USC
SCHOOL OF
MEDICINE

Nov. 11, 1996

Ronald Kaufman, MD
Medical Director, LAC+USC
GH- Rm 1110

Re: Ms. RR, breast cancer patient with inadequate palliative care.

Department of
Medicine

General Internal
Medicine

Dear Dr. Kaufman,

Ms. RR. was found to have unresectable left breast cancer in April 1996 on fine needle biopsy. Medical oncology followed her in outpatient clinic and gave a course of chemotherapy in August 1996. The patient declined further chemotherapy. From October 26-29, 1996, the patient was hospitalized at LAC+USC Medical Center for severe headache. CT scan showed possible metastases in the base of the brain. Morphine SR, hydromorphone and tylenol #3 were all used for the pain. None was completely satisfactory, but the patient chose tylenol #3 to take home. She feared that taking morphine would shorten her life and preclude a miracle healing. During that hospitalization and before, no a DNR status was not determined. On discharge the regular medical-surgical VNA service rather than the hospice VNA program was requested.

On November 7, 1996, the family brought Ms. RR. the LAC+USC Emergency Room for readmission because of further deterioration, including inability to walk, eat, drink and talk. The patient had facial grimacing on any movement, particularly with movement of her neck. Lumbar puncture revealed a pleocytosis and malignant cells indicative of carcinomatous meningitis. About 10 family members attended a family conference on the morning after admission. I discussed Ms. RR's diagnosis, prognosis and the urgent need to control her pain. All the family agreed to a DNR status. All but Adjoa, a daughter, agreed to instituting morphine as needed to control pain. Liquid tylenol #3 was considered initially, but was not given because of the patient's inability to swallow. One milligram or hydromorphone IV were associated with dystonic eye movements which resolved with benadryl. I sent family members to an outside pharmacy to purchase a Duragesic Patch 25 micrograms (the LAC+USC pharmacy no longer carries Duragesic) to give a continuous opioid dose. I ordered morphine 4mg IV Q1H prn for breakthrough pain. On Nov. 9, 1996 the pain was not controlled after the patch had been on for 15 hours. The daughter still objected to morphine being given for breakthrough pain. We kept the patient another day to manage pain before discharge to home hospice followup. Pain was well controlled from later on Nov. 9 until the patient died in hospital at 12:15 pm on Nov. 10, 1996. The patient's daughter was distraught and hysterical, screaming in the halls of the ward. The remainder of the family were prepared and coped with their grieving fairly well.

The lack of a pain and palliative care team to manage Ms. RR's terminal illness led to poor pain control, lack of VNA hospice support for the patient and her family and two unnecessary admissions to LAC+USC Medical Center at taxpayer's expense.

University of
Southern California
1200 North State Street
GNH 8435
Los Angeles,
California 90033
Tel: 213 226 6571
Fax: 213 226 2718

Also the students, houseofficers, fellows, nurses involved in her care before the Nov. 7, 1996 admission did not have the opportunity to witness the appropriate palliative care of this patient. If pain and palliative care consultation was available and called 3-6 months earlier, the patient and her daughter would have had a much better chance of coming to terms with the disease.

I understand how desperately the department chiefs and administrators are trying to maintain the highest possible census at this hospital, however, it will not serve our long-term goals to do so at the expense of patients like Ms. RR.

Sincerely,

David Cundiff, MD
General Internal Medicine

cc: Shirley Shot Nomoto, RN, Quality Assurance Committee
Mark Finucane, Director