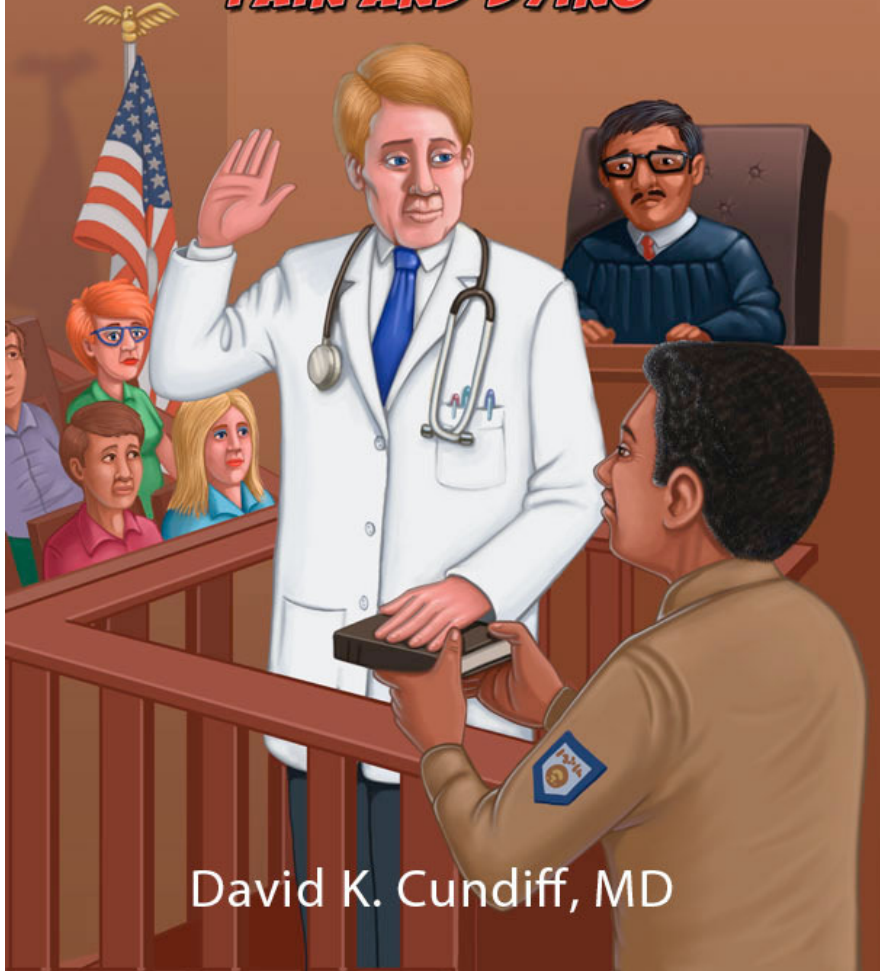


WHISTLEBLOWER DOCTOR
THE POLITICS & ECONOMICS
OF
PAIN AND DYING



David K. Cundiff, MD

Whistleblower Doctor

**The Politics and Economics
Of Pain and Dying**

by

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Executive Summary

A one-month experience working in three hospices in England convinced me to focus my medical career on alleviating pain and suffering of terminally ill cancer patients. After finishing my fellowship training in hematology and medical oncology (cancer) at the UC San Diego Medical Center, I resolved to find a way of integrating hospice principles and philosophy with my practice of cancer medicine.

I worked at the LA County Department of Health Services (LAC-DHS) from 1979-1998, including nine years of directing the Pain and Palliative Care Service at the LA County+USC Medical Center (LAC+USC Medical Center). By the early 1990s, the Pain and Palliative Care Service became very popular with the patients, residents, nurses, social workers, and other caregivers. Overworked residents and nurses saw that we alleviated pain of their patients while reducing work for the hospital caregivers' and allowing patients to be comfortably at home. We provided their patients with outpatient hospice follow-up and 24 hour – 7 day phone availability that prevented many readmissions for uncontrolled symptoms. In addition, we educated the doctors and nurses in pain management and palliative care techniques.

Unfortunately for the financial bottom line of the hospital, the better the Service controlled pain and distressing symptoms the more the hospital lost. Our success in controlling pain and providing comfort to over 400 terminally ill patients led to an estimated 4,000 fewer reimbursable inpatient days in 1994, saving the taxpayer over \$9 million in Medi-Cal spending. However, LAC-DHS management did not appreciate the savings to taxpayers by the Service, since our efficient and effective outpatient care reduced the Medical Center's revenue by the same \$9 million.

By the time that cancer and AIDS patients reached the end stages of their diseases, they almost all had Medi-Cal insurance. Consequently, prolonged hospitalizations for terminally ill cancer and AIDS patients served as a “cash cow” for the LAC+USC Medical Center. This population comprised less than 1% of patients treated but yielded as much as 15% of the \$700 million Medical Center Medi-Cal revenue. Since Medi-Cal paid a high all inclusive

daily fee for acute hospital care and little for outpatient treatment, the LAC+USC Medical Center needed a high inpatient census to maximize revenue. For all six hospitals of the LA County Department of Health Services, state-of-the-art pain management and palliative care for all terminally ill cancer and AIDS patients as practiced by our service would have reduced federal and state MediCal reimbursement by about \$250 million per year. This discouraged appropriate outpatient pain management and palliative care for cancer and AIDS patients.

As the Pain and Palliative Care Service had an increasingly adverse effect on inpatient census, management became more and more hostile to me. They reassigned me to additional full-time duties, took away two federal grants for improving the evaluation and treatment of pain, did not permit me to apply for other outside funds to improve pain management, and refused to allocate resources in keeping with the volume of work.

Financial Crisis Hits LA County – Department of Health Services

In the summer of 1995, the LAC-DHS faced the largest budget shortfall in its history – \$655 million deficit out of an operating budget of \$2.3 billion. To resolve the budget crisis, the Los Angeles County Chief Administrative Officer's proposed budget to the Board of Supervisors for 1995-96 included the closure of the LAC+USC Medical Center. After all of the politicians and County Administrators completed their negotiations over the crisis, the LAC+USC Medical Center was saved, but employees and services of the LAC-DHS were downsized by nearly 15%. Under the cover of this crisis, the LAC-USC Medical Center management closed the Pain and Palliative Care Service and transferred me to attending in internal medicine inpatient wards and outpatient clinics.

In conjunction with the LAC-DHS downsizing of personnel and services in September 1995, management negotiated a \$1.2 billion five-year Health Department bailout from President Clinton to save the LA County Government from threatened bankruptcy. The strings attached to the bailout included reengineering the LAC-DHS to shift considerable resources from inpatient care to out-of-hospital services. I rejoiced that, finally, financial sanity would

come to the LAC-DHS and that pain management and palliative care would have to be recognized as a necessary component to comprehensive care, requiring significant resources.

Inexplicably, the federal Medicaid bureaucracy increased rather than decreased our inpatient reimbursement rate and did not increase funding for outpatient services. I had hoped for a comprehensive change in the system of funding the LAC-DHS to per patient (capitated) reimbursement or another system that encouraged outpatient care. Paradoxically, complying with the conditions of the federal bailout by shifting resources from inpatient to outpatient care would have severely reduced revenues to the LAC-DHS. Consequently, resources were never shifted.

Challenging the LA County+USC Medical Center \$900 Million Replacement Project

After averting the Medical Center closure by receiving the federal bailout in 1995 and securing an outrageous daily fee rate for Medi-Cal inpatients, LAC-DHS management next set its sights on replacing the aging Medical Center with as large a hospital as possible. The more beds in the new hospital the more of the 8,300 LAC+USC Medical Center employees would salvage their jobs. This increased ongoing census raising strategies that precluded an effective pain and palliative care service designed to help terminally ill patients remain comfortably at home rather than in inpatient beds.

Policies and procedures throughout the Medical Center encouraged unnecessary hospitalizations and encouraged more days in hospital than needed for those admitted appropriately. Major deficiencies in primary care services in affiliated clinics and comprehensive health care centers paid off financially with more emergency admissions to the hospital. As had long been the case at LAC-DHS hospitals, admitted patients could wait days or weeks for surgery, diagnostic studies, or specialty medical procedures. Nearly everyone believed that the long waits were due to underfunding of the LAC-DHS. While the LAC-DHS was indeed underfunded relative to any contemporary standard, the LAC-DHS depended on long waits of Medi-Cal patients to increase revenue. Inefficiency paid better than efficiency.

In a highly contentious meeting in November 1997, the LA County Board of Supervisors approved a 600-bed replacement hospital instead of the management-supported proposal of 750 beds. This meant that up to 4,000 jobs would be lost at the Medical Center.

Later that month I published an editorial in the LA Times, advocating that the LAC-DHS lease acute care hospital beds from private hospitals or buy existing hospitals instead of spending \$900 million on a replacement hospital. Since LA County had 20,000 acute-care licensed beds of which only 10,000 were filled in an average day, I argued that a replacement hospital of any size would waste taxpayers' money. Instead, I recommended immediately switching to per patient (capitated) reimbursement from Medi-Cal, reorganizing the LAC-DHS as a health maintenance organization and leasing or buying the necessary acute-care beds from the private sector. Then, we could effectively compete with the rest of the LA community health care providers by making efficient use of hospital beds and shifting more resources to out-of-hospital care, like hospice. With capitated reimbursement, we would no longer be financially dependent on institutionalized inefficiency and waste fueled by the dysfunctional funding system.

Management responded to my editorial with resounding silence. No one issued a verbal or written rebuttal; despite the fact that I claimed that the Health Department fostered dysfunctional policies and procedures that purposefully raised the census solely to increase reimbursement.

In February 1998, I audited my inpatient medical service, carefully documenting the unnecessary patient days in hospital. Applying my findings to the census figures of the LAC+USC Medical Center, I calculated that the average inpatient census should have been about 480 patients rather the actual 860 (i.e., 44% of days were unnecessary). In March 1998, I sent the results of this audit and my suggestions for re-engineering the LAC-DHS to the federal and California State Medicaid offices and to 11 legislators. Only the California State Medicaid office even replied to the conclusion from my audit that the Medical Center was defrauding Medi-Cal out of over \$200 million per year by institutionalized inefficiencies. Chief among these strategies to raise the inpatient census was inadequate

pain management and palliative care services, accounting for 28% of the unnecessary inpatient days in my audit.

Complaints about Poor Treatment of 83 Patients

After the Pain and Palliative Care Service closed in September 1995, I assumed full-time duties as an attending physician on the general medicine wards and in the outpatient clinics. In those roles, I found numerous instances of poor pain and symptom management of cancer and AIDS patients. Over five years, I wrote to the LAC+USC Quality Assurance Committee about 83 patients mostly concerning specific cases of poor pain management. I also formally submitted these cases as patient care complaints to the Medical Board of California. The QA Committee did not acknowledge receipt of the complaints. The Medical Board responded that the patient and/or patient's family would have to submit the complaint rather than a physician who was aware of the substandard care. Unfortunately, all the patients were dead and I had no access to the charts at that point to contact the families.

Fired and Medical License Revoked

Four days after I sent the results of my inpatient service audit to Medicaid administrators and legislators my supervisor placed me on paid administrative leave. Seven months later management fired me supposedly for my clinical decision (a judgment call) to stop the drug warfarin (trade name Coumadin – a blood thinner) in an alcoholic patient with a leg thrombus (deep venous thrombosis). The patient later died of thromboses migrating to his lung. Although I had no previous malpractice judgments or disciplinary actions in 25 years of practice, I later lost my medical license over the same case.

I defended my judgment to stop the Coumadin in my patient by pointing out that Coumadin is contraindicated in alcoholic patients because of the bleeding risk. My medical resident diagnosed alcoholism by documenting in the chart that the patient reported drinking a six-pack of beer per day for 20 years. Neither the prosecuting attorney nor the judge disputed that alcoholism is a contraindication for using Coumadin for deep venous thrombosis.

Consequently, the decision in the case hung on whether the patient was an alcoholic.

The prosecuting attorney responded by bringing the patient's daughter to the stand to testify about her account of the events of her father's illness. Since she was a substance abuse counselor, the Deputy Attorney General and judge also considered her as a quasi expert witness. The daughter said that her father did not drink cans of beer but quart bottles of Colt-45 Malt Liquor—not more than two quarts of malt liquor per day on weekends. She testified that she had never seen her father drunk and that he was not an alcoholic. The Deputy Attorney General brought no other substance abuse expert witness to challenge the diagnosis of alcoholism documented in the chart by my medical resident who, under cross examination, stood firmly by the accuracy of her medical history.

The patient's daughter subsequently brought a wrongful death civil suit against me and LA County which the County settled over my objections for \$175,000. In a deposition of the daughter before the settlement, my attorney showed her a 40-ounce magnum of Colt-45 Malt Liquor, asking if this was her father's preferred drink. After she said it was, she acknowledged her error in calling it a quart (32 ounces) in the medical hearing. Two magnums of malt liquor are equivalent in alcohol to 8 1/3 12 ounce cans of beer. Only an alcoholic with a high tolerance could consume this much in a day and not appear drunk.

I lost in a Civil Service Hearing, in a California State Medical Board hearing, and in a California Superior Court appeal. Referring to the daughter's testimony, Administrative Law Judge H. Stuart Waxman wrote in his decision to revoke my medical license, "... (the patient) drank less than two quarts of malt liquor per day on weekends. (The evidence did not disclose his drinking customs during his workweek.)" Rejecting my defense that it would have been malpractice for me to continue the Coumadin in an alcoholic, Judge Waxman ruled that I should have continued the Coumadin.

He would not allow into evidence the results of a survey of internists and anticoagulation experts done by my expert witness, Dr. Matthew Conolly UCLA Professor of Medicine, and me that showed a remarkable variation of medical opinion about the best management of the case. After hearing my testimony on the lack of scientific evidence supporting anticoagulant treatment of deep

venous thrombosis, Judge Waxman asked me if I was treating another patient with identical circumstances, I would again stop the Coumadin. I said, “Yes.”

In his decision on my case, Judge Waxman wrote, “...Respondent is now even more convinced than he was in 1998 that he made the correct decision in discontinuing the anticoagulant medication he had been approving for BR, and he made it very clear at the administrative hearing that, if faced with the same situation today, he would make the exact same decision. Respondent is entitled to that opinion. However, he is not entitled to foist that opinion on an unsuspecting public, more that 2,000,000 of whom suffer DVT annually. Those popliteal DVT patients who may be treated by Respondent in the future are now at even greater risk of pulmonary embolism than before because of Respondent’s ongoing belief that the standard treatment for the condition, accepted by vast majority of the medical profession, is nothing more than “dogma.” No probationary order can adequately address and prevent that risk to the public. That risk to the public is too great to permit Respondent’s continued practice of medicine.”

Discovering that Anticoagulation Increases Deaths Overall

This case led me to research the evidence basis for Coumadin and other anticoagulants for thromboses in the legs and lungs (deep venous thromboses and pulmonary emboli). To my great surprise, I found all the published studies supporting anticoagulants for thromboses in the legs and lungs to be flawed. In court, my expert witness Dr. Conolly and I testified about a particular randomized controlled clinical trial comparing standard anticoagulants (heparin and Coumadin) to phenylbutazone (an anti-inflammatory drug). The prosecuting attorney objected to us entering the trial into evidence, arguing that, in malpractice proceeding, you cannot have expert witnesses debate the evidence-basis of a medical test or treatment. He said that all that matters is the prevailing opinion of the medical establishment as expressed by opinion leaders. The judge sustained the objection.

I have subsequently published a number of articles in *Medscape Journal of Medicine*, showing that anticoagulants are not evidence-based to reduce mortality for deep venous thrombosis. I

found that 28 other medical indications for anticoagulants to be likewise based on scientific errors and biases of drug company funded investigators. None of these challenges to “standard” anticoagulant treatment has been rebutted by any anticoagulation expert in academia or government.

Worldwide, about 100,000 people bleed to death from anticoagulants each year. Tens of thousands more die of ‘rebound hypercoagulation’ after the discontinuation of anticoagulants. My research strongly suggested that my patients did not die a week after I stopped heparin and Coumadin because of the lack of anticoagulants but rather because of rebound hypercoagulation.

Conclusion

By relating my 19-year saga in the LAC-DHS, I hope to focus attention on three issues that are much more important than my case.

My termination indirectly resulted from perverse financial incentives that increased pain and suffering and impaired training of health care providers in pain management, compounding the other barriers to effective and compassionate palliative care of the dying. A wide-based restructuring of the LAC-DHS is needed to stop the powerful economic and political disincentives to good care. One aspect of that restructuring would be to give the LAC-DHS the same kind of capitated reimbursement for indigent patients that it currently gives to contracted HMO providers for Medicaid patients. The best form of capitated reimbursement for health care in the LAC-DHS is not typical bureaucracy intensive HMO treatment. Instead, I recommend “Physician Managed Care” (<http://doctormanagedcare.com/PMC/Book.pdf>).

Secondly, anticoagulation of people for clots in the legs and/or lungs is ineffective in reducing deaths from clots. It costs tens of billions of dollars in the USA alone. Drug company financial clout has exerted its influence on academic researchers, medical journal editors, government regulators, and the medical media to foster this practice.

Finally, anticoagulation is one of many standard medical treatments that is not evidence-based to work or is evidence-based not to work. In the United States, we will never be able to control

medical costs and provide universal access to quality medical care until we stop paying for test and treatments that don't work (doctormanagedcare.com/chaptersMDM.pdf).

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