
Public Hearing

before

NEW JERSEY LEGISLATIVE COMMISSION FOR THE STUDY OF PAIN MANAGEMENT POLICY

“To provide State regulatory agencies’ and health insurers’ perspectives and recommendations regarding acute and chronic pain management and treatment”

LOCATION: American Cancer Society
New Jersey Division, Inc.
North Brunswick, New Jersey

DATE: October 28, 1998
7:00 p.m.

MEMBERS OF COMMISSION PRESENT:

Assemblywoman Charlotte Vandervalk, Chairperson
Assemblywoman Joan M. Quigley
Douglas Ashendorf, M.D.
Harold Bobrow, R.Ph.
Christopher J. Bowden, M.D.
Alan D. Carr, D.O.
Peter D. Corda, D.O.
Sharon Gibson, R.N.
Paula Sue Krauser, M.D.
Michael F. Schaff, Esq.

ALSO PRESENT:

Donna C. Bocco
Jack Goldberg, M.D.

Eleanor H. Seel
David Price, Commission Secretary
Office of Legislative Services



Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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Cooper Cancer Institute

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ASSEMBLYWOMAN CHARLOTTE VANDERVALK (Chairperson):

Good evening, everybody. I appreciate the turn out, and I think maybe what we should do is -- we'll start down at this end. And I think it would be nice if the panel members would just introduce themselves to the audience so everyone knows. Donna Bocco, by the way, will be an appointee whenever the formalities are worked out, as will Dr. Goldberg sitting next to her.

And we thank you, Dr. Goldberg, for being the host this evening in these facilities.

But why don't you each start, and then we'll work our way down.

MS. BOCCO: My name is Donna Bocco, and I'm a recent retiree from full-time work as the Director of Advocacy here at the American Cancer Society. And I am now a volunteer. I am the President of DCB Associates, which is a health-care advocacy group, and I have been dedicated for the last -- more than 10 years at this point to the issue of cancer pain control because of personal experience with my mother. I was very much involved in cancer and cancer pain issues, suffered terribly.

ASSEMBLYWOMAN VANDERVALK: Thank you.

DR. GOLDBERG: I'm Jack Goldberg. I'm the Medical Oncologist and the head of the Cooper Cancer Institute in Camden, New Jersey. I'm also the American Cancer Society Professor of Clinical Oncology, and it's to that role and my interest in oncology and concern about pain management that I became the first -- or second, I guess it is, chairperson of the New Jersey Pain Initiative, and I represent that as part of the American Cancer Society.

MS. GIBSON: My name is Sharon Gibson. I'm a registered nurse, and I'm in private practice where I employ holistic health disciplines

including massage therapy, aroma therapy, reflexology, and I'm nationally certified in therapeutic massage and body work.

DR. KRAUSER: I'm Paula Krauser. I'm a psychologist and family physician, and I teach at Robert Wood Johnson Medical School.

MR. SCHAFF: Hi. I'm Michael Schaff, and I think I have the good fortune of being the only attorney on this panel. I'm from Wilentz, Goldman and Spitzer. I head their health-care group. I'm the chair-elect of the health and hospital section of the State Bar and various other titles with a bunch of different organizations.

DR. ASHENDORF: I'm Doug Ashendorf. I'm a physiatrist specializing in pain management -- private practice in Clark, New Jersey.

MR. PRICE (Commission Secretary): I'm David Price with the Office of Legislative Services, and I'm here as Secretary to the Commission.

ASSEMBLYWOMAN VANDERVALK: I'm Charlotte Vandervalk. I'm a member of the New Jersey Assembly, and I'm chairing the Commission.

DR. BOWDEN: Hi. My name is Chris Bowden. I'm a medical oncologist, and I am the Associate Director for Clinical Research and Development at Janssen Research Foundation in Titusville, New Jersey.

DR. CARR: My name is Alan Carr. I'm an anesthesiologist and pain specialist in South Jersey in private practice.

ASSEMBLYWOMAN QUIGLEY: I'm Joan Quigley. I'm Assemblywoman representing Hudson and Bergen counties, and in real life, I'm a hospital administrator. (laughter)

DR. CORDA: Pete Corda, Director of Professional Pain Management of South Jersey and, also, Medical Director of Kennedy Surgical Center.

MR. BOBROW: I'm Harold Bobrow. I'm a practicing pharmacist from Maplewood, New Jersey.

ASSEMBLYWOMAN VANDERVALK: Thank you very much.

The first person to testify this evening is Dr. Bernard Robins, President of the State Board of Medical Examiners.

Good evening, Doctor.

B E R N A R D R O B I N S, M.D.: Ladies and gentlemen of the Commission, I'm Bernie Robins. I'm President of the State Board of Medical Examiners, and I appreciate the opportunity you have afforded me to testify before you.

The New Jersey State Board of Medical Examiners is dedicated to seeing that their licensees are providing the most humane, complete, and state-of-the-art pain relief to patients in New Jersey. The chilling effect of the disciplinary measures designed to curtail the abuses of inappropriate and fraudulent and addicting treatment with controlled, dangerous substances has been recognized by the Board and appropriate actions have been taken.

The chief measure taken has been to revise our regulation N.J.A.C. 13:35-6.6 so that there is no longer a limitation on the amount of narcotic medication which can be given to patients with chronic pain, providing that there are safeguards in place such as documentation, re-evaluation, referral, and consultation when indicated. The regulatory revision is consonant with

and comparable to those promulgated by other state Boards in the United States who are enlightened and forward sighted on these issues.

The Board would, however, bring to your attention the fact that historically there has been abuse by physicians of the use of narcotic medications. This abuse, taking the form of unnecessary and improper addicting of patients, self-treatment because of access, and diversion for profit or criminal purposes, still are present; and the Board must protect the public and patients by having their enforcement and disciplinary tools available.

Legislating or regulating the minimum amount of pain medication which must be given -- and that has been on the horizon -- is really drawing a bright line in the sand, which our Board cannot reasonably be expected to be able to enforce. This would also cause a tendency to inappropriately overtreat. So our problem is that if you undertreat, theoretically, you could be subject to criticism, and if you overtreat, you're certainly subject to criticism. It is better to educate physicians, set reasonable standards for conduct, and not demand behavior which will force our licensees to be between a rock and a hard place.

On the issue of nonpharmacologic techniques of pain management, the Board would suggest that they conform to the following guidelines.

1. That they not be experimental. Experimentation should be confined to academic settings under the control of Ethical and Scientific Review Boards.

2. That they are carried out in accordance with standards for equipment and techniques such as we have instituted for office surgery, anesthesia, and special procedures and our recently adopted regulations on

office anesthesia and surgery. And parenthetically, we have just included a pain management section for evaluation and credentialing in the office setting.

3. Education, experience, and recommendation should be required of practitioners of these techniques, and that is built into our credentialing procedure.

In sum, I would like to reiterate that the State Board of Medical Examiners believes that the current regulations, as they have been rewritten this year, are appropriate for the protection of the patients in the area of pain management by our licensees, but the Board will continue to work to offer the patient the very best possible care through our licensees in this area of pain, which is a very difficult one.

That's my formal presentation. I would be happy to answer any questions you might have for me.

ASSEMBLYWOMAN VANDERVALK: Are there any questions from the panel?

Yes.

DR. KRAUSER: The Federation of the Board of Medical Examiners has recommended the states look at what is to be considered experimental treatments and alternative treatments. Has the New Jersey State Board looked at that?

DR. ROBINS: We would do so on a perspective case-by-case basis as such alternative management measures are brought to our attention. We have not devoted the resources to looking through the entire area in the generic or global sense. It might be an agenda that we would undertake, but in a priority sense, we're not there.

DR. KRAUSER: So there are no guidelines to what you would consider -- be considering experimental? I mean, for example, therapeutic touch.

DR. ROBINS: That would be a nonpharmacologic technique. I'm not so sure that we would regulate that, if it would be in the province of the capability of the practitioner to do it. I don't see anything statutory or regulatory that we would control that. If it involved invasive procedure, pharmacologic agents, then I could see where there would be some downside risks that we might have to get involved in. The example you gave, I think, would probably not.

DR. CORDA: Doctor, how does the Board regulate other specialties, other than pain management, for experimental versus nonexperimental or acceptable practice versus nonacceptable? In anything else, too? Is there any guidelines that you are able to do in that, or that's not really part of your view?

DR. ROBINS: Our mission is to protect the public in the areas of credentialing and licensure, in discipline if there's aberrant behavior, and in regulatory control over the activities of our licensees. Experimental procedures are really -- don't rise to the level of our attention unless we understand that there is patient harm involved. If there is, then we have to investigate that very thoroughly, and we do. Short of that, we don't have any a priori standards. It's something that I have not thought of before, and we might consider doing that. Again that's an enterprise that would take a tremendous amount of input, and I'm not sure I would know how to go about that. It's something for us to consider.

At the present time, if there's no evidence of patient harm, we probably would not have a chilling effect on what's happening. It is true that when we get evidence of patient harm and that we can pin it down to any procedural technique, we would have to intervene. That's not been our recent experience.

ASSEMBLYWOMAN VANDERVALK: Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Dr. Robins, I think I heard you say that you believe that some group was considering legislating minimum application or administration--

DR. ROBINS: I read it in the newspaper. I read it in the newspaper. I'm not trying to personalize it at all.

ASSEMBLYWOMAN QUIGLEY: No. No. No. I just wondered where this came from.

DR. ROBINS: I read it in the newspaper that one state had legislated or is contemplating legislating a disciplinary action against a practitioner if, in fact -- and there was an anecdotal case in the paper, which somebody had not given enough medication to take care of pain needs of a patient. And, therefore, the legislature had thought that they would want to have a statute saying that undertreated would be inappropriate professional act. I have just -- concerns about that, and I--

ASSEMBLYWOMAN QUIGLEY: We hadn't thought of it yet--
(laughter)

DR. ROBINS: I'm sorry if-- I hope I didn't open up that Pandora's box.

ASSEMBLYWOMAN QUIGLEY: --but it sounds unreasonable to me.

ASSEMBLYWOMAN VANDERVALK: Yes.

DR. ASHENDORF: To amplify the question of my colleague. Specifically, I think there is something of a gap in, I guess, what you would call off-label prescribing of medication. There is a gap between -- and you could say between the research that's in progress and the clinician who is treating. Some of these off-label applications are common to us all and are completely acceptable in terms of their benefit-to-risk ratio. For instance, the utilization of tricyclic antidepressants for migraine headache, prophylaxis, or for some cases of chronic pain there's very little debate; although, the FDA has never given their blessing. And, I think, in this society where research requires a lot of money and many of these medications have lost their patent, there's very little incentive for anyone to do this kind of research.

The finding recently that neuro II defects could be prevented by the judicious use of folic acid is an example of something that's been kicking around conceivably for many years, which just became established as beneficial. How does the Board look at off-label prescribing, and where does that become experimental, as opposed to acceptable standards?

DR. ROBINS: I respond empathically to your question, because I'm a diabetologist. I've had some extensive use of medication for diabetic neuropathy -- the chronic pain of diabetic neuropathy, including the tricyclic group of drugs. And the Board's position has been that off-labeling is perfectly appropriate when there's an indication -- there's a reasonable scientific basis for it. We wouldn't hold anybody to using only the FDA list, providing that

there's no evidence of patient harm, that it's being used appropriately in a controlled way -- I don't mean a controlled experimental way -- of documentation, consultation, safety revisit, and all the rest. There's no judgmental decision of the Board against off-label usage.

Verging into experimental, I have never heard the Board deal with that particular issue, and you're bringing it to my attention. And I'll bring it back on several levels that you've talked about it and reconsider. I don't have a position on it now, nor can I tell you the Board does.

DR. ASHENDORF: From the standpoint of someone who attends the meetings, what we often find are that because the research and development is so prohibitively expensive, what seems to be happening is that as certain pain pathways are elucidated in research, what researchers tend to be doing is going back to old medications, which physiologically should work, and, in fact, are finding new uses for very old medications. The newest classification, which is getting a lot of attention, is the NMDA receptor antagonists, which seem to have some very useful benefits in the treatment of both neuropathic pain and malignant pain. Here's a group of drugs that have been around for maybe 30 years, which are basically being reinvented, as that pathway is being discovered as being significant. Are there side effects in this drug? Absolutely. This class of drugs.

Dextromethorphan, which is found in every common cough medicine, may be beneficial in this way, but we've just recently found out it's highly teratogenic. Who knew? But I think the real question is, when does the off-label use become in the view of the Board experimental and a potential danger to the patient? And if there is some risk, even possibly some significant

risk, at what point should we -- and through what vehicle should we get an understanding as to whether it's acceptable to treat patients with a drug?

DR. ROBINS: I think that you have to understand that the Board's impetus is on the basis of anecdotal evidence of adverse outcome: bad news that would require us to respond to an investigation. The Board's resources and expertise is not to be able to set up scientific criteria. It is merely to review the literature, get expertise from the community because it has to be from beyond our own membership. It has to analyze benefit-cost ratio, benefit-risk ratios and see whether -- historically, whether these drugs that you're now talking about reinventing that wheel do have adverse effects that would be demonstrably and palpably dangerous to use. Under those circumstances, we probably would intervene. Short of that, I suggest that we wouldn't. It would seem to me that it's up to the scientific community to establish the basic scientific foundations for the pharmacology of the agents. It's not really our job.

DR. ASHENDORF: If a licensee were unsure, how would you suggest the licensee might proceed in order to find out whether it's acceptable in terms of professional standards?

DR. ROBINS: I think the same way we do. We go to all of the experts that we can reach -- the academics, the pharmacologic industry -- those people who have great clinical experience, and we say, "Tell us about this." And that's happened frequently -- every day or every week that that sort of an episode occurs. It doesn't happen to occur historically in my memory with "experimental drugs," but it does turn up with many other areas of our licensees' purview. We have to then do an analysis based on the available

evidence that we have. And if we think, and we have to be pretty sure, that the risk outweighs the benefits, then we would probably, because in my experience this has not arisen in our pharmacologic agents -- but if it did show that, then we would say that's inappropriate. We would take a stand at that point. Short of that, we feel that we don't wish to have a chilling effect or be the preventors of advancement in clinical medicine -- certainly not in an arbitrary way.

In response to the problem of pain management, we changed our regs so that there is no longer a ceiling on accessibility and usage with certain safeguards. We would probably do that across the board as these issues came up. Pain certainly made us respond.

DR. ASHENDORF: Thank you.

DR. ROBINS: I did the best I could for you, Doctor.

DR. ASHENDORF: I think we touched on that.

ASSEMBLYWOMAN VANDERVALK: Dr. Goldberg.

DR. GOLDBERG: I think that one of the things that concerns me is the educational aspect. I think that's, obviously, a very important part of this thing. And usually the Board's response to education is after an incident. Is there-- Have you thought about ways of beginning to disseminate or develop educational activities?

DR. ROBINS: And thank you, Doctor, I really appreciate that. It isn't in my prepared statement, but I really think it's a critical feature. And what my thinking has been is that the biggest missing link from the prescriber's perspective is a good, sound, up-to-date, and continually updated education on the management of pain and with/without drugs or any other way. And I think that even today-- I went through the experience at a committee meeting

in which a physician appeared before us because of a mismanagement of a patient in pain intervention. It was a drug-seeking patient, and the doctor -- very well trained, specialized in a field of medicine -- didn't really have at that doctor's fingertips the ability to make the diagnosis of drug-seeking behavior. And with serious consequences, the patient was further addicted and wasted years of mismanagement.

The point being that education was missing. Education is necessary, and the Board should play a bigger role in that. What are our opportunities?

1. We put out a newsletter. We update periodically information about regs, treatment, etc.

2. We make ourselves available to speak -- grand rounds at hospitals, any organization that wants to hear about it.

3. We wish to and try to integrate our activities with those of the Academy of Medicine, the Medical Society whenever possible, when we're on the same wavelength. And this is one of the areas where we basically are on the same wavelength.

Our proselytizing our own licensees, as far as an education, pretty much is restricted up to this point to that. Beyond that, I don't have the capabilities of doing it. And by capabilities, I mean an infrastructure. It comes down to time, money, personnel. We don't have it. How much can we dedicate of our budget to spread the word further? Special bulletins, booklets that you do get -- some of them are probably in front of you. We haven't been underwritten by industry, privately. We're a government agency. We can't do that. We can't reach out particularly, and we haven't had-- Perhaps we can

be stimulated by this sort of group to have further underwriting for those educational needs.

We have the desire to do that because, Dr. Goldberg, I think that's the critical feature that I don't do for my licensees. We can set a regulation up for them, do this, don't do that, stay between these lines, but that isn't the same thing as giving them a miniresidency in pain management or in pharmacologic control of pain. We, the Board, learned because we see by hard experience the mistakes of others. So we're pretty well educated, but that's a rare and unique opportunity that we have, and it should be. We have 27,000 licensees. How many of them do you think are really knowledgeable in this area? I would tell you not sufficient at all.

I think that if there's anything that I would like to see come out of this is the opportunity for things -- what's the right word? -- organizations such as our Board, as an agency of government and as an oversight group of professionals, to be able to offer more education. I think that's a critical feature, and if you're looking for the roadblocks to appropriate pain management, that's a major one. I offer our Board's expertise, experience, etc., and our desire to educate. We do have limitations.

ASSEMBLYWOMAN VANDERVALK: Doctor, one of the conflicts that we have-- We constantly hear about the fear of physicians being charged under our criminal justice system and -- or having their license removed. In your experience -- I'm not asking you for exact numbers, but you had just mentioned that there was 27,000 licensees -- do you have a handle on how many doctors are -- I don't want to say convicted -- that the BME finds, in fact, they have violated the law in a given year?

DR. ROBINS: In the area of CDS?

ASSEMBLYWOMAN VANDERVALK: Yes.

DR. ROBINS: In the first place, I can't answer on the criminal, so I-- They're really quite separate. For an administrative agency--

ASSEMBLYWOMAN VANDERVALK: Well, let's just say as your Board then because that's really where your expertise comes.

DR. ROBINS: Yes. There really is a split path. They overlap sometimes, but sometimes they're quite separate.

ASSEMBLYWOMAN VANDERVALK: Right.

DR. ROBINS: I think that we are able to prosecute administratively several dozen a year for professional misconduct in the area of inappropriate prescribing, etc.

ASSEMBLYWOMAN VANDERVALK: Okay. Can you break that down as far as whether they're self-abusing or selling or just poor practice?

DR. ROBINS: Statistically, by the numbers, I can try to get it for you. If you want, I'll be happy to.

ASSEMBLYWOMAN VANDERVALK: I would very much like to have that, if that's possible.

DR. ROBINS: Sure. I can't tell you that now. I don't whether we've done that analysis.

ASSEMBLYWOMAN VANDERVALK: Right. Okay. Because I know I've heard in forums that in other states they claim that it's so insignificant compared to the number of practitioners that it really shouldn't enter as a real focus when we're trying to establish appropriate pain management. That it's just such a -- the percentages are so small that we

should keep that in mind. So it would be good to look at the hard data from our own state.

DR. ROBINS: I'd like to just answer that. I will do that. But above and beyond that, there's an irreducible number of criminal activities that you should -- should play no part in your decision making because that's quite independent. I think the majority, aside from the criminal activity, is self-treatment and mismanagement of patients. That is highly amenable to two courses of action -- education, primarily, and rehabilitation. And there are significant rehabilitation opportunities in the state and in the country, and you should know that our Board wants more than anything to rehabilitate a physician because that's a huge societal investment. We don't want to see that wasted. That is available, and we obviously work on that. We have a formal program for the impaired physician with the physicians' health program. And we carefully and anonymously supervise that activity so that there's a fairly high rehabilitation rate and a fairly low recidivistic rate. Nothing is 100 percent or 0 percent, but education is the major thing that should affect decision making on your part, not the criminal side. That's a few, and that's going to happen.

ASSEMBLYWOMAN QUIGLEY: Madam Chair.

ASSEMBLYWOMAN VANDERVALK: Yes.

ASSEMBLYWOMAN QUIGLEY: Perhaps to amplify your question, what we would want from Dr. Robins is a list of the kind of disciplinary actions that have been taken. And perhaps, as he mentioned, if rehabilitation is successful, we could also find those whose licenses have been

restored after corrective action has been taken. And that would give us a picture of--

ASSEMBLYWOMAN VANDERVALK: A better handle on it.

ASSEMBLYWOMAN QUIGLEY: --the kinds of offenses and then what the follow-up is.

ASSEMBLYWOMAN VANDERVALK: That would be fine if you could do that.

DR. ROBINS: Okay. Then I have to ask a favor of this Commission. If you're going to ask questions that are going to take some shuffling -- either electronic or card shuffling, one or the other -- I would ask you that you present those requests in written form so that I can -- not make mistakes in what you really want.

ASSEMBLYWOMAN VANDERVALK: Well, I think you get the general flavor for what we're looking for.

DR. ROBINS: I get the general idea, but I think--

ASSEMBLYWOMAN VANDERVALK: And we're not looking for a new work study for yourself, but simply if that data exists-- If that data exists, you could forward it to us, and we'll make sure that the Commission members get it.

ASSEMBLYWOMAN QUIGLEY: You do issue -- do you not? -- monthly reports on disciplinary actions taken against physicians, a compilation of that. We're not looking for anything beyond that.

DR. ROBINS: Okay. That I think is easy. Okay.

ASSEMBLYWOMAN QUIGLEY: Yes.

ASSEMBLYWOMAN VANDERVALK: All right. If there's nobody else or--

Yes. Okay.

DR. CARR: Dr. Robins, for people who want to practice pain management in the state, has there been any talk on the Board for mandatory-seeming credits per cycle -- so many credits in different areas to cover pain management? Now they do that, like with HIV, in certain states in quality assurance and quality control.

DR. ROBINS: You're getting into an area of questions that is of extreme importance to me personally. What is our obligation as a licensing body, an oversight body, to make sure that we have competency and general competency and specific procedural competency? We are just starting to get into that. The first area that we've done it in -- well, there are several areas.

1. The first is in our credentialing, alternative credentialing process for special procedures -- anesthesia. I point a finger because like -- one of your speakers is going to talk about that. I'm sorry. But in anesthesia, yes, those people who are not certified in anesthesia, nor are going to do supervision or conscious sedation, will require some ongoing CME credits. That's a breakthrough in that area.

2. Physicians who are doing acupuncture have to have had a certain amount.

3. We are kind of planing it in areas of telemedicine perhaps, perhaps.

4. The whole area of competency, how to audit it, how to make sure of it, is just reaching the point of starting to be looked at in a formal way.

There are a lot of pros and cons about CME itself. I'm not a great advocate of CME by the sign-in sheet in the back of the room near the lunch that's being served. (*sic*) I think you all know what I'm talking about.

ASSEMBLYWOMAN VANDERVALK: You get two credits for tonight. (laughter)

DR. ROBINS: I didn't even go near it. (laughter)

But I think more serious looking at competency is something that we would like to undertake. It is an initiative that I'm moving forward, but don't hold your breath.

DR. CARR: Would that competency be via training or direct supervision of technique, or how would it be?

DR. ROBINS: It really depends upon what we're talking about. Are you talking about pain management?

DR. CARR: Yes.

DR. ROBINS: I think that if we're going to establish an area for credentialing in our alternative credentialing mechanism for pain management, that will require -- and I did put that down. (referring to written statement) It will require education, experience, and recommendation. All three will be required. Whether we will build in at some time ongoing competency via CME, that's a major initiative and takes a lot of thinking.

DR. CARR: And one of the--

DR. ROBINS: And also requires tremendous amount of Board resources.

DR. CARR: Multiple Boards, too. In pain management, you have so many multidisciplinary approaches to it -- psychology to anesthesia and everything in between. So it makes it more difficult.

DR. ASHENDORF: Charlotte, I had one more question.

ASSEMBLYWOMAN VANDERVALK: Yes.

DR. ASHENDORF: This is a sensitive issue, and I'm going to leave this question as open ended as I can. In terms of pain management in end-of-life issues, does the Board have any opinion or guideline in how that should be approached? I can be more specific. In the event one were to -- a pain management physician's goal -- primary goal -- were to keep someone comfortable in a terminal illness, and if by doing so, one might precipitate the demise of that individual, conceivably, by oversedation. And what is walking that line between comfort and complication? Does the Board have any guidelines on how that ethical issue should be addressed?

DR. ROBINS: The Board's position has been-- The principle is that a patient deserves a quality of life that includes freedom from pain as much as possible. That does raise the possibility and the specter of some adverse effects anywhere -- respiratory, depression to death, etc. -- and complications. We don't wish to legislate that or regulate that. It's part and parcel of the judgment and professional expertise of somebody who is managing pain.

The ethical issues, apart from those medical issues that I just talked to, are going to be dealt with. And I'll tell you how we're starting to deal with those. I just established a bioethics committee at the State Board of Medical Examiners. The bioethics committee will have a task force from the

greater bioethics community, and we will be taking, selectively, subjects to discuss and to analyze and to reach either policy or regulation that will be suggested to the Board. And one of the topics will be end-of-life matters and particularly pain management in end-of-life issues. So I'm attacking the ethical side by the establishment of a bioethics committee with wide input, because I don't think that the Board, without a great deal of philosophical introspection and advice and counsel from people wiser in the field than we are, should attempt to deal with that type of subject. I think that's beyond our purview but not beyond our interest. Yes, we are going to get into that.

DR. CARR: Thank you.

ASSEMBLYWOMAN VANDERVALK: Dr. Corda, your hand was up before. Did you still have some--

DR. CORDA: That's okay.

ASSEMBLYWOMAN VANDERVALK: Okay. All right.

Well, I certainly thank you. It's been a very productive dialogue. Thank you very much.

DR. ROBINS: Thank you for the opportunity. Good luck.

ASSEMBLYWOMAN VANDERVALK: Thank you.

Dr. Nolan Tzou from the Morristown Memorial Hospital.

N O L A N T Z O U, M.D.: Actually it's pronounced Tzou, like zoology.

ASSEMBLYWOMAN VANDERVALK: Tzou, thank you. Okay.

DR. TZOU: I am also an anesthesiologist specializing in chronic pain management, and I was asked by Morristown Memorial to present their views on pain management and some of the problems that we've encountered at the hospital.

I know there have been two previous public hearings on pain management. Unfortunately, I wasn't able to attend either one of those, and I don't know if I'm going to be reiterating some of the things that other people have said.

ASSEMBLYWOMAN VANDERVALK: The other hearings were-- The first one was for providers and basically providers, and the second one was basically patients. So -- but please share with us.

DR. TZOU: Okay. I'm pleased to report that Morristown Memorial has taken an active role in providing acute, chronic, and cancer pain management for its community. Morristown is the largest hospital in the Atlantic Health System, and over the past year, the administration and medical staff have been developing a pain committee to address acute and cancer pain within our hospital. Members of our committee consist of anesthesiologists specializing in pain management, nurses, oncologists, and surgeons. All of these would be directly involved with patients in pain.

To do a baseline assessment, a hospital-wide survey was distributed to patients, nurses, medical and surgical residents, and a sample survey was done to over 200 nurses, as well as the medical and surgical doctors. The average age of the patients was 61 with a range from 9 to 97. Sixty-five percent of our patients recently had surgery and 80 percent had experienced pain within 24 hours of completing the survey.

Significant findings of that showed that patients who experienced pain and requested medication had received it within less than an hour of asking for it. Also of significance was that both the nurses and doctors had discussed with their patients the importance of treating their pain. It was also

noted that in reviewing the responses to our hospital, it was clear that our hospital had a very high approval rating with respect to patient satisfaction. When reviewing the questionnaire for the nurses and doctors, it also became clear that basic understanding, as far as pain management dosaging schedules, risk of addiction -- became clear that further education was needed. And so our hospital is actually embarking upon a hospital-wide campaign to educate health-care workers on pain management.

In terms of chronic pain, there are several problems, and I am sure that actually providers have mentioned this in the past. These are things that my colleagues and I have also seen. For example, I have several patients with chronic back pain who, once they have reached maximum medical benefit, are then sent letters from their insurance carriers saying that they're going to then be dropped. Another example is the elderly patients with spinal stenosis. I actually have a fairly large percentage of patients who come through my office with this diagnosis. They're poor operative candidates, and there are very few alternatives for them besides medications and epidural steroid injections. It has been rumored that Medicare is considering dropping reimbursement for steroid injections, and if they did this, this would obviously be to the detriment of a lot of patients.

It is our position that a multidisciplinary approach to these patients is the best way to treat the wide variety of patients and disease states that cause chronic pain. Again, one of the issues that you already discussed was addiction and narcotic abuse. It seems that these patients are in pain. The risk of addiction is very low, and we found that in our practice.

With respect to cancer pain, many issues factor into why the patient is undertreated. And you already talked about the lack of education that's present on the level of the oncologists, the nurses, and throughout the hospital and even on the patient level. Education has to go on at all levels, not just at the medical level as well.

I wanted to keep it short.

ASSEMBLYWOMAN VANDERVALK: Thank you very much.

Yes.

DR. CORDA: Doctor, do you find that you're referral based? Do you get many referrals because either the physicians are not educated in pain management or in medicine bases, or that they are fearful of the DEA or similar organization coming down on them and that's why they want you to handle narcotic medications for the patients?

DR. TZOU: We've gotten a lot of referrals particularly from orthopedists, who are concerned about patients, who they feel uncomfortable writing narcotics prescriptions, and so then comes -- rule out RSD, reflex sympathetic dystrophy, which is a chronic pain syndrome, versus addiction. And since we are a multidisciplinary pain center at Morristown, perhaps we're better equipped to handle those patients. And if there is an issue as far as addiction, we can send them to the psychiatrist and make sure that they get appropriate care and make sure that that's ruled out.

DR. BOWDEN: Have you identified or given any thought to in cancer pain management who might be the person that does some of the front line, the initial discussions with patients when they start on medication? Because in my experience, the starting of a long-acting opioid preparation with

appropriate breakthrough medication and then discussions about managing the side effect, albeit, constipation and things like that, would take a long time. And if you're in a very busy practice, it would be helpful potentially if you had some skilled caregivers, nurse-practitioners, nurses, residents, who are able to do those things. Have you given any thought to doing that in terms of--

DR. TZOU: We have discussed it within our hospital. When I was at Sloan-Kettering, we used to have exactly that, nurse-practitioners, nurses, and doctors on every level talking to patients about potential side effects from narcotics and other adjuvant medications.

DR. BOWDEN: And now, do you have any plans for trying to implement that? At this point, it would seem, again, the resource issue starts to-- Everyone has the best intentions, but it becomes very difficult I think to get these people, and certainly to get an insurance company to reimburse for a 30-minute education session would be, I think, extraordinary difficult.

DR. TZOU: I think you get to the point there that many insurance companies are not willing to pay for actually sitting down and talking with a dying patient. You hit the nail right on the head. That's part of a problem that we have. There has been some discussion as far as trying to get a nurse specialist or a nurse-practitioner to be able to spend time with patients and talk about these things. We're continuing to develop that at Morristown, and that is one of the things that is of discussion, whether or not we will be able to get insurance companies to pay for this. So I really couldn't tell you.

ASSEMBLYWOMAN VANDERVALK: Well, thank you very much.

Maureen Miner, Executive Vice President of Bayonne Health Care Foundation.

MAUREEN MINER: Thank you.

ASSEMBLYWOMAN VANDERVALK: Good evening.

MS. MINER: Thanks for the opportunity to speak. I will just take a few minutes. I'm interested in presenting, especially to this important group, since you expressed an interest in pain management. I speak with one voice, but I play out many roles. I'm presently Executive Vice President at an urban community hospital. I'm a former staff member, long-time volunteer and advocate for American Cancer Society.

I'm a widow whose husband of 32 years died of a second primary cancer, lung cancer, earlier this year. For most of his adult life, Ed knew pain. One of the hardest things I had to do was help him live despite a diagnosis of cancer again and then help him die. A fun-filled, youthful, 56-year-old businessman, friend, father, husband, neighbor wanted to die at home peacefully. The pain relief we sought was too little, too late, and it didn't have to be that way. We received treatment for Ed at the hospital where I work. I have no complaints about his treatment at the hospital. We were treated like family. I have no question that still today his caregivers care about him and about me. I asked them to lend their voices to me for my five minutes tonight and speak in unity to you, today, so that you hear from patient, caregiver, and health professional.

Nobody should be allowed to die in pain. His radiation oncologists were two wonderful women who admit they want help soon themselves. They need better information. They want pain manager. They

want someone to work with each patient on an individual plan for pain relief. They want more information readily available to them on alternative therapies, like massage and reflexology, imaging, and aroma therapy and biofeedback. And they want a link to the patient when he or she is discharged to home or hospice care. And it's in that realm where our ability to manage pain disappeared.

Nobody should be allowed to die in pain. Ed's oncologist says, "It's not an ethical issue." This is his voice. "It's not a morale issue. It's a QA issue. If the patient died in pain, we failed to manage it." We cannot wait long. We need pain teams. The patient needs early access. Pain is subjective. You know it when you have it. You know it when you have some relief.

Oncologists especially need a rotation in and continuing education in and more continuing education in pain management. The pain of the terminal cancer patient is not like other pain. We must be more aware. We must be more sensitive. We must find ways to give comfort to dying patients.

Nobody should be allowed to die in pain. Ed's anesthesiologist, a person we came to associate with pain management, said to me, "I think we must make a paradigm shift from everything we ever knew or thought we knew about pain, its identity, its remedy, its relief." The rules relating to addiction for terminal patients do not apply. I have this sidebar. All of these people knew that the first thing and, in fact, it's the thing that helped us have the tools to deal with terminal cancer that brought us to Bayonne Hospital's Emergency Room together was Ed's need for acute assistance for alcohol addiction. So everybody in his pain management team for lung cancer realized

that he had had an addiction to alcohol and that, in fact, he was well on a wonderful road to recovery.

The rules relating to addiction do not apply. The patient has a right to a comfortable life and a peaceful death. We must educate everyone, and that includes patients and family members to speak up for their rights, physicians to improve their knowledge, nurses to remember that every individual patient needs to be seen as a pain case by case. We must find the sources of pain and bring relief to the person who perceives it. How do we know we manage the pain? When the family says and means, "I know you did all you could."

I don't know how many of you have had the personal experience of being with a loved one who died in pain. I hadn't before. I don't know how committed each of you is, personally, to improve our ability to manage pain in people who have pain. Pain is subjective. It's not objective. It's only found in people. And I don't know how long it will take for this whole process of hearing, researching, and reporting to result in action.

I do know that there are very complicated issues associated with those who have to live with pain and those who are dying with pain. And I know that you are talking about an assortment of other issues, not just that that has to do with cancer pain or terminal pain. I do know we have the medicines and methods and knowledge to manage pain. And I do know that right now countless individuals need relief from pain so that they can live a better life.

Nobody should have to live with unmanaged pain and nobody should die in pain. Thanks.

ASSEMBLYWOMAN VANDERVALK: Thank you very much. I know that was difficult, but you said it very well. You said you were a great spokesperson for that perspective, and the world needs to hear more of that.

MS. MINER: Thanks for the opportunity.

ASSEMBLYWOMAN VANDERVALK: Dr. Goldberg.

DR. GOLDBERG: I think you have obviously stated the problem from a personal point of view very, very eloquently. From a health-care executive point of view, how do you look at that, having been in a -- from a personal point of view, now looking at the institution of which you're a part of? How do you go forward in helping the institution to help now in terms of education and support to individual people who now are in pain?

MS. MINER: Well, it's interesting that you asked that because I've been working, for probably two and a half, out of the four and a half, years that I've been at Bayonne Hospital, with small teams who are interested, with the physicians who bring professional education to the Allied health professionals, as well as physicians, with these individuals, who have, for instance, cancer committee and their own opportunities to make it a topic to bring in the speakers that can speak perhaps from certainly a different perspective than my own personal one and let them have the information and the knowledge to take some action. I have asked, as a result of my own personal experience, to develop it -- a pain team -- in our hospital. And I know that it is being put together right now. So I think I'm answering your question in saying that I would use myself to encourage the hospital team to take some positive action.

DR. GOLDBERG: Do you see the hospital's resources as being available and ready to take on that task?

MS. MINER: Yes, but the area that we found that -- personally that I found the missing link was in an area the hospital doesn't have direct control over. It was the home care/hospice care. And so every one of these individuals that you heard from is certainly willing to talk to those people, but we haven't got a matching link once people are out of the hospital setting. I'm not worried about the hospital setting. I'm worried about the home setting. For years, I think, many of us have had a sort of ideal -- dying peacefully at home and comfortable in familiar surroundings with our loved ones nearby.

Probably part of the difficulty for us was that his death came right around Christmas holiday time. Well, what that means is people are short staffed, if the phone call doesn't get answered between 8:30 p.m. and 8:30 a.m., which is when everybody's crisis time seems to be-- And so it's the missing link that I can't truly provide for.

ASSEMBLYWOMAN VANDERVALK: Yes. Donna Bocco.

MS. BOCCO: I would second that. I wanted clarification and you did. Underlining the missing link in my own case, with my own case with my own mother, it was a hospice situation. It was a home situation for all of the reasons you articulated, and really what it became was an absolute and complete horror show that went on for two months that seemed like 10 years. It was an unwillingness to acknowledge that the patient was defining the pain. Well, enough medication was given. "We don't understand. Are you sure that you're giving the patient the pain?" The hospice team was accusatory, belittling. It was absolutely incredible. They were afraid to speak to the

physician in charge of the hospice because he had a bad temper. It just went from bad to worse. The only relief that we had in terms of morale support and simple suggestions came from the local pharmacist. The medical team completely failed in the home care situation.

And I was employed by the American Cancer Society. I mean, I knew what had to be done. I just couldn't get it done.

DR. BOWDEN: I think that's really tragic because in a lot of my experience with hospice nurses and hospice people and personnel in taking care of individuals dying of cancer was very positive in terms of getting PCAs set up at home and being able to manage the pain. I really feel bad for both of you, and hopefully, that's something that we might be able to -- if we can help in some way, that will be an improvement. Because this really is very unfortunate.

I think a second-layer issue, which is just as important, that you both alluded to, is even if you have adequate resources, very good, top-notch hospice agencies, equipment, and good interfacing between the primary care physician, whoever that may be, yourself, and the patient, is that you are working during what-have-you and during this period of time, which as you alluded to was two months or it could be a very long time, to have to continue on and you're working or something. And I don't think our country at this point can step back and relieve people of their responsibilities or provide for some type of aid in that situation. I think that's a secondary issue that also is very problematic, but I really feel bad about the hospice thing. I don't know the state too well. My experience is in another state. I think it's too bad.

MS. BOCCO: I also shared with Mr. Price, who circulated it, an article from the *Journal of Oncology Management*, which talks about the plight of patients in nursing homes vis à vis pain control. I mean these are our parents and our grandparents, folks.

DR. BOWDEN: One of the things that we might be able to do would be to identify who is good and who is not so good and who can offer some of these hospice services. And perhaps get some feedback from their patients and their caregivers, and they'll tell us who is good at doing this and who is not so good.

DR. ASHENDORF: I have a interesting issue which I think may have been more significant than you realized in the care of your husband. Was it your feeling that your husband's history of substance dependence may have contributed to undertreatment consciously or unconsciously on the part of his providers?

MS. MINER: It's a possibility. It's a possibility. I do know that by the time we finally did receive morphine, specifically, it came too late and it was too little. And part of the reason for that is, even if you surf the Internet, you can understand that there is such as thing as a paradoxical reaction in an individual who has had drug addictions and the pain medications don't work. They don't work immediately. It takes a period of time for them to. So I can't say that, but it's a possibility.

DR. ASHENDORF: I'm a little unsure by the way you described it what actually happened in the interaction between you and your husband, the hospice, and the medical provider. Was he given inadequate medication? Was he not believed? Where was the breakdown?

MS. MINER: I think he probably-- I think it's a series of things. The pain was anticipated by the treatment team but, in fact, no special management for day after day after day until something else was tried before we got to the opiate medication.

DR. ASHENDORF: I see there was a period of time--

MS. MINER: Right.

DR. ASHENDORF: --where the pain was very inadequately managed.

MS. MINER: Right.

DR. ASHENDORF: From the time that the opiates were introduced, do you feel that he was well managed at that point?

MS. MINER: Two days.

DR. ASHENDORF: I'm sorry.

MS. MINER: He had died in two days.

DR. ASHENDORF: I see.

One other issue I would like to touch on, and this is a very difficult question, but I alluded to it with Dr. Robins. If you and your late husband had had an opportunity for an intervention which could have provided a better quality of life that which might have hastened his demise -- I'd like your own personal opinion about how you would have reacted to someone asking you that.

MS. MINER: I think they kind of skirted around it. When you get a hospice team, they tell you one of the first things, when you expect the person is possibly or probably dead, don't call 911. Call our doctor or call our nurse, and they'll pronounce the person. That's the words they used. And

they said don't be surprised, but one of the next persons to cross your threshold will be a police officer and right next to the bedside table is going to be the final medication that was administered by self or by caregiver. So there's always the specter of concern about taking one's life, giving too much medication. It's raised right away. It's written on the home care papers, even as reminders. I still have them, "Don't call 911. Expect the police." That kind of thing. The thought is certainly there.

DR. ASHENDORF: How did you and your husband react to that kind of innuendo?

MS. MINER: Up until the day he died, we tried not to pay attention to dying but to living. Living a quality life was important to both of us, and I think pain interfered with his final quality of life in a way it didn't have to.

ASSEMBLYWOMAN VANDERVALK: Thanks. I do want to thank you again.

MS. MINER: I appreciate the opportunity.

ASSEMBLYWOMAN VANDERVALK: Yes. Yes.

Dr. Ervin Moss, Executive Medical Director of the New Jersey State Society of Anesthesiologists.

ERVIN MOSS, M.D.: I want to apologize to Mrs. Miner in having heard her speak and knowing what she went through because I'm addressing this in a different light. I'm really not addressing cancer pain.

What I want to make the Chairwoman of the Commission aware of is the negative side of what has become a business in pain management. This is very unusual for myself as a medical director of an anesthesia society

to come up to speak like this, but the Executive Committee of the Anesthesia Society agreed that it was appropriate for me to talk.

It's also a national problem recognized, in fact, just last week in Orlando, Florida, where I attended a meeting of the American Society of Anesthesiologists and included in here the little brochure, a publication entitled "Abuses and Excesses in Pain Management." It was written by the Chairman of the Committee. At that time, he was not the Chairman, but now he's become the Chairman of the ASA. The last page -- then I'll read my street presentation -- was presented in the House of Delegates and approved by the Board in the House of Delegates, and that is that the "ASA Committee on Pain Management perceives that a primary concern of the membership in regard to the practice of pain management is the lack of evidence for the validity of certain, if not most, pain management practices. It is the Committee's opinion that such evidence can be portrayed best and only by careful evaluation of outcomes of patient experiences with these therapies," and you can read the rest of it.

Dr. Ashendorf, we also passed a statement on ethics, which I'll send you, concerning the questions you were asking about. In the case of Mrs. Miner, you'll notice that as soon as the morphine was given that was the end of the pain and the suffering, and I've seen that myself with a very good friend of mine, Dr. Sprew (phonetic spelling), who was a director of our anesthesia society. A few hours after we gave him his last shot of morphine, that was it. So that's usually what you find.

Anyway in 1992, the Federal Department of Health and Human Services published its first Clinical Practice Guidelines dealing with the subject

of acute pain management. In the text, it accused physicians of failing to render adequate pain relief for patients in pain. Of course, a lot of that came to the fear of being prosecuted, and Dr. Robins has addressed that, and that they are liberalizing the fear that pharmacists will turn in pain managers, which they have been doing, because they write too many prescriptions. And I've seen that come before the Anesthesia Society.

The guidelines stated that "recognition of the widespread inadequacy of pain management has prompted corrective measures within multiple health-care disciplines, nursing, and pain management groups." Although the guidelines focused on acute pain, it spun off numerous specialists treating chronic pain and cancer pain using combinations of drugs, nerve blocks, radiofrequency neurolysis, cryotherapy, chemical neurolysis, acupuncture, biofeedback, diet and nutrition, TENS, dorsal column stimulators, implantable narcotic pumps, holistic medicine, and physical therapy.

Storefront pain centers have appeared with the frequency of 7-Elevens. Yellow pages and newspaper ads promise pain relief. Even billboards have cropped up advertising pain centers. These centers are not always staffed with trained, certified pain specialists. In fact, one pain office in New Jersey was staffed by a C.R.N.A., who under the Board of Nursing is an R.N., whose charge for an epidural block was \$2000 plus a medical evaluation and consultation costing \$400.

I reported this to the Board of Medical Examiners two years ago, and yesterday I received another complaint on the same nurse who represents himself as a doctor in an affidavit that we had obtained by someone who came

to his office and was told he was a doctor. The bill this time was \$7500 for two epidural blocks.

Two offices, now closed, were owned by a doctor -- and I called the Board yesterday, and he was supposed to have appeared after two years at the last meeting, and he will be there in three months. And I don't know how many patients he sees a day, but by then, he probably doesn't care if he gets thrown out of the practice of pain management. Two offices, now closed, were owned by a doctor specializing in Q-tip insertions into the nostrils. The Q-tips were supposed to be soaked in a local anesthetic to block the universal pain pathway, the sphenopalatine ganglion, but most likely were soaked in cocaine, hence, the feeling of well-being following the twice-a-day treatment. The cost was around \$500 a day. When the insurance company refused to pay, in one case, a \$12,000 bill, I appeared on behalf of the patient in court and against the doctor who was being sued to explain that I had written to 10 world-famous experts, and all agreed that the treatment was a hoax. And by the way, this doctor is in practice, and because the Board closed him down, he was caught shooting fentanyl into his veins in the parking lot of a Jersey City hospital.

ASSEMBLYWOMAN QUIGLEY: I knew I recognized that story.

DR. MOSS: Another case was the billing of \$18,000 for 180 posttreatment phone calls made once a day by a pain center in New York City to a Trenton patient. I advised Prudential, as a pro bono consultant, not to pay, but Prudential paid against my advice. In other words, they had a computer set up where they called every patient. It was \$100 a call. They called 180 days in a row and got \$18,000.

In the early days of the rediscovery of pain management -- and I say rediscovery because you all know, and there's anesthesiologists at this table know that this goes back to the turn of the century -- the insurance companies did not know how to pay. After two days of pro bono reviewing of Prudential's group pain claims and seeing how they were paying any amount billed with complete lack of understanding of the services rendered, I offered to work eight hours a day for Prudential, without salary -- free -- but at 10 percent of what I would save them. My goal was to become very rich, actually a millionaire, but the offer was turned down. It would probably have embarrassed the executives.

In hearing Mrs. Miner talk, if all that money was diverted where it really should be by the insurance companies, and that is to reputable, honest pain specialists or research into the need that you have for pain treatment and cancer, and so forth, think of what we would have.

In more recent years, the insurance companies have done a complete turnaround. And I should mention that I've been Chairman of Economics in this state for my Society since 1968 -- so it's my 30th year -- and I've seen the progression. I started to do pain in New Jersey in 1963 and in 1957 in New York state, then I moved here. I stopped January 1 of last year for reasons of-- And I'm still practicing. I've been in the operating room since 7:30, got up at 5:00, did four major cases, and drove here, and I'm 72.

In more recent years, the insurance companies have done a complete turnaround, and now they're paying amounts for acute and chronic pain management services that are unrealistic. For example, Medicaid will be \$50.40 for a therapeutic epidural block, and Medicare will pay 80 percent of

\$108.00. A reasonable fee for the service using the ASA relative value guide would be 550 or to 650. Prudential HMO will pay 400, which is a discounted UCR rate. Some insurance companies do not pay for postsurgical epidural catheters and for daily treatment. Most do not pay for patient-controlled analgesia or will pay small daily fees for two postoperative days. Thus, while relief of chronic pain and acute pain is expected by patients and by the government, the question of how and who is to pay for these services is in question.

The insurance companies on the other hand are often faced with bills that are obscene in scope and for services that are often unnecessary and that are delivered by self-proclaimed pain specialists. One recent case I reviewed for Motor Club of America -- again a pro bono -- was for \$60,000 at \$5000 a piece for 12 blocks. Even after paying \$30,000 of the fee and after a committee of the New Jersey State Society of Anesthesiologists reviewed the claim and questioned the amount and the number of blocks performed, the Motor Club of America adjuster was afraid not to pay the balance lest the doctor sued. Another pain specialist, a neurologist, charges \$8000 for a block, which I would be glad to perform for \$560.

The abuses are not only by anesthesiologists, but by other specialists who have entered pain management, including orthopedic surgeons, neurosurgeons, neurologists, and physiatrists. At this time, the only board offering examination and certification in pain management is the American Board of Anesthesiologists. Other specialty boards are now working on a certification of our credentialing process, which is most needed.

In the ASA Newsletter of October 1997, which is attached, the article was published and titled “Abuses and Excesses in Pain Management.” The author, Douglas Merrill, M.D., is now Chairman of the ASA Pain Committee. Case studies are included that mirror the cases related from my experience as Executive Medical Director of the New Jersey State Society of Anesthesiologists and as a member of the excessive fee committee of the Board of Medical Examiners. A copy is included.

Dr. Merrill has made recommendations to which I have made additions.

1. The credentialing, training, and certification of the pain specialist should be verified when setting up a hospital pain clinic.

2. Insurers should have the right to demand similar credentialing from those who practice in free-standing pain centers.

3. Since many pain patients have been seen by numerous other physicians, all possible records should be obtained to avoid duplication of treatment and tests.

4. Not all patients seeking pain relief are in need of blocks. Medications properly combined and prescribed may suffice.

5. There cannot be acceptance of a limitless number of procedures. There must be accountability of those who perform unusual number of procedures without successful outcomes. I trained under E. A. Roverstein, which was sort of like the father of American anesthesiology, at Bellevue in the '50s. I learned blocks in an anatomy lab. And there was a policy then: you did five sympathetic blocks and three epidural blocks, and if they didn't work, you found other treatments. I see cases where there's

eighteen and twenty sympathetic blocks and twelve and fifteen epidural blocks, and they just continuously are performed.

6. Creation and use of treatment guidelines including preset criteria and intervals for treatment plan re-evaluation.

7. Referrals should be made to other specialists, behavioral medicine, neurology, physical therapy, rehabilitation medicine, and surgery when no improvement results from the blocks.

8. The self-referral issue: I myself practiced pain management from '63 to '97 in New Jersey and performed approximately 15,000 procedures. All patients were referred to me only by one, an orthopedic surgeon, a neurosurgeon, or a neurologist. All other doctors I would not accept. Today, pain specialists accept patients directly, and this practice is called self-referral. The patients are not returned to a referring doctor who can compare and evaluate the improvement of the patient. There is a tendency of the self-referral specialist to perform more blocks as a primary treatment. The outcome, or QA results, especially in the office clinic, are performed by the diagnosing doctor who is also the treating doctor. There is a need for outcome studies. That I think is underlined. Credentialing and outcome studies -- these two things in pain management.

9. Dr. Douglas Merrill quoted John Bonica, an early pain specialist, that "blocks are continued until the patient is completely cured or reaches a plateau with this form of therapy." In other words, a patient can have a complete relief from one block and may reach a plateau of relief after three to five blocks. To continue to perform blocks numbering ten to twenty

is unacceptable. At some point, the doctor, if honest, will admit that there must be another pathway to take.

The more physicians abuse the system, the more extreme the responses of the insurers. As a result, those of us who have practiced pain management have given it up rather than accept the fees paid for their expertise. I say this in the plural because one of the leading, older pain managers at Overlook just gave up the practice of pain management, when here it is supposed to be a blossoming specialty. The solution may be the use of consultants with integrity, who from a neutral position but with knowledge of the skills, risks, responsibilities involved in treating patients with pain, to arbitrate with the insurers a fair and reasonable fee schedule.

The majority of pain specialists, including anesthesiologists, do not follow the patterns of abuse related in my presentation. It is important that insurers do not penalize those who provide excellent care to their patients. I firmly believe that the insurers can be educated to recognize the value of a service performed without abuse to the system and act to deny or in some way discipline those who abuse not only the system, but the patients who are subjected to unnecessary procedures.

Who have I not aggravated tonight? (laughter)

ASSEMBLYWOMAN VANDERVALK: It's a lot of material in here. You do have your card here. I have a feeling we might be calling on you at some point in the future for some additional information, if we may, sir.

DR. MOSS: Anybody, can I answer any questions, or is it too late?

Again the anesthesiologists know me, but one thing unusual about anesthesia in this state is that one Dr. Robins mentioned, that there are some CME requirements for-- Everything that's been done in this state from the office standards that were just passed, that took me 14 years to get through -- 14 years-- The first death that I reported and went to the Board of Medical Examiners for is 1984. The hospital standards are now 10 years old. Our malpractice has gone in half in this state. November 14 we meet to rewrite the hospital standards. The same-day surgery centers' standards are the same.

Anesthesiologists have been proactive, and that's what I'm doing here tonight. I'm being proactive. I recognize a problem where a huge amount of money is being drained by people who shouldn't be getting it and even if they're anesthesiologists. My Society backs me on this. It should be going to the treatment of cancer pain. It should be going to maybe research, but not whether research should be done on offices. I was listening to some of the questions. There's marvelous residencies in this country turning out fellows. The fourth year of an anesthesia residency, you can take a fellowship in pain. Hopkins, they're doing the research if you want to know where the research is being done.

I'm sorry. Dr. Ashendorf.

DR. ASHENDORF: I was wondering. There seem to be a lot of contradictions going on. On the one hand, we have some insurance companies paying egregious sums of money, and on the other hand, we can't get appropriate care for someone who is dying at home.

DR. MOSS: I know.

DR. ASHENDORF: There is a glaring absence of anyone from the insurance industry through tonight.

ASSEMBLYWOMAN VANDERVALK: I noticed that.

DR. ASHENDORF: And this was supposed to represent regulators, of whom none have shown up, and the insurance industry, of whom none have shown up. What is their responsibility in this?

DR. MOSS: Maybe they'd knew I'd be here. (laughter)

ASSEMBLYWOMAN QUIGLEY: I think they knew we'd all be here.

DR. MOSS: I just wrote up to 11 CEOs and not one has answered, and that was November 27. So it's not unusual not to hear from--

DR. ASHENDORF: What do you think their responsibility should be?

DR. MOSS: Their responsibility? As I said, I think that their responsibility is to understand pain management. Take the funds that they have and reward those who do good for the people and not reward those like this MCO adjuster who is willing to give \$60,000 for 12 blocks. And that's even listed by Dr. Merrill. He uses an example like that. It's not uncommon in this country. They have no comprehension. When I offered to work for Prudential for nothing, I think they didn't want me to because the executive in charge of that division would have been embarrassed if I came in and said, "We get paid \$18,000. You shouldn't pay this. You shouldn't pay that. You should pay this. This is a fair fee." They seem to need education. We've tried to. I've met with and called and talked and tried to get fair reimbursement.

There's two extremes. I had a service call yesterday for a dryer, and the man said it's \$60 to come to your house, but you're going to do an epidural block from Medicaid and you're going to get \$40 or \$50. Or Medicare is -- forget it. I mean, it's 80 percent of 108, and there's a lot of responsibility in it. It's being distributed wrong, and I don't know what the solution is. It should be going to cancer.

DR. ASHENDORF: Have you, for instance, sir, seen the critical care paths which have been introduced by the Department of Insurance?

DR. MOSS: Yes. Yes. I wrote a comment for our Society. I didn't agree with them, unless you do. I felt that some of them to line pockets. If you'll follow the algorithm down--

DR. ASHENDORF: I did, sir.

DR. MOSS: --and someone took the conservative way, there was no way to get to the surgical way if the conservative way failed. The algorithm was a dead end.

DR. ASHENDORF: I'm familiar with it, sir.

DR. MOSS: Okay. No. We wrote-- I wrote rather. It's my job to do it. It was protestitive. I hope I did right for you because--

DR. ASHENDORF: So you are in agreement that in this case the regulatory agencies have not addressed the pain management issues here.

DR. MOSS: No.

DR. ASHENDORF: Is that correct?

DR. MOSS: That's right.

ASSEMBLYWOMAN VANDERVALK: Yes, go ahead.

ASSEMBLYWOMAN QUIGLEY: What we usually hear -- and I'm speaking to both doctors in this case -- from the legislative side are complaints that insurance companies are not paying -- that they're not paying enough. They're not paying for treatment that is needed. And, yet, you're telling us that frequently they are extravagantly paying. What percentage of these outrageous overpayments are there compared to denials?

DR. MOSS: What percentage? Well, I don't see the denials as much as I see the overpayments because that's part of-- I get these complaints all the time.

ASSEMBLYWOMAN QUIGLEY: Are they common?

DR. MOSS: Like yesterday, I mean-- There's all kinds of-- What they've done is they've unbundled the block. This gentleman in Atlantic County. He does a block, and he puts the needle in. And if he puts one drug in, that's a certain code, 6289. Then he puts another drug through the same needle at \$2000 for the same needle but a drug in each one. Then he went to cervical, then he -- unbelievable. You say, "Well, who pays for these?" In some cases, the patient's insurance will pay a certain amount, and then they go after the patient for the balance. That's when I went to court against the doctor who was using Q-tips in his nose because he was going after the balance. I actually went on my own, not as -- pro bono again -- to try to be a patient advocate.

ASSEMBLYWOMAN QUIGLEY: Do you see that the insurance companies are doing anything to monitor their own activities? Are there any standards that they can compare each other against or--

DR. MOSS: No. I do not see it. I had two days that I spent actually in Prudential's Group Insurance in Roseland, and I was able to look at pain and how they were paying. Nobody knew what they were doing basically. And if you put the codes in -- like for me I used to be an epidural block, one code, but now I see a code for sedation. That's \$600. Then I see a code for the use of epiduragram, that's a C-arm, and then a use of a fluoroscopy -- that's \$1100 more -- and then the ASA relative value guide is no longer being followed because these are all surgical codes. And the anesthesiologists-- Don't forget, there's all specialists doing pain now. They don't have to use the guide. They set a fee of something else. Yesterday's fee with the nurse and anesthesiologist doing the case was \$1700 for the office, \$450 for a trigger point, which was called a neurolytic trigger point, and that is just an injection under the skin on the point that hurts with a little novacaine -- that's a trigger point or some-- Then they broke-- Then the codes were unbundled, and the company that called me to review it was--

A lot of these insurance companies use other companies to either pay or review, like Allied is used by some insurance companies to pay. They never pay, but they are used by them. Then there's other, like United Review, just reviews claims because the other insurance companies don't know how to handle them, and that's how I get to them. I do all this without ever saying I want to be paid because I learn from it.

ASSEMBLYWOMAN QUIGLEY: What do you think they should do?

DR. MOSS: What do I think they should do? The insurance companies? I think they have to be educated, and that's what I said at the end

of this presentation, if there were some sort of a panel, like this panel, and you have anesthesiologists, you have various people involved in pain specialty, especially the need for the cancer pain-- Maybe with the prestige of this panel, you can approach the major insurers and demand--

ASSEMBLYWOMAN VANDERVALK: We tried that. They didn't show up. (laughter)

DR. MOSS: Oh, I'd keep trying. I'm having a dispute with Medicaid now. We'll probably go to court on that. Medicaid pays us a 1956 fee rate in this state. I've written you about it, but that's a long time ago.

ASSEMBLYWOMAN QUIGLEY: Well, I think the only thing that's worse than seeing resources wasted is seeing resources misdirected, not going to patients--

DR. MOSS: That's right.

ASSEMBLYWOMAN QUIGLEY: --who need them, and, yet, going to pay for fraudulent activities or close to fraudulent.

DR. MOSS: There was a statement made by the author, Dr. Merrill, of the enclosure, and that was the insurance companies react to the excessive billing and they cut back. They cut back on people that are really doing a day's service or -- not a day's work, but a service for a patient. And that's the reaction to those who abuse the system. And that's why I was able to say to my Executive Committee I going to come tonight and I'm going to talk about abuse. And they said, "Absolutely. Absolutely."

Just like they said they're going to talk about self-regulation. All these standards, the anesthesiologists know here, that we put into effect in New Jersey have never been duplicated in the United States, and we forced the

Board and forced the Department of Health to regulate us because we knew that that was the safe way to go. And through it, we got all the mandatory and monitoring equipment. We got all the machines that were denied us by hospital administrators. We found machines in this state that were made in 1950 being used in good hospitals in the state. When that law was passed in 1989 and now with the office standards, if those machines aren't replaced in six months, those offices will be closed and there will be a penalty by the Board.

New York is duplicating these regulations. Rhode Island is duplicating them. Massachusetts is duplicating them, and New Jersey has become a leader in all three fields.

ASSEMBLYWOMAN QUIGLEY: You and your board should be commended for that.

DR. MOSS: But now we doing this because I do see a lot of abuses. And as someone who practiced pain from the very beginning, I think that-- I trained in '57 and started pain-- There were times I was-- In the '70s and '60s, I was seeing eight and ten pain patients a day. I didn't even know I had a clinic. I mean, I didn't know. They were just coming and I was seeing. There was no-- The medical school didn't have a pain clinic in Newark. But I wasn't smart enough to realize it was a business, and it is a business.

With due respect to Morristown -- I heard the excellent presentation. You look in the anesthesiology journal and you'll see jobs available, pain specialists, pain specialists, pain specialists. The hospitals see this as-- It's needed. There's no question that it's needed, but I look at it -- it's needed for the type of patient like Mrs. Miner's husband and cancer pain. I'm

not saying you shouldn't give relief to back pain, but I'm saying that's where the abuses are right now. Because there are a lot of people doing them that are not specialists, at least in anesthesiology. I'm not pushing it. It's not an issue of scope or practice because anybody can do it. In New Jersey, it's a plenary license. If an orthopedic surgeon wants to do it -- and there's plenty to do it.

I once checked with Medicare because I'm on the CA Committee of Medicare, Carrier Advisory Committee. I couldn't believe some of the fees. They did a study in the United States. More orthopedic men do blocks than anesthesiologists at that particular point of time. So there are other specialists doing them. But at least our specialty under the American boards has a certificate in pain. About -- what is it? -- 10 or 15 years ago you used to be able to write a check and get a certificate. Remember? What was the name of that?

DR. ASHENDORF: Dr. Moss, I might add that beginning in the year 2000 there's going to be a cojoint, subcertification, which is going to be offered through the Board of anesthesiology, neurology, and physical medicine and rehabilitation, and that exam will be administered jointly--

DR. MOSS: Good. Good. There has to be.

DR. ASHENDORF: --and certification issued in each of those specialties.

DR. MOSS: That will clean house.

Now I'll tell you why I quit. Because I'm not qualified anymore. When I took care of patients at the very end of '97, I realized I could only offer them what I learned in previous years. And all of the pain is different today. A good pain specialist doesn't necessarily do blocks. Because I've heard the use

of drugs and the proper drugs and other psychopharmacological drugs and all the combinations that you have. I didn't have that training, and I thought, I'm inadequate. Even with 15,000, I just stopped doing it, left it to the younger people who are coming out of good residencies. And there's a lot of residencies. There's great pain specialists in this state, but there's also a lot of people who shouldn't be doing it.

ASSEMBLYWOMAN VANDERVALK: Yes.

DR. GOLDBERG: But in part you know you've created-- I sort of look at it as if you go to Midas, you get a muffler.

DR. MOSS: Yes.

DR. GOLDBERG: You have a shtick. You have a procedure. (laughter) The whole anesthesia community in terms of pain management is geared around procedural issues. And you just said it.

DR. MOSS: Yes.

DR. GOLDBERG: And that is that the key is that there's a lot of medical pain management--

DR. MOSS: That's right.

DR. GOLDBERG: --that's not being done and as you hear.

DR. MOSS: No. But good residents coming out of-- Anesthesiologists coming out of -- and I know them -- are coming-- Although they have procedures, also treat with drugs or don't do the blocks, the younger ones.

DR. GOLDBERG: I would hope so. But the problem is, is that when it comes down to how much you get reimbursed for sitting down and discussing medical pain management and its side effects and the supportive

care that's required versus doing a block, it's a big difference in terms of reimbursement and in terms of what you've come into this from as an anesthesiologist. Although I'm not painting everybody with the same brush, you come at it from a very particular point of view.

DR. MOSS: That's right. That's where it all started from.

DR. GOLDBERG: Right. And I have no problem with that, but now the world, as you said, has turned. There's a much more availability in terms of medical management, and yet, that is a slice that is undereducated, underreimbursed, and underused.

DR. MOSS: Absolutely. I agree with you.

DR. GOLDBERG: So the question is, how do you see anesthesiologists address -- because they're still in the forefront of pain management in this country.

DR. MOSS: Well, don't forget that the fact, though, pain -- the reason pain management wasn't included in the office regulations, because I sat on the committee from the beginning, was that when I said pain management, there were people on that Board, multispecialty board, that thought I meant that when you come in with a headache you get two aspirins. That's pain management. Where if I give a shot of Demarol in the office, you mean to tell me I have to be certified and have to have all this equipment, so they threw pain management out, not understanding pain management. There's a big, wide spectrum. There's the pain management of the two aspirins for a headache, and there's the cancer pain management, the radical pain management, the neurolysis, the neuro-- When I started, they did rhizotomies. They would surgically cut nerves. And now an anesthesiologist can do that

without an operation. There's pumps-- I mean, there's a tremendous, wide spectrum.

I'm looking at the fact that you're right. The ones I'm talking about, where the abuses are, are really oriented towards the procedure. Somebody walks in off the street, and they have a block. I think that there's more to pain management than just the block. I think that those who are in pain--

You have a center and you have a center. Am I right or wrong? I mean you're the pain specialists.

DR. CORDA: I think you would agree that some of the problem with regulating the pain management just as you're getting it is that there is not enough outcome studies. And that's where it gets abused because what happens is, right now, there's no studies to say that after four epidurals, after three epidurals, and they don't work that -- try some other thing or try some other modality. There's nothing else where somebody can come on and do sixteen epidurals or do 160 trigger-point injections because you're really actually on the forefront of a new specialty that has new technology and new things that have not really been shown in outcome studies so that you can set up as standard. So it's kind of like a free-for-all, and that's when you get the abuses in there, because it's very hard to regulate for any regulatory agency or specialty to come in and to say, "Listen, this is the standard of care. This is what we know. This is not enough outcome studies."

And that's why I think that the ASA and a lot of other subspecialties are rushing to get outcome studies because there's no way you can regulate it. It's very hard to regulate it at this point in time. Now, as we

know, anytime you practice there's an area of judgment, but the area is too broad right now because there's not enough outcome studies to really show a standard.

DR. MOSS: The thing is that the word neurolytic to me means one thing, and I can't see 12 neurolytic blocks. I mean, done a week apart, if it's a neurolytic block. I've looked at some of these charts, and they'll say 1 cc of hypertonic saline, not 10, 1 cc hypertonic saline. There's a lot going on.

And then I see, of course, the use of a second person. That's a problem. And the insurance, Medicare-- I'm on the CA Committee. Medicare recognizes that. That's hurting us. The reaction is that it's one of the reasons why MAC, monitored anesthesia care, is being attacked by Medicare across the country because all of a sudden there's been a tremendous need for it. And that is because every pain specialist -- there are a lot of pain specialists -- for every block has someone give an anesthetic, which is another 600 simoleons and has been increasing the cost of pain. I never charged in my life 15,000. I used sedation. I used a little Valium or sedation, or if I had a nurse/anesthetist on the other side of the table, there was never any charge. But that's not what's happening now. It's become a big business, and that's what I'm here about.

DR. CORDA: Right. And part of the problem, also, is that the CPT codes are really not made for pain management. They're either made for surgery or anesthesia.

DR. MOSS: Or their surgical codes.

DR. CORDA: But they're really not developed for pain management so that's where you get this conflict or overlap where people are

trying to bill. Even when they try to bill appropriately, it doesn't fit in either way, so they swing it one way or the other.

DR. MOSS: My purpose was to call attention to the committee (*sic*) that that was a phase of pain management that does exist out there. I gave you some examples.

I have another one I forgot to-- How about bubbling peroxide through the veins.

ASSEMBLYWOMAN QUIGLEY: Sounds nasty.

DR. MOSS: We have someone who takes about 5 percent peroxide they buy in the drug store, puts in an IV, and the patient's lying in his office, and they put 500 cc's of a solution of peroxide because the peroxide will go to all the different cells in the body and stop the pain.

DR. ASHENDORF: Dr. Moss?

DR. MOSS: Yes.

DR. ASHENDORF: What kind of self-policing, regulatory steps do you think we can offer regulators in an attempt to self-police--

DR. MOSS: I shouldn't--

DR. ASHENDORF: --given the uncertainties and the lack of outcome studies at this point? What can we offer them?

DR. MOSS: I used to rely on the Board because there was a time when the Board would take a complaint directly from an insurance company. If I saw something really bad, I'd say, you know what, send it down here, and I'd give them the address. The problem is like this nurse who has a pain clinic up in North Jersey -- that's been on the books now, as of yesterday, almost two and a half years.

DR. ASHENDORF: I mean proactively, not in the disciplinary sense, in terms of offering guidelines--

DR. MOSS: I have no--

DR. ASHENDORF: --in an area that has a lack of evidence-based medicine.

DR. MOSS: I think--

DR. ASHENDORF: As we've recently seen with motor vehicle auto insurance reform, in the absence of such regulations, someone has done that for us actually.

DR. MOSS: That's right.

DR. ASHENDORF: Now, if you were to be a little more proactive, what would the position of the New Jersey State Society of Anesthesiologists be towards guidelines in the use of these procedures?

DR. MOSS: I've had experience with that. We set guidelines for epidural anesthesia, for obstetrics, which is highly abused, it has nothing to do with pain management, except for women in labor. That's pain. We're the only state that did. It was just reversed in Orlando last week. They didn't accept it. We said, "You get paid for what you do." You put in the epidural. It takes a half hour. That's seven units, that's it. No way can it add up to \$2000 or \$3000 or \$4000, which I'm seeing, which sometimes goes above the fee of the obstetrician. But when I called up a hospital to say we feel that we have a guideline for you to bill, they resigned en masse from my Society. So I haven't got discipline-- I have enough guts coming here tonight. I haven't got the disciplinary--

DR. ASHENDORF: Aside from the billing issues, though, sir, the utilization of the procedures themselves is what I'm-- I think they're both valid issues, one is billing. I think that's separate and distinct.

DR. MOSS: The other thing that I'm hopeful of is that the ASA, which is our-- We're a component Society. In two documents coming out of Orlando last week has addressed the issue, one on abuse and one on what they recommend to be an outcome study. A lot of times when I look at these charts, like I reviewed those \$60,000, no where did it say patient approved between cases. They did a block and there was some method of knowing what happened. There was nothing. It was just do the blocks. No evidence. The only way to do it would be for someone-- I used to get the cases on the Board, then I'd be protected. If the Board would send it to me, I would have the protection of writing as a consultant to the Board and be protected, and nobody would sue me. I would look at these and be able to say it. We have several people in the Anesthesiologists Society who handle complaints like that.

DR. ASHENDORF: Again I'm more interested in the proactive rather than the reactive disciplinary. Thank you.

DR. MOSS: Do you know what? I think if everybody had ethics, if all these people had integrity, and they're not just anesthesiologists-- They know what they're doing.

DR. ASHENDORF: I disagree. I think that within the realm of well-intention medicine, I think there is a lot of misadventure, which is done in the best of intentions and done in the absence of outcome studies and guidelines.

ASSEMBLYWOMAN VANDERVALK: Yes.

DR. KRAUSER: I just want to add one other problem. As a primary care physician, even though you don't accept referrals from primary care physicians, a lot of HMOs have only one pain specialist on their whole network for a broad area. And if that person happens to be an anesthesiologist who specializes in the Bronx, we're left without any alternative in terms of pain treatment, and for me that's a big problem because it's kind of (indiscernible).

ASSEMBLYWOMAN VANDERVALK: That's a good point.

Thank you very much, Doctor.

DR. MOSS: Thank you.

ASSEMBLYWOMAN VANDERVALK: Is there anyone else in the room-- That's all we had signed up in advance for the hearing tonight, but is there anyone else here who would like to add anything before we close? (no response)

All right. Thank you very much.

If the members of the panel of the Commission could stay for a few moments, I think we have some discussions before we break. Thank you.

(HEARING CONCLUDED)