that should have been followed . . . was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable."¹⁴²

The court in *Helling* based its decision to impose a standard of care on the ophthalmology branch of medicine on the fact that the procedure itself, the glaucoma pressure test, was simple and harmless. Similarly, in the area of pain management, the simplicity and harmlessness of administering effective medication for pain relief suggests that such a standard of care could be imposed on physicians practicing pain management. As previously discussed, adequate pain management is actually less expensive for hospitals, since undermedicating for pain often hinders the healing process, which in turn prolongs hospital stay and may increase the chances of pneumonia, heart attack, and blood clots. Furthermore, it has been proven that adequate dosages of pain medication are harmless in that, contrary to many doctors' beliefs, addiction to narcotics given for pain relief is unlikely to occur when such narcotics are used for a short period of time following surgery or injury. Additionally, adequate relief from pain would deter many patients suffering

¹³⁷*Helling v. Carey*, 519 P.2d 981 (Wash. Sup. Ct. 1974).

¹³⁸*Id.* at 982.

¹³⁹*Id.*

¹⁴⁰*Id.*

¹⁴¹*Helling*, 519 P.2d at 983.

¹⁴²*Id.* at 984.

from severe pain from considering the possibility of physician-assisted suicide to escape their pain. In that way also, mandating adequate pain relief would benefit patients and families alike and avoid the harm of watching a loved one suffer a long, painful death.

Therefore, based on its simplicity and harmlessness, and in congruence with the *Helling* court's decision, a court could conceivably impose a standard of care which requires adequate pain relief in certain instances on those in the medical profession who practice pain management. However, my proposal does not request such an imposition of a standard of care. Rather, I propose that courts recognize on a case-by-case basis a medical malpractice action when a physician fails to render adequate pain relief. The jury should be able to decide, based on expert testimony, whether a physician has breached his or her duty of care in failing to render adequate pain relief.

Another argument for requiring medical personnel to provide adequate pain relief is linked to the issue of physician-assisted suicide. On the one hand, there is an argument that physician-assisted suicide should be legalized so that patients suffering from severe pain may not have to endure prolonged suffering, when death will inevitably be the end result. This argument is also related to the undermedication of pain, as it is often those patients who are being undermedicated for their pain who are suffering from such intense pain that they would rather die. On the other hand, there is also an argument that legalizing physician-assisted suicide may deter physicians from relieving the pain and improving the care of patients who are dying or are in severe pain.¹⁴³

A solution to this problem would be to require physicians to provide adequate pain relief medication to patients, with the realization that the physician will not be penalized if the medication hastens the patient's death. This would be an appropriate measure, since physicians currently tend to undertreat pain in severely ill patients due to the prospect of being perceived as assisting in the patient's death.¹⁴⁴ Additionally, proscribing a rule that it is morally wrong and against a physician's ethical code to provide assistance to a dying patient ignores reality, as a physician's primary goal should not be to fight the patient's wishes.¹⁴⁵ Instead, a physician should strive to "ease [a] patient's suffering through treatment, medication, or by assistance in dying as a last resort."¹⁴⁶

¹⁴³This argument was advocated by the New York State Task Force on Life and the Law. Elizabeth Rosenthal stated, "the panel argued successfully that if assisted suicide were legalized, some physicians might refrain from relieving the pain and improving the care of people who were dying, in severe pain, or badly depressed." Donald E. Spencer, *Practical Implications of Health Care Providers in a Physician-Assisted Suicide Environment*, 18 PUGET SOUND L. REV. 545, 549 (1995).

¹⁴⁴Davidson, *supra* note 119, at 154.

¹⁴⁵*Id.* at 157.

¹⁴⁶*Id.*

A patient's desire for suicide should be a signal to the physician that greater efforts are needed to comfort the patient and provide more adequate pain relief.¹⁴⁷ The problem does not only exist in terminally ill patients, however. Approximately half of all patients suffering from acute pain are undermedicated for that pain.¹⁴⁸ Although in some circumstances there may be a medical justification for failing to immediately alleviate pain, such as to enable physicians to discover the nature of the underlying illness or injury, physicians should not allow patients to suffer prolonged pain from that illness or injury simply because the physician is concerned about the patient becoming addicted to the pain medication. Factors personal to the patient, such as previous drug abuse, weigh more heavily into the prospect of a patient becoming addicted than the pain medication itself. Absent an individual's being particularly prone to drug addiction, a physician should be required to administer adequate pain relief.

In order for a physician to be found liable for medical malpractice, the elements of medical negligence must be met. The elements of medical negligence include the following: "1) existence of a duty running from the physician to the injured party; 2) breach of this duty by the physician; 3) injury to the patient which is proximately caused by the physician's breach of duty; and 4) the existence of damages arising from the breach of duty."¹⁴⁹ In malpractice cases, the standard of care typically depends on whether or not the physician's conduct was "reasonable in light of the performance of other physicians under like conditions."¹⁵⁰ Discussing standard of care, the court in *Zoterell v. Repp* stated:

The difficulties and uncertainties in the practice of medicine and surgery are such that no practitioner can be required to guarantee results, and all the law demands is that he bring and apply to the case in hand that degree of skill, care, knowledge and attention ordinarily possessed and exercised by practitioners of the medical profession under like circumstances.¹⁵¹

Since laypersons do not ordinarily possess knowledge of the level of skill possessed by physicians, proof of medical negligence typically requires the plaintiff to establish both the duty and the breach of the duty by using expert testimony.¹⁵² The expert must provide testimony concerning the prevailing standard of care as required in the particular case, as well as the defendant's

¹⁴⁷Glasson, *supra* note 71, at 97.

¹⁴⁸*Giving New Guidance to Care Givers*, U.S. NEWS & WORLD REPORT, Mar. 16, 1992, at 14.

¹⁴⁹ LOISELL & WILLIAMS, MEDICAL MALPRACTICE 8-4 (1995).

¹⁵⁰*Id.* at 8-2.

¹⁵¹*Zoterell v. Repp*, 153 N.W. 692, 695-96 (Mich. Sup. Ct. 1915).

¹⁵² LOISELL & WILLIAMS, *supra* note 149, at 8-33

failure to act in compliance with that standard of care.¹⁵³ Without this expert testimony, the jury will be unable to decide whether or not there was a breach of duty by a physician.¹⁵⁴

Concerning a medical malpractice action for the failure to adequately medicate for a patient's pain, a duty must first exist requiring the physician to provide adequate pain relief medication. The physician must then breach this duty to the patient. Injury to the patient which is proximately caused by the physician's breach of duty can be found in the patient's prolonged physical pain. Damages arising from the breach of duty would include compensation for the patient's unjustified pain and suffering.

In order for a plaintiff to prevail in a medical malpractice action of this sort, the plaintiff must provide expert testimony concerning the reasonableness of the defendant physician's conduct in light of the circumstances and in comparison to other physicians in similar circumstances. Currently, courts do not recognize a duty on the part of physicians to adequately medicate for a patient's pain; however, the need to do so is evident. Studies discussed previously indicate that close to fifty percent of patients being treated for acute pain are being undermedicated for that pain. Furthermore, physicians themselves, when surveyed, admitted that terminally ill patients were being undermedicated for their pain, and that pain management was not being effectively taught in medical schools. Since physicians themselves have recognized the inadequacies of pain management, this certainly shows that a recognition of a physician's duty to adequately medicate for pain is needed. As it did in the *Ladish* case, a jury should be able to hear expert testimony and decide whether or not a physician has breached his or her duty of care in failing to render appropriate pain relief medication.

V. CONCLUSION

The recognition of a physician's duty to provide adequate medication for patients in pain is necessary in order to consider today's system of pain management acceptable. Far too many patients are suffering unnecessary, severe pain, often due to a physician's mistaken belief that the patient will become addicted to pain medication if given. Furthermore, terminally ill patients are subjected to needless pain in their final stages of life, which is sometimes a result of physicians' fear of overmedicating for the patient's pain and thus being perceived as assisting in the patient's death.

In order to deal with these problems, courts must recognize a legal obligation on the part of physicians to render adequate pain relief. In order to avoid fraudulent claims, the instances in which a doctor should be liable for malpractice for failing to provide adequate pain relief medication should be limited to those instances in which the plaintiff presents objective evidence of his or her pain.

¹⁵³*Id.*

¹⁵⁴*Id.*

The result of holding doctors to this higher standard of care will be fewer terminally ill patients wishing to die, as well as quicker recovery from injury or illness. Without this recognition, pain management in America will remain inadequate, and unjustified, prolonged pain and suffering will continue to be the prevailing norm in our hospitals.

TONYA EIPPERT

