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# Medical Passports

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"This was the best exam I've ever had. You really examined me very well and I feel very fortunate to have been directed to you and I think you explained my situation better than anyone else. But I really can't see you again. I live in Wakefield." This occurred this week.

I explained to the patient that Providence was also in Rhode Island, so that, unlike seeing a doctor in Boston, a medical passport was not required. However, it seems that crossing the Pawtuxet River represents a bridge too far for some South County residents.

When I moved my practice from Warwick to Providence six years ago, one of my patients, a 72-year-old man with Parkinson's disease, told me he wouldn't be able to see me anymore. It was too far and too difficult to get to. "But you don't drive," I responded. "Your son drives you, and you live in Lincoln, so it's about the same distance. I doubt your son will mind." "Well, it's too complicated, just too much." "Have you ever been to Boston?" I asked. "Sure. My dad took me to see the Red Sox when I was 12."

Thirty years ago, the first study ever done to slow progression of a neurodegenerative disorder was initiated. This was a study to slow Parkinson's disease and I was the principal investigator for the Rhode Island site. A patient from Newport called, excited to be able to participate in the trial. "You mean I'd have to travel to Providence? You won't come to Newport?"

One of the early acts of the Continental Congress in 1775 was to abolish passports and visas for travel between the colonies. This was widely accepted by the revolutionaries and even supported by the Loyalists, but the various colonies' governors, appointed by the king, were not agreeable, as the passports were a source of income. Of course, after the colonies won independence and the country was unified, the notion of passports made no sense and was abolished.

However, in a little known response to a highly contentious law restricting trade between colonies, the Legislature of the State of Rhode Island enacted a law requiring notarized inter-state traveler documents to travel outside the state. These were obtained in the department of Public Affairs, a bureau that was absorbed by other state departments in 1952. However, many people in Rhode Island were, and remain unaware, that this occurred. As part of the law, these travel documents for "routine travel" and commercial travel were withdrawn. However, a proviso in the bill developed the so-called "medical passports" for Rhode Islanders to use medical facilities outside the state. Later laws stopped the use of these documents as well. As a result of the original law and the lack of publicity attendant on the withdrawal of the laws, many in Rhode Island failed to appreciate that these passports were no longer required. This led to the current situation in which many people who were born in Rhode Island find themselves either unable to cross state lines or to travel distances beyond 10 miles. They learned this from their parents and teachers and simply passed on this out-of-date information.

**There are other theories, however, of why people born in Rhode Island won't travel. Two are genetic.**

There are other theories, however, of why people born in Rhode Island won't travel. Two are genetic. Epidemiological studies have shown that the resistance to travel clearly runs in families. While this is partly explained by the previous theory, that is, nurture rather than nature, several tantalizing clues have been found with genome-wide association studies, employing anti-logarithmic epicritical fusion functional analysis. The implicated genes have been linked to particular speech patterns (eg, "cod" for "card" as well as use of the word "bubbler") and an insatiable appetite for quahogs.

A third theory, which is also genetic, is based on the observation that the self-imposed travel restriction in Rhode Island is north-south only. People who won't travel north will travel west, or

east, even across the ocean. This theory, which has little actual data to support it, is based on a subtle difference in melatonin secretion that occurs as people travel on longitudinal meridians. Those who avoid travel have higher than normal melatonin increases with going north and larger decreases when going south during the appropriate seasons. This increase in melatonin is thought to de-regulate a trans-ketolase involved in the synthesis of gene regulator phyotokine type b flat minor, found primarily in neuronal cells in the hypothalamus, linked to circadian rhythm and dopamine reuptake. It is hypothesized that longitudinal travel alters the sleep-wake cycle, while simultaneously reducing pleasurable responses and increasing the likelihood of an addictive response, which in this case would be a negative, or aversive response.

An interesting observation was made by anthropologists who have found a similar reluctance to travel on north south lines in one aboriginal group in Australia but not in others. This appears to be unrelated to level of education, supporting a physiological explanation rather than a learned response.

Undoubtedly more hypotheses exist to explain this Rhode Island phenomenon. You are invited to submit your own for possible publication.

Happy April Fool's day! ❖

## Author

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# Pain management: Considering the medical, legal aspects in patient care

HERBERT RAKATANSKY, MD

Pain relief is one of the oldest and most imperative moral obligations of physicians. Hippocrates taught: "Cure sometimes, treat often, comfort always." Pain relief, however, is fraught with difficulties due to conflicting medical, legal and social incentives. Standards that define best practices may help resolve these conflicts.

Since there is no objective measure of pain, we depend only on the reports from patients. Given the subjectivity of pain, the doctor is placed in a difficult position.

Our efforts at pain control may result in over prescription. The opioid epidemic is partially the result of over enthusiastic prescription of these effective medications. Recently a particularly egregious doctor was convicted of murder following patient deaths from overdosing. And the fear of consequences from prescribing too much medication may result in under treatment and suffering from inadequate relief of pain.

Patient satisfaction is increasingly a factor in evaluating doctors and may affect their compensation. Addicted patients who visit their doctors and, properly, do not receive the drugs they request may report dissatisfaction, stating that their pain was not relieved.

"Standards of care" describe appropriate clinical care protocols but also generate the possibility of consequences from violating them. A doctor who under or over treats pain may be accused of malpractice just as he would for violating any standard of care.

In 2000 the Joint Commission required that hospitals have policies that mandate formal assessment of pain and assess its relief. Patients are asked routinely and repetitively to quantify their pain.

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Detailed guidelines for chronic opioid use were endorsed by the American Pain Society and the American Academy of Pain Medicine in 2008. (1) Recent guidelines issued by the RI Board of Medical Licensure for the use of opioids in non-cancer chronic pain are yet another standard of care. Even the American Bar Association (for its own reasons) believes that "Adequate pain and symptom relief be considered a basic legal right and clinical duty."

In 1991 a North Carolina jury considered the case of Henry James who had terminal prostate cancer and intractable pain that allegedly was treated inadequately. His family was awarded $15 million in a judgment against a nursing home and its staff.

A more significant precedent was established in California in 1998. William Bergman had advanced lung cancer and was treated initially in a hospital and then by hospice, where he died. His family felt he had been inadequately treated for pain in the hospital. They complained to the California Medical Licensure Board but no action was taken. The family then sued both the hospital and the attending physician, Dr. Wing Chin. They were accused not of malpractice; rather they were accused of elder abuse. The hospital settled. Dr. Chin was found guilty at trial and the family was awarded $1.5 million.

Elder abuse is a state issue and the laws vary.

In California the law defines "failure to provide health care for medical needs" as elder abuse. California law now requires doctors who do not wish to provide opioids for severe, intractable pain to inform patients that there are other doctors who will.

RI elder abuse law (42-66-4.1) defines

abuse as "willful failure by a caregiver with a duty of care to provide goods or services necessary to avoid physical harm, mental harm…." "Willful" is defined as "intentional, conscious and directed toward a purpose." It seems reasonable to conclude that conscious decisions not to prescribe medication to relieve pain could be interpreted as "willful."

Massachusetts Law (19C, 1) defines abuse as "an act or omission which results in serious physical or emotional injury…." The law in Connecticut is very similar.

The precedent for considering inadequate pain relief as elder abuse cannot be ignored. Critical is the fact that elder abuse damages generally are not covered by malpractice insurance.

There is yet another smaller but vulnerable population. Several years ago an elderly patient with chronic, severe dementia was admitted to the Miriam Hospital for treatment of an infection. She had decubiti and though she was nonverbal, she demonstrated evidence of severe pain when she was moved and had her decubiti treated. This pain appeared to be relieved by 1 mg of morphine, a dose that had no other perceptible effect. Her only relative (and proxy) was her son. When he heard of the use of morphine he absolutely denied permission. Pastoral, social service, case management and multiple medical consultations did not change his decision. The case was presented to the ethics committee.

The ethics committee considered the principles of beneficence and autonomy. It was clear that a competent adult with the capacity to make medical decisions may refuse any and all treatments including pain medication. It was felt, though, that the refusal of pain medication by a proxy was not in this patient's best interest and that such an order (not to give pain medication) need not be honored. The hospital had a written policy about pain relief but it did not address this unusual situation. That patient was afforded proper pain relief. More importantly, the pain policy was amended to include a process to address future similar situations. A stepwise protocol now protects, in a timely way, these vulnerable patients who are unable to speak for themselves.

The continued failure to relieve this patient's pain might have been considered a transgression of a standard of care and the doctor and hospital might have been subject to a malpractice suit. Even more significantly, failure to relieve the pain might have been considered to be elder abuse with its attendant civil and criminal consequences.

Medically appropriate institutional and governmental policies that protect patients of all ages by ensuring adequate pain relief also protect the doctors and other caregivers who provide relief of suffering in accordance with these policies. Therefore it is essential that doctors, both individually and collectively through the Rhode Island Medical Society (RIMS), participate actively in the formulation of these policies and standards of care, both at their institutions and at the governmental level. ❖

## Reference

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