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# Pain Management for the Elderly

Terrie M. Lewis

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## PAIN MANAGEMENT FOR THE ELDERLY

Terrie Lewis<sup>†</sup>

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I had this frozen arm and incredible pain. If you blew on my left arm, I would scream. The nurse told me I was holding my hand in a funny way—which is typical of stroke patients—and she sat on my arm! I slugged her with my good arm and yelled, “That hurts like hell!” She said, “Oh,

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you're becoming combative," and brought in two fat nurses who tried to sit on it again. If I had a pistol, I would have shot them.<sup>1</sup>

## I. INTRODUCTION

Pain. "An unpleasant sensation occurring in varying degrees of severity as a consequence of injury, disease, or emotional disorder. Suffering or distress."<sup>2</sup> In the United States, up to 120 million people suffer from chronic pain.<sup>3</sup> Chronic pain may affect as many as one in every five elderly people—those age sixty-five and older.<sup>4</sup> Forty-five to eighty percent of the elderly who live in nursing homes suffer from major pain problems.<sup>5</sup> Pain interferes with the ability "to reflect, to enjoy human relationships, and even to think and function on a most basic level."<sup>6</sup> While most people believe there is an ethical obligation to relieve pain, pain is still undertreated by healthcare professionals.<sup>7</sup>

The focus of this article is on pain in the elderly in the United States. Questions to be discussed include: How prevalent is pain in the elderly population? What impact does pain have on the daily lives of elderly people, including on their physical health? What impact does pain have on an elderly person's death? How do healthcare providers respond to and treat pain? If there is an ethical obligation to relieve pain, why is pain undertreated? Does the legal system address pain in the elderly? What can be done to help the elderly live and die free from pain?

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1. Don Lattin, *Expert on Death Faces Her Own Death. Kubler-Ross Now Questions Her Life's Work*, S.F. CHRON., May 31, 1997, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/1997/05/31/N42913.DTL>.

2. AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 597 (4th ed. 2000).

3. Press Release, Joint Commission on Accreditation of Healthcare Organizations, Pain: National Summit Focuses on Relief for Millions of Americans (June 25, 2001), <http://www.jcaho.org/news/nb332.html>.

4. M.G. Young, *Chronic Pain Management in the Elderly*, PATIENT CARE 31, 31 (Sept. 30, 2000) as reported in Partners Against Pain, an online information service for physicians and patients, at [http://www.partnersagainstpain.com/html/profed/pmc/pe\\_pmc7.html](http://www.partnersagainstpain.com/html/profed/pmc/pe_pmc7.html).

5. F.M. Gloth, *Geriatric Pain: Factors that Limit Pain Relief and Increase Complications*, 55 GERIATRICS 46, 46 (2000) as reported in Partners Against Pain, *supra* note 4.

6. Sandra H. Johnson, *Relieving Unnecessary, Treatable Pain for the Sake of Human Dignity*, 29 J.L. MED. & ETHICS 11, 11 (2001).

7. *Id.*

## II. THE NATURE OF PAIN

Pain is categorized as either acute or chronic. Acute pain is usually short-lived but, if untreated, can turn into chronic pain.<sup>8</sup> Chronic or intractable pain is defined as pain where the cause cannot be removed or treated and “no relief or cure has been found after reasonable efforts.”<sup>9</sup> Chronic pain is generally characterized as pain lasting more than four weeks and rated as a seven or above by the patient on a numerical ten-point pain intensity scale.<sup>10</sup> Chronic pain has myriad causes including headache, back pain, arthritis, cancer, and other serious illnesses.<sup>11</sup> In some patients, chronic pain may have multiple, simultaneous causes.<sup>12</sup> In other patients, the underlying cause of chronic pain remains unknown.

Chronic pain affects the physical, psychological, social and spiritual well-being of the patient.<sup>13</sup> When inappropriately treated, chronic pain causes emotional suffering and increases the risks of lost livelihood and social integration.<sup>14</sup> Patients who suffer from chronic pain also suffer from sleep deprivation, depression and anxiety as a result of their pain.<sup>15</sup> Severe chronic pain “often leads to mood disorders, including depression and in rare cases, suicide,”<sup>16</sup> and uncontrolled pain can be an important contributing factor to requests for clinician-assisted suicide or euthanasia.<sup>17</sup>

8. Laurie Tarkan, *New Efforts Against an Old Foe: Pain*, N.Y. TIMES, Dec. 26, 2000, available at <http://www.nytimes.com/200/12/26/science/26PAIN.html>.

9. Jackie Sexton, *Pain Management: Medical, Legal, Ethical Issues*, KELN.ORG BIBLIOGRAPHY, Dec. 1999, <http://www.keln.org/bibs/sexton.html> (last visited Apr. 3, 2002).

10. Melissa Hendricks, *Just Give Me Something for the Pain*, JOHNS HOPKINS MAG., June 1999, <http://www.jhu.edu/~jhumag/0699web/pain.html>.

11. *Id.*

12. A. JACOBS, D.B. CARR, R. PAYNE ET AL., MANAGEMENT OF CANCER PAIN, CLINICAL PRACTICE GUIDELINE NO. 9, 1 (Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Publication No. 94-0592) (March 1994).

13. *Id.*

14. AM. ACAD. PAIN MED., *The Necessity for Early Evaluation of the Chronic Pain Patient* (2001), <http://www.painmed.org/productpub/statements/earlyevalustmt.html> (last visited April 14, 2002).

15. A. Won et. al., *Correlates and Management of Nonmalignant Pain in the Nursing Home*, 47 J. AM. GERIATRICS SOC'Y 936, 936 (1999) as reported in *Partners Against Pain*, *supra* note 4. See also Young, *supra* note 4.

16. *Id.*

17. JACOBS, CARR, PAYNE ET AL., *supra* note 12, at 4.

## III. PAIN IS PREVALENT IN THE ELDERLY POPULATION

Pain is a fact of life for most people over the age of sixty-five. Even those who are seemingly healthy and living independently in the community can suffer from major pain problems.<sup>18</sup> The elderly who are coping with cancer or living in nursing homes have an even greater incidence of pain.

Studies in the past ten years have shown the elderly live and die in pain. The most recent study was reported in April 2001 by Brown University.<sup>19</sup> This nationwide study was conducted in 1999 and analyzed the pain reporting of over 2.2 million people in the United States in nursing homes.<sup>20</sup> Brown University Medical School researchers found that 41.2% of nursing home patients in moderate or excruciating pain on April 1, 1999, were still in pain 60 to 180 days later.<sup>21</sup> In the same study, nearly fifteen percent of patients residing in a nursing home for two to six months reported persistent pain.<sup>22</sup> Director of the Department of Community Health, and co-author of the study, stated, "Our findings demonstrate woefully inadequate pain management among a frail, old and vulnerable population of Americans. Important ground has been gained in the last decade in pain management, but these results highlight the urgent work yet to be done."<sup>23</sup> This study duplicates the findings of previous studies conducted by Brown University and other researchers. In 1998, Brown University published a study of 13,625 cancer patients over the age of sixty-five who were living in 1,492 nursing homes from 1992 to 1995.<sup>24</sup> Out

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18. Raphael J. Leo & Amarpreet Singh, *Pain Management in the Elderly: Use of Psychopharmacologic Agents*, 10 ANNALS OF LONG-TERM CARE 37, 37 (Feb. 2002) Twenty to fifty percent of persons sixty-five and older living in communities experience chronic pain. *Id.* The typical sources are arthritis, cancer, diabetic neuropathy, herpes zoster and osteoporosis. The elderly suffer from chronic pain twice as frequently as younger people. *Id.*

19. Scott J. Turner, *Researchers Find Pain Widespread and Severe in Nursing Homes*, 25 GEO. ST. J. 25 (2001), [http://www.brown.edu/Administration/George\\_Street\\_Journal/vol25/25GSJ25e.html](http://www.brown.edu/Administration/George_Street_Journal/vol25/25GSJ25e.html) [hereinafter *Pain Widespread and Severe*].

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. Roberto Renabei et al., *Management of Pain in Elderly Patients with Cancer*, 279 JAMA 1877, 1882 (1998); Scott J. Turner, *Poor Care for Cancer Patients in Nursing Homes*, 22 GEO. STREET. J. 32 (1998), [http://www.brown.edu/Administration/George\\_Street\\_Journal/vol22/22GSJ32e.html](http://www.brown.edu/Administration/George_Street_Journal/vol22/22GSJ32e.html) [hereinafter *Poor Care*]; Tarkan, *supra* note 8.

of the 13,625 patients studied, 4,003 stated they were in pain on a daily basis.<sup>25</sup> A 1997 study by the Washington University School of Medicine in St. Louis found that most nursing home patients suffer from some pain, one-third are in constant pain, and more than fifty percent experience severe pain.<sup>26</sup> The Gallup Organization also conducted an American pain survey in 1999.<sup>27</sup> They found more than half of Americans sixty-five and older suffer from pain on a daily basis.<sup>28</sup> Obviously, many people are studying this problem. Unfortunately, the problem is not going away.<sup>29</sup>

#### IV. PAIN INTERFERES WITH AN ELDERLY PERSON'S DAILY LIFE AND PHYSICAL HEALTH

Living in pain interferes with an elderly person's ability to have a satisfactory life. Experiencing pain causes physical reactions in the body.<sup>30</sup> When the body is experiencing pain, stress-related hormones are secreted.<sup>31</sup> These hormones cause body tissues to break down.<sup>32</sup> Fluid retention becomes more likely when the body is in pain.<sup>33</sup> The cardiovascular system reacts with tachycardia, hypertension, ischemia, and ventricular arrhythmias.<sup>34</sup> The respiratory system is affected.<sup>35</sup> The digestive system slows in its functioning when the body is experiencing pain.<sup>36</sup> Some studies have even linked rapid growth of tumors to poor pain control.<sup>37</sup> In addition to physical reactions, pain may cause irritability or

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25. Turner, *supra* note 24.

26. Diane Duke, *Elderly with Dementia Have Trouble Reporting Pain, According to Study*, WASH. U. IN ST. LOUIS RECORD, Feb. 20, 1997, available at <http://wuppa.wustl.edu/record/archive/1997/02-20-97/1700.html>.

27. ARTHRITIS FOUNDATION, SPEAKING OF PAIN: HOW TO TALK WITH YOUR DOCTOR ABOUT PAIN, at <http://www.arthritis.org/conditions/speakingofpain/factsheet.asp> (last visited Apr. 13, 2002).

28. *Id.*

29. *Pain Widespread and Severe, supra* note 19.

30. INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN, PAIN CONTROL: THE NEW "WHYS" AND "HOWS," PAIN CLINICAL UPDATES (Daniel B. Carr ed., May 1993), available at <http://www.iasp-pain.org/PCUOpen.html>. Interestingly enough, the bodily reactions to pain occur even if the patient is unconscious from sedation during surgery. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

inappropriate emotional responses.<sup>38</sup> An elderly person suffering from pain is less able to enjoy life.

#### V. PAIN AFFECTS THE DYING PROCESS FOR THE ELDERLY AND THEIR FAMILIES

Death at the end of life need not be physically painful.<sup>39</sup> While pain in dying can be reduced or eliminated in nearly ninety-five percent of the terminally ill, almost fifty percent of Americans die in pain.<sup>40</sup> This is true today even though pain management and elimination of pain as part of the dying process has been receiving attention for the past ten years. Some healthcare providers and members of the legal community believe that requests for assisted suicide are, in reality, requests to alleviate the pain the patient is experiencing.<sup>41</sup> In truth, most people are more afraid of pain during the dying process than they are afraid of death itself.<sup>42</sup>

#### VI. PRACTICE METHODS FOR THE TREATMENT OF PAIN

There is a well-established protocol for the treatment and management of pain.<sup>43</sup> The first step is to review the patient's medical records including taking a medical history.<sup>44</sup> The history should include the type, intensity, and frequency of pain the patient is experiencing.<sup>45</sup> Underlying diseases, which may be the cause of the pain, should be determined.<sup>46</sup> Physical and psychological exams should be performed and note should be

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38. Duke, *supra* note 26.

39. *Oregon Doctor Disciplined for Inadequate Treatment of Pain*, ELDER LAW ISSUES (Fleming & Curti, P.L.C.) Oct. 4, 1999, Vol. 7, No. 14, <http://www.elderlaw.com/1999/ISSUE714.HTML> (last visited Apr. 20, 2002).

40. John Cloud, *A Kinder, Gentler Death*, TIME, Sept. 18, 2000, <http://time.qpass.com/time/magazine/article/qpass/0,10987,00.html>.

41. Sexton, *supra* note 9.

42. Press Release, The Robert Wood Johnson Foundation, Fighting Dying Patient's Pain (Aug. 8, 1997), [http://www.rwjf.org/app/rw\\_news\\_and\\_events](http://www.rwjf.org/app/rw_news_and_events) (on file with author).

43. *2001 Annual Review of State Pain Policies, A Question of Balance, Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*, Pain & Policy Studies Group, University of Wisconsin, Comprehensive Cancer Center (February 2002), available at <http://www.medsch.wisc.edu/painpolicy/publicat/01annrev/contents.htm> [hereinafter *2001 Annual Review*].

44. *Id.* See Section II: Guidelines, Evaluation of the Patient.

45. *Id.*

46. *Id.*

made of the limitations on the patient's life because of the pain experienced.<sup>47</sup> Both the patient and the patient's family should be educated on the nature of pain and its treatment.<sup>48</sup> In some cases, the patient should be helped with stress management skills.<sup>49</sup> These steps should be taken prior to or in conjunction with actual treatment of the physical pain.

Before treatment of the pain begins, the physician should write a treatment plan.<sup>50</sup> The plan should include objectives for the treatment including cessation of pain, improved life functions, what other treatment may be employed, and whether other evaluations may be conducted concerning the pain and the method of treatment.<sup>51</sup> The physician should discuss the treatment plan with the patient and, if appropriate, the patient's family.<sup>52</sup> The risks and benefits of employing controlled substances, such as morphine, for pain treatment should be discussed.<sup>53</sup>

Generally, treatment for pain should start with non-steroidal anti-inflammatories (NSAIDs), such as aspirin, ibuprofen, and naproxen.<sup>54</sup> If these do not control the pain, physical therapy can be added.<sup>55</sup> If these options do not work, chiropractic care and surgery may become options.<sup>56</sup> The use of opioids generally comes after surgery when other medications have not eliminated the pain.<sup>57</sup> Periodic review and evaluation of the patient's treatment plan should take place.<sup>58</sup> The physician should discuss with the patient or family members the patient's ability to participate in life

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47. *Id.*

48. Maureen Habel, *Chronic Pain: Stopping a Downward Spiral*, NURSEWEEK, <http://www.nurseweek.com/ce/ce50a.html> (an online continuing education workshop on pain management) (last visited March 9, 2002).

49. *Id.*

50. *2001 Annual Review*, *supra* note 43, at Section II: Guidelines, Treatment Plan.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Treating Chronic Pain*, (citing E. Krames, *Intraspinal Opioid Therapy for Chronic Nonmalignant Pain: Current Practice and Clinical Guidelines*, 11 J. PAIN SYMPTOM MGMT. 333, 352 (1996)), <http://www.spineuniverse.com/treatment/chronic2.html> (last visited April 20, 2002).

55. *Id.*

56. *Id.*

57. *Id.*

58. *2001 Annual Review*, *supra* note 43, at Section II: Guidelines, Periodic Review.

activities.<sup>59</sup>

The treatment protocol for pain management of an elderly person is slightly different than it is for a younger person. In an older person, it becomes critical for the physician to more carefully monitor the drugs used and their effectiveness against the pain.<sup>60</sup> This analysis becomes more critical when treating the elderly for several reasons. First, the elderly are more sensitive to NSAIDs and use of these drugs can produce dangerous side effects in an elderly person, such as stomach ulcers and bleeding.<sup>61</sup> Second, the elderly person might be suffering from more severe pain than warrants starting at NSAIDs and working through the list of potential treatments. Third, the elderly frequently are not used in drug studies, and even if they are, the fact that the elderly are usually taking many different types of drugs at a time is not taken into consideration.<sup>62</sup> A medication appropriate for a younger person might be inappropriate for an elderly person because of the drug's tendency to cause confusion or dizziness, for example.<sup>63</sup> Despite the high prevalence of pain in the elderly, current drug research and pain management research devote little attention to the elderly.<sup>64</sup> "Of all reports about pain published annually, fewer than one percent focus on pain management in the elderly."<sup>65</sup>

## VII. THE ETHICAL OBLIGATION TO CONTROL PAIN

Ethically, physicians, nurses and other caregivers have a well-accepted duty to appropriately treat the pain of an elderly person.<sup>66</sup> Without appropriate pain treatment, patient autonomy is destroyed.<sup>67</sup> Choices in medical treatment become limited because the treatment of the pain becomes the primary, critical goal.<sup>68</sup> In addition, chronic pain interferes with "the realization of almost all

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59. *Id.*

60. Leo & Singh, *supra* note 18.

61. Cynthia Starr, *Opioid Analgesia: An Essential Tool in Chronic Pain*, 32 PATIENT CARE 47 (July 15, 1998).

62. Leo & Singh, *supra* note 18, at 39.

63. *Id.* at 43.

64. JACOBS, CARR, PAYNE, ET AL., *supra* note 12, at 127.

65. *Id.*

66. Johnson, *supra* note 6.

67. T.P. Hill, *Freedom from Pain: A Matter of Rights?*, 12 CANCER INVEST 438 (1994), [http://www.pain.com/library/detail.cfm?Articles\\_id=1467](http://www.pain.com/library/detail.cfm?Articles_id=1467).

68. *Id.*

other human values.”<sup>69</sup>

#### VIII. IN VIEW OF AN ETHICAL OBLIGATION TO RELIEVE PAIN, WHY IS PAIN UNDERTREATED?

There are three main reasons pain in the elderly is undertreated. The first reason is the difficulty of assessing the presence and extent of pain in the elderly. The second reason is the elderly patient's own beliefs about pain and pain management. The third reason is caretakers' and healthcare personnels' beliefs about pain and pain management, particularly regarding the elderly. Each of these individually or all of these together can interfere with pain management.

It may be more difficult to assess the presence and extent of pain in an elderly person than in a young person.<sup>70</sup> Both physical and cognitive problems can interfere with the assessment. If the elderly person has difficulty hearing, it can be difficult to communicate accurate information about pain control. Cognitive impairment, delirium and dementia pose serious barriers to pain assessment.<sup>71</sup> An elderly person suffering from dementia may be unable to reliably report pain.<sup>72</sup> Or, even if able to reliably report pain at the moment, a cognitively impaired elderly patient may have unreliable recall of previous pain.<sup>73</sup> A healthcare provider's routine in assessing patients may interfere with pain diagnosis and management.<sup>74</sup> Physicians and nurses might not recognize the symptoms indicating the presence of pain.<sup>75</sup> The patient's contact with the physician might not be long enough for an accurate

69. Johnson, *supra* note 6, at 11.

70. D. Lynch, *Geriatric Pain and Its Assessment*, 9 PAIN DIG. 307, 307 (1999) as reported in Partners Against Pain, an online information service for physicians and patients, at [http://www.partnersagainstpain.com/html/profed/pmc/pe\\_pmc7.html](http://www.partnersagainstpain.com/html/profed/pmc/pe_pmc7.html).

71. JACOBS, CARR, PAYNE, ET AL., *supra* note 12, at 129.

72. Duke, *supra* note 26. One Minneapolis doctor reports asking an elderly patient if she suffered from any pain. The patient reported she had no pain. The patient's son had accompanied her to the doctor appointment and reminded her she had complained of pain in her arm just that morning. At that point, the patient remembered she did have pain and reported it to the physician. Telephone Interview with Dr. Melissa Flint, Family Practice, Woodlake Clinic, Richfield, Minnesota (Apr. 12, 2002).

73. Duke, *supra* note 26.

74. Leo & Singh, *supra* note 18, at 38.

75. *Id.*

assessment or evaluation of the patient.<sup>76</sup> The physician might not even ask if the patient is experiencing any pain.<sup>77</sup> If the physician does recognize that the patient is in pain and prescribes medication, the physician might not diligently follow up with the patient to determine if the medication is working adequately.<sup>78</sup>

The patient's own belief systems can interfere with his or her pain treatment. Many patients believe that pain is a natural and inevitable sign of aging.<sup>79</sup> The elderly person might believe that nothing can be done about his or her pain or that before something can be done, it will be preceded by a battery of painful tests.<sup>80</sup> The person may believe that the pain he is experiencing is a sign of serious illness or impending death and that reporting the pain will interfere with his ability to live the rest of his life independently.<sup>81</sup> In some cases, the elderly person may believe that the pain is punishment for past actions or that acknowledging or reporting the pain is sign of personal weakness.<sup>82</sup>

Caregivers and those in the healthcare system also contribute to the undertreatment of pain in the elderly because of their own misconceptions about pain. Caregivers sometimes believe that the elderly, particularly those with dementia, have a higher tolerance for pain than the elderly person actually has.<sup>83</sup> Caregivers can also view a demand for pain relief as an attention-seeking device by the elderly person.<sup>84</sup> In addition, many caregivers are reluctant to prescribe the necessary pain relievers because they fear the patient will become addicted to the medication or they fear legal repercussions for prescribing certain effective pain medications.<sup>85</sup> Both caregivers and elderly patients may have the mistaken belief that the process of dying must always be painful.<sup>86</sup> Proper pain

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76. *Id.*

77. *Id.*

78. *Id.*

79. J. Kaldy, *Dispelling the Myths & Misconceptions of Pain Management*, 1 CARING FOR THE AGED 27, 27 (2000) as reported in Partners Against Pain, an online information service for physicians and patients, at [http://www.partnersagainstpain.com/html/profed/pmc/pe\\_pmc7.html](http://www.partnersagainstpain.com/html/profed/pmc/pe_pmc7.html); see also ARTHRITIS FOUNDATION, *supra* note 27.

80. Kaldy, *supra* note 79; see also ARTHRITIS FOUNDATION, *supra* note 27.

81. Kaldy, *supra* note 79.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*; see also Press Release, The Robert Wood Johnson Foundation, *supra* note 42.

86. Press Release, The Robert Wood Johnson Foundation, *supra* note 42.

management is not always easy and requires action on both the part of the patient and the healthcare provider.

#### IX. LEGAL AND ETHICAL RAMIFICATIONS COMPLICATE PAIN MANAGEMENT IN THE ELDERLY

A physician treating terminally ill patients for excruciating pain can be caught between ethical and legal dilemmas--accusations that the pain relief provided hastened the death of the patient or accusations that the physician failed to provide enough pain relief to keep the patient comfortable. In both cases the physician can end up in court.

##### A. *State of Kansas v. Naramore*<sup>87</sup>

Dr. Lloyd Stanley Naramore was charged by the State of Kansas with the attempted murder of Ruth Leach, a seventy-eight-year-old woman who was suffering from terminal cancer.<sup>88</sup> Mrs. Leach was initially hospitalized in May of 1992.<sup>89</sup> Three months later, Mrs. Leach was still hospitalized and receiving pain medication through morphine patches.<sup>90</sup> As her disease progressed, the pain medication was not keeping Mrs. Leach comfortable.<sup>91</sup> Leach's nurse suggested the family call Dr. Naramore to increase Mrs. Leach's pain medication.<sup>92</sup> Dr. Naramore came to the hospital and discussed the situation with family members.<sup>93</sup> Since by that time Mrs. Leach had developed a high tolerance for pain medication, Dr. Naramore explained to the family members that additional pain medication could slow her respiration.<sup>94</sup> He told them there was a real danger she could die.<sup>95</sup> The family members told Dr. Leach to give her more pain medication because they wanted her free from pain.<sup>96</sup> When Mrs. Leach's respirations declined significantly, Leach's son stated, "Let me make one thing perfectly clear: I'd rather my mother lay there and suffer for ten more days

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87. *State v. Naramore*, 965 P.2d 211 (Kan. Ct. App. 1998).

88. *Id.* at 213.

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

than you do anything to speed up her death.”<sup>97</sup> The family was obviously conflicted about the level of pain management. Mrs. Leach died three days later after having been transferred to another hospital.<sup>98</sup> Two years later, Dr. Naramore was charged with attempted murder.<sup>99</sup>

During Naramore’s trial, his experts testified that his sole intention was “to provide comfort and relief of (Mrs. Leach’s) suffering.”<sup>100</sup> After a jury trial, Dr. Naramore was found guilty of attempted murder and sentenced to prison for five to twenty years.<sup>101</sup> When Naramore appealed the conviction, it was reversed.<sup>102</sup> By that time, he had spent more than two years in prison.<sup>103</sup> Six years had passed since Naramore first treated Ruth Leach. Naramore sued the state of Kansas for \$1.4 million for wrongful prosecution.<sup>104</sup> His attorney stated in documents filed against the state, “Although Dr. Naramore has his license back and has resumed practice, his life has been, in many ways, destroyed. His career, his reputation and his marriage have all been ruined.”<sup>105</sup> Although most advocates of pain management using opioids contend that worrying about legal action based on painkiller overdoses is misdirected, this case gave many doctors cause for concern.<sup>106</sup>

### B. *Bergman v. Chin*<sup>107</sup>

While Dr. Naramore was charged with attempted murder for his management of an elderly patient’s pain, Dr. Wing Chin in

97. *Id.* at 215.

98. *Id.*

99. *Id.* at 213.

100. *Id.* at 221.

101. *Id.* at 213. Naramore was also charged and found guilty of intentional and malicious second-degree murder in a withdrawal of life support case. *Id.* His sentence was five to twenty years to run concurrently with his sentence in the Leach case. *Id.* The withdrawal of life support case was also appealed. Both convictions were reversed on appeal. *Id.* at 224.

102. *Id.* at 224.

103. *Naramore Suing State*, MORNING SUN.NET KANSAS NEWS, Nov. 7, 1999, [http://www.morningsun.net/stories/110799/kan\\_1107990003.shtml](http://www.morningsun.net/stories/110799/kan_1107990003.shtml).

104. *Id.*

105. *Id.*

106. *Kansas Doctor Convicted of Murder in End-of-Life Cases; Reversal on Appeal*, ELDER LAW ISSUES (Fleming & Curti, P.L.C.) Oct. 19/26, 1998, Vol. 6, No. 16/17, <http://www.elder-law.com/1998/issue616.html>.

107. *Bergman vs. Chin*, [2002] 46 Trial Dig. 4th (Trial Dig. Publ’g) 2, 2 (Cal. Alameda County Super. Ct. June 13, 2001), *available at* 2001 WL 1517376, at \*2.

California was held liable for failing to adequately treat an elderly patient's pain.<sup>108</sup> The California jury awarded the family of William Bergman \$1.5 million for undermedicating Bergman's pain as he was dying from lung cancer.<sup>109</sup>

Bergman was hospitalized for five days at the Eden Medical Center in Castro Valley, California, in February of 1998.<sup>110</sup> While Bergman was hospitalized, he reported pain intensity repeatedly at 7, 8, 9 and 10 where ten is the worst pain imaginable.<sup>111</sup> Dr. Chin only prescribed Demerol on an as per needed basis.<sup>112</sup> When Bergman decided to leave the hospital and go home rather than endure additional testing, Dr. Chin only prescribed Vicodin, an oral medication.<sup>113</sup> Bergman was known to have difficulty swallowing and family members insisted that Bergman be provided more effective pain medication.<sup>114</sup> At that point, Dr. Chin ordered a morphine time-released patch and a shot of Demerol.<sup>115</sup> Two days later, a hospice nurse visiting Bergman at home found him in "out of control" pain.<sup>116</sup> The hospice nurse attempted repeatedly to contact Dr. Chin and was finally told to contact another doctor.<sup>117</sup> Another doctor prescribed liquid morphine, which was effective in relieving Bergman's pain.<sup>118</sup> Experts for the Bergman family testified "that the modern course of treatment for a patient in intractable pain . . . was to provide around-the-clock pain medication, with additional pain medication 'as needed' for breakthrough pain."<sup>119</sup> In the experts' opinion, because medical

108. *Doctor Tagged with \$1.5M Verdict in Landmark Elder Abuse Case*, ANDREWS NURSING HOME LEGAL INSIDER, July 2001 (Westlaw 2 No. 11 ANNHLLI 1).

109. Bergman, 46 Trial Dig. 4th at 2, available at 2001 WL 1517376 at \*2; see also *Doctor Tagged with \$1.5M Verdict in Landmark Elder Abuse Case*, supra note 108.

110. Bergman, 46 Trial Dig. 4th at 2, available at 2001 WL 1517376 at \*2.

111. *Id.* The plaintiff's attorney conceded that "Bergman never protested that his pain was being inadequately treated. 'He didn't want to be a patient, and he wasn't a complainer.'" The patient's family knew he was in pain, as did the nurses who noted his pain was at the 7, 8, 9, and 10 level. Mark Crane, *Treating Pain: Damned If You Don't?: That's What a California Jury Said, In a Controversial Verdict That Could Change the Way Physicians Respond to Patient's Pain*, MED. ECON., (Nov. 19, 2001). The medical profession needs to recognize that elderly patients in particular will not complain about pain.

112. Bergman, 46 Trial Dig. 4th at 2, available at 2001 WL 1517376 at \*1.

113. *Id.* at \*2.

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

boards, medical literature and statutes require proactive pain treatment, “the care rendered by [Dr. Chin] was ‘appalling’ and ‘egregious.’”<sup>120</sup> The defendant claimed his pain treatment of Bergman was within the standard of care and was acceptable.<sup>121</sup>

The plaintiff’s theory of the case was that mismanagement of an elderly person’s pain is elder abuse under California law.<sup>122</sup> In a verdict believed to be the first time a physician has been held liable for reckless conduct and elder abuse, the jury awarded \$1.5 million to the Bergman family.<sup>123</sup> Despite the fact that the verdict was derived from an elder abuse statute, an Alameda County judge reduced the judgment to \$250,000 based upon medical malpractice limitations imposed when surviving relatives are suing on behalf of a deceased patient.<sup>124</sup> However, liability for elder abuse under California law does require the defendant, Dr. Chin, to pay the Bergmans’ attorney fees, which could run into hundreds of thousands of dollars.<sup>125</sup>

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120. *Id.*

121. *Id.*

122. *Doctor Tagged with \$1.5M Verdict in Landmark Elder Abuse Case*, *supra* note 108 (reporting the application of California’s Elder Abuse and Dependent Adult Civil Protection Act, Cal. Welf. & Inst. Code § 15600). The plaintiffs chose to bring the suit under elder abuse laws because California’s malpractice statutes do not allow for survivors to bring a claim for a deceased patient under medical negligence. Rebecca Porter, *Failure to Treat Pain is Elder Abuse, Jury Finds* (Bergman v. Eden Medical Center), TRIAL MAG., Sept. 1, 2001, at 87. The plaintiff’s burden of proof under elder abuse is recklessness, which is more difficult to prove than negligence. *Id.* The plaintiffs alleged that Dr. Chin departed from pain management standards published by the Agency for Health Care Policy and Research (AHCPR). *Id.* The plaintiff also showed that Chin “practiced in an environment that provided notice of the responsibility to treat pain aggressively.” *Id.* The Eden Medical Center was also named in the suit and settled separately for an undisclosed amount before trial. *Id.* Interestingly enough, before bringing suit, the Bergman family reported Dr. Chin to the Medical Board of California. *Doctor Tagged with \$1.5M Verdict in Landmark Elder Abuse Case*, *supra* note 108. The Board investigated the matter, concluded “the pain care was indeed inadequate,” but did not take any action against Dr. Chin. *Id.*

123. Bergman, 46 Trial Dig. 4th at 2, available at 2001 WL 1517376 at \*1; see also *Kansas Doctor Convicted of Murder in End-of-Life Cases; Reversal on Appeal*, *supra* note 106.

124. Tyche Hendricks, *Judge Cuts Big Award in Pain Case, Family of Dead Man Argued Elder Abuse*, S.F. CHRON., Aug. 21, 2001, at A11. Plaintiff’s attorney plans to appeal the reduction of the judgment. Jim Geagon stated, “We feel it is draconian. This limitation of \$250,000 first raised its head in 1976 and it has never been changed. [The 1976 amount] has the equivalent value today of about \$90,000.” *Id.*

125. *Id.*

### C. Other Cases

While Dr. Chin's case raised the awareness of pain management in the case of terminally-ill patients, it was not the first time some type of action has been taken because of poor pain control. In 1990, a North Carolina jury ordered a nursing home to pay \$15 million to the family of a deceased nursing home resident.<sup>126</sup> The patient, Henry James, was dying of prostate cancer that had spread to his bones.<sup>127</sup> The patient's physician had prescribed morphine to be administered every three to four hours for pain.<sup>128</sup> Instead, the nursing staff regularly substituted Darvocet, a less effective oral painkiller.<sup>129</sup> Sometimes the nursing staff gave Mr. James orange juice and told him it was medication.<sup>130</sup> Evidence showed the patient was totally without pain relief for a total of three days.<sup>131</sup> North Carolina's Division of Facility Services investigated the case.<sup>132</sup> They fined the nursing home ten dollars for each day Mr. James did not receive his prescribed dose of morphine--a total of \$230 for twenty-three days of unnecessary pain.<sup>133</sup> The jury awarded \$7.5 million in compensatory damages and an additional \$7.5 million in punitive damages.<sup>134</sup> At the time, successful civil suits against nursing homes usually brought awards of \$1 to \$2 million.<sup>135</sup>

In September 1999, an Oregon doctor was disciplined by the Oregon Board of Medical Examiners for failing to provide adequate pain management for at least six of his patients.<sup>136</sup> Dr. Paul Bilder agreed to disciplinary measures rather than face a court proceeding.<sup>137</sup> Dr. Bilder conceded that his patient care "showed unprofessional or dishonorable conduct and gross or repeated acts of negligence."<sup>138</sup> The Board of Medical Examiners noted at least

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126. Tinker Ready, *Family Wins \$15 Million in Nursing-Home Suit*, RALEIGH N.C. NEWS & OBSERVER, Nov. 27, 1990, at B2.

127. *Id.*

128. *Faison v. Hillhaven Corp.*, No. 89CVS64, 1991 WL 453508, at \*1 (N.C. Hertford Super. Ct. Nov. 1991) (LPR Jury).

129. Ready, *supra* note 126.

130. *Id.*

131. *Faison*, 1991 WL 453508, at \*1.

132. Ready, *supra* note 126.

133. *Id.*

134. *Id.* see also *Faison* 1991 WL 453508, at \*1.

135. Ready, *supra* note 126.

136. *Oregon Doctor Disciplined for Inadequate Treatment of Pain*, *supra* note 39.

137. *Id.*

138. *Id.*

six cases where Dr. Bilder provided inadequate pain relief.<sup>139</sup> At least three of the patients were elderly. One was an elderly man dying of cancer and in significant pain.<sup>140</sup> The hospice nurse requested pain relief for the patient.<sup>141</sup> Another was a sixty-three-year-old woman with acute respiratory failure.<sup>142</sup> Her nurse requested morphine to treat the patient's anxiety over treatment for her pulmonary disease and diabetes.<sup>143</sup> The third was an eighty-two-year-old patient with congestive heart failure.<sup>144</sup> He complained to a nurse that he could not breathe and became increasingly agitated.<sup>145</sup> In all cases, Dr. Bilder refused to supply appropriate pain medication.<sup>146</sup> The Oregon Board of Medical Examiners required Dr. Bilder to complete a one-year peer-review program, seek psychiatric help on a regular basis, and take a course on doctor-patient communication.<sup>147</sup>

#### D. Reaction to *Bergman v. Chin*

Doctors, ethicists and The Compassion in Dying Federation, an Oregon-based advocacy group, all responded positively to the *Bergman v. Chin* decision. The Compassion in Dying Federation provided legal assistance to the Bergman family and support physician-assisted suicide and aggressive pain management.<sup>148</sup> Their Director of Legal Affairs, Kathryn Tucker, stated, "[u]ndertreatment of pain is widespread and is a much greater problem than over-treatment. This verdict is a wake-up call . . . [p]hysicians who ignore established guidelines and allow their patients to needlessly suffer must face consequences."<sup>149</sup>

California bioethicist, Ben Rich, stated that the award was pivotal: "juries are prepared to hold physicians and acute-care hospitals accountable for failure to properly manage pain."<sup>150</sup> Rich

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139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. Crane, *supra* note 111.

149. *Id.*

150. *Jury Awards \$1.5 Million in Suit Over Untreated Pain*, CHI. TRIB., June 15, 2001, at 17. Ben Rich is a University of California-Davis professor of bioethics. *Id.* Rich has written many published articles on pain management. *Id.*

also stated that “[t]he failure to properly manage the pain of a dying patient is intolerable. The lay public takes the duty to relieve pain as a moral mandate for physicians . . . .”<sup>151</sup> Sandra Johnson, chairwoman of the center for Health Care Law and Ethics in St. Louis said she expected “to see [lawsuits] much more frequently” when undertreatment of pain has occurred.<sup>152</sup> Robyn Shapiro, a bioethics scholar at the Medical College of Wisconsin found the verdict “exciting [because] it sends a message to physicians and other health care providers that pain management has to be an integral part in . . . provid[ing] adequate care.”<sup>153</sup> Fifteen state medical boards have adopted pain management guidelines proposed by the Pain and Policies Studies Group at the University of Wisconsin’s Comprehensive Cancer Center.<sup>154</sup> The director of the group, David Joranson, noted that the states adopting the guidelines are in the minority.<sup>155</sup>

While ethicists reacted positively to the jury decision in *Bergman v. Chin*, not all doctors were pleased. As might be expected, associates of Dr. Chin reacted negatively. The president of Eden Medical Center, the hospital where William Bergman was treated, found the verdict “worrisome” because it happened to someone like Dr. Chin—a physician well-regarded by his colleagues.<sup>156</sup> A pain specialist at Berkeley, Dr. Michael Park, felt it

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151. Julie Sevrens Lyons, *California Court Issues Landmark Ruling for Patients with Pain*, KNIGHT RIDDER TRIB. BUS. NEWS, Aug. 22, 2001, 2001 WL 26627097.

152. *Jury Awards \$1.5 Million in Suit Over Untreated Pain*, *supra* note 150. Johnson is an attorney, a law professor and a provost of St. Louis University. *Id.*

153. Maria LaGanga & Terence Monmaney, *Doctor Found Liable in Suit Over Pain Court: Man’s Treatment was a Case of Elder Abuse, Jury Says. Family is Awarded \$1.5 Million*, L.A. TIMES, June 15, 2001, at A1.

154. Matthew Yi, *Elder Abuse Verdict Challenges Physicians on Pain. Doctors Must Balance Relief Against Addiction*, S.F. CHRON., June 15, 2001, at A25.

155. *Id.* A report by the “Pain and Policies Studies Group” at the University of Wisconsin, Comprehensive Cancer Center, dated February 2002, gives an update on the adoption of the “Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.” Fourteen new state medical board policies were adopted in 1999; 11 more were added in 2000 and 2001. At the time of the publication of the February 2002 report, only six states did not have policies of some kind for the treatment of chronic pain (Alaska, Connecticut, Delaware, Hawaii, Illinois and Indiana). Minnesota’s State Medical Board passed the model guidelines in the Fall of 2000. Not all states with policies adopted the model guidelines. *2001 Annual Review of State Pain Policies, A Question of Balance*, Pain & Policy Studies Group, University of Wisconsin, Comprehensive Cancer Center (February 2002), <http://www.medsch.wisc.edu/painpolicy/publicat/01annrev/contents.htm>.

156. Yi, *supra* note 154.

was “dangerous for lawyers and courts to decide what doctors need to do.”<sup>157</sup> Dr. Park expressed concerns about allowing patients to control the amount of pain medication they would receive.<sup>158</sup> “How do you define a satisfactory amount of (pain) medication? When (the patient) says it’s okay? If the patient says I don’t feel okay, do you just simply give more?”<sup>159</sup> The president of the Alameda-Contra Costa Medical Association, Dr. Sharon B. Drager, found fault with the use of a zero-to-ten scale to assess pain.<sup>160</sup> According to Dr. Drager, the zero-to-ten pain scale “is an extremely subjective way to assess pain since virtually every seriously ill hospitalized patient considers his pain to be in the seven-to-ten range of the scale.”<sup>161</sup> A pain management specialist near Sacramento, Dr. Harvey Rose, expressed concern that “more doctors are going to say, ‘I’m not going to treat pain, period.’”<sup>162</sup> From their statements, it might appear that these doctors find patient autonomy is of less importance than the doctor’s ability to control treatment.

Some doctors found the verdict a positive move in the right direction in pain management. The Director of Pain Management Services at Santa Clara Medical Center, Dr. William Longton, felt “rais[ing] the consciousness of physicians on how to manage pain” was a good thing.<sup>163</sup> However, if it caused additional regulation of the medical profession and increased fear by physicians that they were either over- or undermedicating, that would not be a positive step.<sup>164</sup> The chief of oncology at Kasier-Santa Teresa Hospital in San Jose expressed the view that “there is no reason why any patient should be in severe pain for any extended period of time.”<sup>165</sup> The California legislature took the case as an indicator that some things in pain management needed to change. In October 2001, the California legislature passed and the governor signed new legislation on pain management.<sup>166</sup> The law requires doctors to take courses in pain management and end-of-life care.<sup>167</sup> The law

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157. *Id.*

158. *Id.*

159. *Id.*

160. Crane, *supra* note 111.

161. *Id.*

162. Lyons, *supra* note 151.

163. *Id.*

164. *Id.*

165. *Id.*

166. Tyche Hendricks, *Pain Management Classes for Doctors*, S.F. CHRON., Oct. 30, 2001, at A15.

167. *Id.*

also requires the State Medical Board to keep track of pain management complaints against California doctors.<sup>168</sup> Those complaints are to be reviewed by a pain specialist.<sup>169</sup> Obviously, Californians are concerned about proper pain management.

While these cases may increase physician's anxiety over pain management, particularly when opioids are involved, they also provide an opportunity for the medical and legal community and elderly patients to consider the ethical and legal ramifications of pain management.<sup>170</sup> A physician's primary duty is nonmaleficence—the duty to do no harm to a patient. When a physician is determining how to treat an elderly patient's pain, particularly at the end of the patient's life, the physician is frequently acting from a position of multiple roles, sometimes called “double effect.”<sup>171</sup> The administering of pain medications, particularly opioids, may sometimes hasten the patient's death.<sup>172</sup> At the same time, the pain medications will relieve the patient's pain, making the patient more comfortable.<sup>173</sup> Which harm is the physician trying to avoid? The pain or the dying? What is the level at which the medication removes the pain or hastens the dying?

#### X. PAIN MANAGEMENT PLANS DOING THE LEAST HARM WITH THE MOST BENEFIT

While pain management may be complicated, elder patient pain can be alleviated without excessive risk of legal action against the physician. The solution to the pain management puzzle can be summed up in these words: mode of operation, education, and communication.

##### A. *Mode of Operation*

Healthcare personnel, hospitals and nursing homes all need to have a protocol for handling pain, particularly for elderly patients. Minnesota adopted the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* in the fall of 2000. That does not mean that the work is done. The Brown University study, reported

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168. *Id.*

169. *Id.*

170. Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J.L. MED. & ETHICS 308, 309 (1998).

171. *Id.* at 319.

172. *Id.*

173. *Id.*

in April 2001, indicated that in Minnesota 25,956 of the 50,693 persons residing in nursing homes experienced pain.<sup>174</sup> A second assessment conducted sixty days later found 16,080 people who were in pain at the first survey, were still in pain.<sup>175</sup> For 39.7% of the patients, the pain was worse than it was at the first assessment.<sup>176</sup> This is particularly distressing and seems to indicate a lack of proper pain management for the nursing home residents. In addition, of those patients with a cancer diagnosis, 45.4% reported pain that was persistent and severe.<sup>177</sup> For the terminally ill, the incidence of persistent, severe pain was even higher, 51.7%.<sup>178</sup> This level of pain in the elderly is unacceptable and needs to be corrected. Hospitals and nursing homes need to implement pain management procedures that are in step with the *Model Guidelines*.

### B. Education

Once the protocol is established, education becomes the next step. Healthcare personnel, patients, and family members need to understand pain management. The relationship and essential

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174. *Pain Widespread and Severe*, *supra* note 19. Statistics for the State of Minnesota can be found at <http://www.chcr.brown.edu/dying/mndata.htm>. One study of ninety-seven elderly hip-fracture patients showed that thirty-eight patients suffered from dementia. R. S. Morrison, *A Comparison of Pain and Its Treatment in Advanced Dementia and Cognitively Intact Patients With Hip Fracture*, 19 J. PAIN SYMPTOM MGMT. 240, 248 (2000) as reported in Partners Against Pain, an online information service for physicians and patients, [http://www.partnersagainstpain.com/html/profed/pmc/pe\\_pmc7.html](http://www.partnersagainstpain.com/html/profed/pmc/pe_pmc7.html). Patients suffering from dementia received one-third the morphine equivalent pain medication as those not suffering from dementia. *Id.* Over seventy-five percent of the patients with a hip fracture did not have standing orders for pain medication. As could be expected, in the patients who could report their own pain, nearly fifty percent reported inadequate pain medication. *Id.* In 1997, Brandywine Nursing Home in Briarcliff Manor, New York, began an innovative program aimed at better treating pain. Laurie Tarkan, *New Efforts Against an Old Foe: Pain*, N.Y. TIMES, Dec. 26, 2000, <http://www.nytimes.com/200/12/26/science/26PAIN.html>. The program included a pain assessment for each patient, treatment consisting of medications, relaxation techniques, massage and even comfort food. *Id.* Participation in the program significantly reduced patients' level of pain. *Id.* Those who rated their pain at a five or above were able to reduce it to a two or three. *Id.* Some patients who rated their pain at an eight-to-ten could even reduce it to zero-to-two. *Id.* Brandywine educated everyone—including the housekeeping and maintenance staff, as sometimes patients were more willing to talk to staff people than to talk to doctors and nurses. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

differences between opioid use and misuse, abuse, tolerance and physical dependence of the drug needs to be understood by healthcare workers, patients, and family members.<sup>179</sup> With understanding comes an ability to reduce pain suffered by the elderly.<sup>180</sup> Patients are more likely to effectively assist in their own pain management if the patient understands the nature of pain and pain management.<sup>181</sup>

### C. Communication

Good pain management requires communication at all levels. When communication does not take place between doctors, nurses, patients, and family members, it is more likely that misunderstandings about pain management will take place.<sup>182</sup> In a study of cases where criminal prosecution occurred or was contemplated, every case came to light because a nurse or a family member reported concerns about the patient to prosecutors.<sup>183</sup> Healthcare providers are not the only ones at fault in this area. Patients often do not communicate their wishes regarding their health care to their physicians or family members. A recent poll

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179. *Will Opiates Send Patients Down the Road to Reefer Madness?*, 11 THE BACK LETTER 41, 41 (1996) (citing 271 JAMA 426 (1994)). Abuse is an intentional misuse of a medication while misuse is an unintentional, inappropriate use of the drug. *Id.* Tolerance is a normal response by the body where the patient needs increasing dosages to get the same effect. *Id.* Physical dependence is not the same as addiction. Addiction is compulsive. *Id.* The addict has lost control over the drug use while the patient who is physically dependent needs the medication to relieve the physical problem of pain. *Id.*

180. Press Release, The Robert Wood Johnson Foundation, *supra* note 42. The Robert Wood Johnson Foundation, known for its grants in pain management research and education, funded a three-year project in pain education. *Id.* The leaders of the project are two nurses, Betty Ferrell and Marcia Grant. *Id.* Believing that nurses are the leaders in many palliative care programs, their goal is to enable nurses to be better prepared to care for dying patients and those in severe pain. *Id.* The project has three goals: (1) improve nursing textbooks in the pain and end-of-life content; (2) support end-of-life care as a subject matter for the national nursing licensing exams; and (3) support nursing organizations in promoting pain and end-of-life care. *Id.* A study of nurses' reactions to pain in the elderly found that nurses with even one day of pain management training were more sensitive to patient's pain and better able to assess the pain present. *Id.*

181. Philip S. Whitecar et al., *Managing Pain in the Dying Patient*, 62 AM. FAM. PHYSICIAN 755, 761 (Feb. 1, 2000). Sometimes the problem lies in the physician subtly conveying the idea that a "good" patient does not complain or need narcotics. *Id.* Education of the physician is necessary to eliminate this problem. *Id.*

182. Alpers, *supra* note 170, at 315.

183. *Id.*

conducted by TIME/CNN, found that while fifty-five percent of those sixty-five and over had an “advance directive” regarding their health care, only six percent had worked with their doctors to write the directive.<sup>184</sup> In addition, while many patients had designated someone to make medical decisions for them in case they were unable,<sup>185</sup> thirty percent of those designated as decision makers were unaware of the designation.<sup>186</sup> Communication is the one of the keys to satisfactory pain management.<sup>187</sup>

Illness and death are inevitable in life. But suffering and pain need not be. Healthcare providers, patients, and family members can work together to implement pain management protocols based on proper mode of operation, proper education and proper communication, so that we can go quietly into the night.

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184. Cloud, *supra* note 40.

185. *Id.*

186. *Id.*

187. Sexton, *supra* note 9.