Inadequate Pain Management:  
A New Tort for Hawai‘i?

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I. INTRODUCTION

Lester Tomlinson was diagnosed with an extremely painful and incurable form of lung cancer.¹ To ensure that his last days would be free from pain and met with dignity, he executed an advance directive requesting that pain medication be administered, even if it hastened his death.² Despite these instructions, Tomlinson spent the last twenty days of his life in “unremitting agony.”³

On January 18, 2001, Tomlinson entered Mt. Diablo Hospital complaining of shortness of breath and chest pain.⁴ An initial assessment indicated continuous pain in his back, shoulder, and lungs.⁵ At times the pain reached an intensity of level 10, which on a scale of 1 to 10 meant the worst pain imaginable.⁶ Hospital protocol required pain assessment at least every four hours, and the facility’s pain standard goal was level 3 or less.⁷ Nonetheless, Tomlinson continuously reported pain ranging from levels 3 to 9.⁸ Records also indicated that Tomlinson lost his glasses in the emergency room and had hearing difficulties, which severely impaired his ability to understand and communicate.⁹ Throughout the six days

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³ Id.

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Id.

⁸ Id.

⁹ Id.
Tomlinson remained hospitalized, nurses failed to notify the hospital physician about his continuous pain spikes.\(^{10}\) When Tomlinson was moved to a skilled nursing facility, the physician’s transfer order contained no pain medication, despite the fact that he had required the pain medication Vicodin daily.\(^{11}\)

An initial assessment of Tomlinson upon admittance into Bayberry Care Center showed pain at levels 6 to 7.\(^{12}\) It also noted that medication effectively relieved the pain.\(^{13}\) In this type of situation, facility procedure required use of a Pain Flow Sheet, which provided for treatment, evaluation, and assessment of the pain, and for continuing care to ensure the patient’s comfort.\(^{14}\) No sheet was initiated, however, and he suffered from uncontrolled pain for three days.\(^{15}\) Tomlinson finally received Vicodin on his fourth day at Bayberry, but only after his daughter Ginger called the assigned physician to report that he was in pain, had no medication, and had become increasingly confused.\(^{16}\) No follow-up assessment was made to determine the effectiveness of the medication.\(^{17}\) When Vicodin failed to relieve Tomlinson’s pain, nurses’ reports indicated that he was “yelling all night” and “screaming in pain.”\(^{18}\) According to Ginger, she once found her father “moaning and crying . . . and asking to

\(^{10}\) Id.

\(^{11}\) Id. Vicodin (manufactured by Abbot) is a prescription drug containing hydrocodone bitartrate (opioid analgesic) and acetaminophen (non-opiate), used to treat moderate to moderately severe pain. PHYSICIANS’ DESK REFERENCE 525 (Thomson PDR, 58th ed. 2004).

\(^{12}\) PIs.’ Mediation Br., Tomlinson (No. C 02-00120).

\(^{13}\) Id.

\(^{14}\) Id.

\(^{15}\) Id.

\(^{16}\) Id. Upon transfer to the nursing facility, Tomlinson was assigned a new physician, Dr. Eugene Whitney. Id. Dr. Whitney’s practice involved making regularly scheduled rounds to various nursing homes, to see patients whose primary physicians would not treat them while in the homes. Id.

\(^{17}\) Id.

\(^{18}\) Id.
die.” She even bought earplugs for her father’s roommate, after he was unable to sleep four nights in a row due to the moaning and crying.

After researching other available pain medications, Ginger requested a prescription for a fentanyl patch. Again, Dr. Whitney prescribed the requested medication, but did not conduct a follow-up assessment. When the patch proved ineffective, Tomlinson’s wife Rosa requested a prescription for a low dose of morphine sulfate to be administered around-the-clock. As was the pattern now, the medication was prescribed but no follow-up assessment was made. Throughout Tomlinson’s stay, Dr. Whitney examined the patient on only one occasion, sixteen days after admittance.

On the twentieth day, Ginger sent a fax to Dr. Whitney informing him that her father had been in pain throughout his stay at the center, and

19 Id.
20 Id.
21 Id. Drugs classified as “opioids” are commonly used to treat moderate to severe pain, including cancer pain and chronic noncancer pain. NAT’L PHARM. COUNCIL, INC., PAIN: CURRENT UNDERSTANDING OF ASSESSMENT, MANAGEMENT, AND TREATMENTS at 38 (Dec. 2001) (citation omitted). Opioids are used when pain does not respond to “nonopioids” such as acetaminophen or nonsteroidal anti-inflammatory drugs. Id. at 33-38 (citations omitted). Opioids can also be combined with nonopioid analgesics, allowing for use of lower doses. Id. at 38. Fentanyl, also sold under the trade name Duragesic (manufactured by Janssen), is a strong opioid analgesic used to treat chronic pain that cannot be effectively relieved by lesser means such as acetaminophen-opioid combinations. PHYSICIANS’ DESK REFERENCE, supra note 11, at 1751.
22 Pls.’ Mediation Br., Tomlinson (No. C 02-00120).
23 Id. Because responses to specific opioids and dosages will differ among individuals, various opioids should be tried until pain is effectively relieved. NAT’L PHARM. COUNCIL, INC., supra note 21, at 38 (citation omitted). Morphine sulfate is a potent opioid analgesic, used to treat moderate to severe pain. PHYSICIAN’S DESK REFERENCE, supra note 11, at 2841. Respiratory depression is a chief danger of using morphine, and it is recommended for use only when deemed essential. Id.
24 See Pls.’ Mediation Br., Tomlinson (No. C 02-00120).
25 Id.
asking whether he should be hospitalized. Ginger never received a response. Lester Tomlinson died later that day.

Although Lester Tomlinson’s experience took place in a California nursing home, inadequate treatment of chronic pain is a recognized problem nationwide. Studies show that those most at risk of inadequate treatment are frail elderly nursing home residents—individuals aged 65 or over. A major factor contributing to this risk is the inability of nursing home residents to personally assert the right to adequate pain relief, stemming largely from the absence of a clear standard of care for pain management. As a result, health care providers have not been held accountable for their actions. However, a legal theory emerging from California has now established a standard of care for pain management, making the prevailing practice of undertreatment unacceptable. This Comment posits that under this newly established theory, existing State laws are sufficient to provide Hawai‘i nursing home residents with effective remedies to assert their right to adequate pain treatment and to hold providers liable.

Part II of this Comment gives an overview of the problem of inadequate pain management in the institutional setting, and explains the significance of this problem for the State of Hawai‘i. It briefly examines the State’s progress in the area of pain management and discusses the

\[\text{\textsuperscript{26}}\text{Id.}\]
\[\text{\textsuperscript{27}}\text{Id.}\]
\[\text{\textsuperscript{28}}\text{Id.}\]
\[\text{\textsuperscript{29}}\text{NAT’L PHARM. COUNCIL, INC., supra note 21, at 11. Chronic pain is defined as “pain that extends beyond the period of healing, with levels of identified pathology that often are low and insufficient to explain the presence and/or extent of the pain.” Id. (citation omitted).}\]
difficulties residents traditionally faced in attaining judicial assistance in asserting the right to adequate pain relief. Part III then examines a theory developing in California that provides patients a cause of action for inadequate treatment of pain under the state’s “elder abuse statute.” It also discusses the implications of the new theory, and its effect on medical malpractice law. Part IV explores various ways in which the new theory can be utilized under existing Hawai‘i State laws. Finally, Part V offers recommendations for non-judicial actions that should be taken based on the new theory, to further protect Hawai‘i’s nursing home residents.

II. THE PREVALENCE OF PAIN IN THE INSTITUTIONAL SETTING

Although up to 95 percent of serious pain can effectively be relieved, nearly half of all Americans continue to suffer unnecessarily in the last days of their lives. While attempts to raise awareness regarding undertreated pain began in the early 1970s, serious steps towards improvement have only begun in the last fifteen years. Reasons for the enduring reluctance by health care providers to address the problem include lack of proper pain management training; fear of drug seeking, addiction, and hastened death; and fear of litigation or disciplinary actions for overprescription of controlled narcotics.


33 See Rich, supra note 30, at 8 (citation omitted).

34 See Robyn S. Shapiro, Health Care Providers’ Liability Exposure for Inappropriate Pain Management, 24 J.L. MED. & ETHICS 360, 361 (1996) (discussing Estate of Henry James v. Hillhaven Corp., No. 89 CVS 64 (N.C. Super. Ct. Nov. 20, 1990)). In this case, a North Carolina court found the defendant nursing home liable for improper administration of pain medication. The jury awarded the estate of a cancer patient $15 million in damages. This was the first time a negligence case was based on the inadequate treatment of pain. Id. (citation omitted).

35 Reasons for the reluctance by health care providers to aggressively treat pain have already been discussed in many articles, and is thus, not the topic of this Comment. For an in-depth discussion regarding barriers to effective pain treatment, see Rich, supra note 30, at 39-55.
Although pain affects individuals of all ages, 55 percent of those aged 65 or over report daily pain.\textsuperscript{36} Of particular concern is the undertreatment of pain of elderly nursing home residents, most of whom suffer from chronic illness.\textsuperscript{37} According to researchers of the first national study of pain in nursing homes conducted in 1999, there is “woefully inadequate pain management among a frail, old and vulnerable population of Americans[].”\textsuperscript{38} They found that approximately 40 to 50 percent of nursing home residents nationwide experienced moderate daily pain or excruciating pain on any given day,\textsuperscript{39} with 41.2 percent reporting the same level of pain 60 to 180 days later.\textsuperscript{40}

\textbf{A. Undertreatment of Pain: A Significant Concern for Hawai‘i}

Inadequate pain treatment presents a special concern for Hawai‘i, which is “third in the nation in terms of growth rate of seniors as a proportion of the population.”\textsuperscript{41} From 1970 to 2000, Hawai‘i’s total

\textsuperscript{36} ARTHRITIS FOUND., \textit{supra} note 31.


\textsuperscript{38} Scott J. Turner, \textit{Researchers find pain widespread and severe in nursing homes}, \textit{25 GEORGE STREET J.}, Apr. 27, 2001, available at http://www.brown.edu/Administration/George_Street_Journal/vol25/25GSJ25e.h tml (quoting Vince Mor, director of the Dep’t of Community Health and co-author of the study) (discussing findings of the study conducted by the Brown Medical School).


\textsuperscript{40} Turner, \textit{supra} note 38.

population grew by 57 percent. In comparison, the population of those aged 60 or over grew by 207 percent, those aged 75 or over by 415 percent, and those aged 85 or over by 482 percent. In 2000, 17 percent of the state’s population was aged 60 or over (207,100 individuals), while 1.4 percent was aged 85 years or over (17,564 individuals). It is estimated that between 2000 and 2020, the number of individuals 60 or over will grow by 73 percent, and the number of individuals 85 or over by 116 percent. Hawai‘i’s life expectancy of 79 years remains the highest in the nation. The leading cause of death for Hawai‘i residents 60 or over is chronic illness, including heart disease, cancer, stroke, and chronic lower respiratory disease.

In 2002, there were approximately 2,483 residents in Hawai‘i nursing home facilities, 2,423 of which were age 65 or over. Hawai‘i nursing home residents have consistently ranked as the most dependent in the nation, with 41 percent of those 65 or over having a disability

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43 Id.


45 PLAN, supra note 42, at 5.

46 PROFILE, supra note 44, at 2. The national average age is 75. Id.

47 Id. at 7.


50 HARRINGTON, supra note 48, at 34 (Aug. 2003). From 2000 through 2002, Hawai‘i nursing home residents have ranked highest in the nation for acuity. Id. at 35. The acuity index is based on characteristics such as being bedfast, needing assistance with ambulation or eating, having an indwelling catheter, incontinence, pressures ulcers, bowel or bladder retraining, or requiring special skin care. Id. at 34.
requiring assistance in one or more activities of daily living, and over half of these individuals having at least two disabilities. Fifty-one percent of Hawai‘i nursing home residents were diagnosed with some form of dementia, compared to the national average of 43.6 percent.

According to the 1999 study, 33.3 percent of all Hawai‘i nursing home residents experienced persistent severe pain on any given day. Of residents suffering from cancer, 42.9 percent reported persistent severe pain. Most disturbing, however, was the finding that 64 percent of terminally ill residents experienced persistent severe pain. Clearly, effective pain management for the terminally ill is overdue.

B. Hawai‘i’s Progress in the Area of Pain Management

At first glance, Hawai‘i appears to be ignoring the issue of adequate pain management. A 2002 national report pointed out that up until the end of 2001, only six states—Alaska, Connecticut, Delaware, Illinois, Indiana, and Hawai‘i—had no official pain policy. In a national progress report on policies relating to pain management in effect as of

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51 This is defined as having one or more of the following disabilities: sensory, physical, mental, self-care, go-outside-the-home-alone. PROFILE, supra note 44, at 6.

52 Id.

53 See HARRINGTON, supra note 48, at 43.

54 Ctr. for Gerontology & Health Care Research at the Brown Univ. Medical School, Facts on Dying: Policy relevant data on care at the end of life, Hawaii State Profile, at http://www.chcr.brown.edu/dying/hiprofile.htm (site last edited May 20, 2004) [hereinafter Hawaii State Profile]. Persistent severe pain is defined as pain reported by a resident upon initial assessment, which worsened or remained severe 60 to 180 days later. Ctr. for Gerontology & Health Care Research at the Brown Univ. Medical School, Facts on Dying: Policy relevant data on care at the end of life, About This Research, at http://www.chcr.brown.edu/dying/ABOUTTHISRESEARCH.HTM (site last edited May 18, 2004).

55 HAWAII STATE PROFILE, supra note 54.

56 Id.

March 2003, Hawai‘i earned a grade of D+, up from a D earned in 2000.\textsuperscript{58} Between 1995 and 2003, Hawai‘i consistently ranked among the bottom fifteen states in the nation for lowest annual rate of serious disciplinary actions by state medical boards.\textsuperscript{59}

On July 9, 2004, however, the Hawai‘i State Legislature enacted a Pain Patient’s Bill of Rights.\textsuperscript{60} The act not only recognizes the right of patients suffering from severe acute or chronic pain to receive aggressive pain treatment (including the justified use of opiates), but also allows physicians to prescribe opiates when it is deemed medically necessary.\textsuperscript{61} Thus, as of July 1, 2004, Hawai‘i residents have a statutory right to request aggressive pain treatment.

Several other significant achievements in the area of pain management merit recognition. In 1999, Hawai‘i’s Tripler Army Medical Center became the first Army medical facility in the nation to score 100 percent for compliance with quality standards set by the Joint Commission


\textsuperscript{60} See Act of July 9, 2004, Ch. 189, 23rd Leg., Reg. Sess. (Haw. 2004).

\textsuperscript{61} Id. In addition, the act authorizes the Hawai‘i board of medical examiners to establish pain management guidelines. \textit{Id.}

\textsuperscript{62} Id.; but see Rich, supra note 30, at 47-48 (stating that despite the fact that an increasing number of states have statutorily addressed the issue of pain management, the impact of these statutes on actual physician practice has been very limited).
on Accreditation of Healthcare Organizations. In 2001, the efforts of Kokua Mau, a partnership of public and private organizations advocating improvement of end-of-life care (overseen by the Executive Office on Aging), were nationally recognized by Harvard University’s Innovations in American Government Program. Kokua Mau placed in the top 100 in the competition in 2002 as well. Most recently in 2004, the St. Francis Medical Center Institute of Cancer was re-accredited as a Community Hospital Comprehensive Program. After an annual examination conducted by the Commission on Cancer of the American College of Surgeons, the program received the highest possible rating.

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The Joint Commission on Accreditation of Healthcare Organizations is an independent, not-for-profit organization, dedicated to improving the safety and quality of care provided to the public in health care organizations. JCAHO evaluates and accredits over 16,000 health care organizations and programs nationwide. It is the predominant standards-setting and accrediting body in the United States. See Joint Comm’n on Accreditation of Healthcare Organizations, Facts About the Joint Commission on Accreditation of Healthcare Organizations, at http://www.jcaho.org/about+us/index.htm (last visited on May 2, 2004).


66 St. Francis re-accredited, HONOLULU ADVERTISER, Mar. 29, 2004, at B3.

67 Id.
Progress in the area of pain management is clearly being made. When efforts by community members and the Legislature prove unable to effectuate timely improvements, however, tort litigation can be a powerful vehicle for change. Until recently, however, this avenue was not available to victims of inadequate pain treatment.

C. Difficulties Faced by Residents in Judicially Asserting the Right to Adequate Pain Relief

A terminally ill patient has a constitutionally protected right to receive adequate pain treatment. Failure to provide adequate treatment thus constitutes professional negligence. Due to the difficulty in defining what actions constitute adequate treatment, however, medical malpractice suits for the undertreatment of pain have been rare.

In medical malpractice suits, the legal standard of care by which to measure a physician’s conduct has traditionally been established through usual and customary practices of the profession. To prove that conduct meets the standard, an expert usually testifies that the defendant’s actions conform to the actual pattern of practice in the community. Courts have generally given medical testimony conclusive weight, irrespective of the effectiveness of the practice.

This judicial deference proves problematic, however, where inadequate treatment is the usual and customary practice. With inadequate care constituting the generally accepted standard, proving

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68 See Furrow, supra note 31, at 28. “Tort liability is a powerful external threat, and it can work in tandem with other constructive pressures in the environment to improve management of patient pain.” Id.

69 See Vacco v. Quill, 521 U.S. 793, 807 (1997) (stating that a State may permit palliative care that may have the “double effect” of hastening death).

70 See Furrow, supra note 31, at 29.

71 See generally id. at 31; see generally Kathryn L. Tucker, Esq., Pain Management: Advising and Advocating for Good Care; Seeking Redress and Accountability for Inadequate Care, 15 NAELA QUARTERLY 17, 18 (Fall 2002).

72 See Shapiro, supra note 34, at 360.

73 See Furrow, supra note 31, at 31.

74 Id. (citation omitted).

75 See id.
negligence becomes extremely difficult. As a result of a new theory established in California, however, health care providers will no longer be able to escape liability.

III. LEGAL ANALYSIS OF A NEW THEORY ESTABLISHING A STANDARD OF CARE FOR PAIN MANAGEMENT

In a recent line of California cases, claims for pain and suffering due to inadequate pain management have been successfully brought under the state’s “elder abuse statute.” A state court’s finding that failure to adequately treat the pain of an elderly patient constitutes abuse, has led to revolutionary changes in both the medical and legal communities. As a result of these cases, a standard of care for pain management has been established, and the ambiguity surrounding pain medication prescription effectively removed. Clinical practice guidelines and standards now

76 See Furrow, supra note 31, at 31-32.

77 See Bergman Case Continues to Spark Discussion and Influence Physicians and Medical Boards, 18 TOPICS IN PAIN MANAGEMENT 12 (July 2003) [hereinafter TOPICS]; see CAL. WELF. & INST. CODE 15600 (West 2000).


80 Clinical practice guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” Furrow, supra note 31, at 32. They offer healthcare providers instructions for proper treatment of specific illnesses or conditions, based on policy and standards developed by the medical community. Id.

Practice standards provide clear definitions of what actions constitute appropriate care in specific clinical circumstances. NAT’L PHARM. COUNCIL, INC., supra note 21, at 77. The guidelines and standards are developed by national specialty societies such as the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, the American Pain Society, and the American Academy of Family Physicians; as well as by the Government and individual facilities. Furrow, supra note 31, at 32; NAT’L PHARM. COUNCIL, INC., supra note 21, at 75.
offer authoritative, legally enforceable statements on adequate pain management, and are presumptive evidence of due care. Consequently, health care providers can no longer escape liability by offering evidence of inadequate treatment as the “usual or customary” practice in the community.

A. Bergman v. Chin—The Seminal Case

In 2001, a California jury found that a physician’s failure to adequately manage the pain of a terminally ill patient was a form of elder abuse. Although it was not the first case to base a claim on poor pain management, it was the first time undertreatment was framed as the cause of action under an “elder abuse statute” in a civil trial. The jury awarded the survivors of the 85-year-old lung cancer patient $1.5 million for unnecessary pain and suffering caused by the inadequate treatment of pain.

On February 16, 1998, William Bergman was admitted into Eden Medical Center where he was diagnosed with multiple spinal compression fractures and a strong possibility of lung cancer. Although the

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81 Furrow, supra note 31, at 32.
83 See Shapiro, supra note 34, at 361 (discussing Estate of Henry James v. Hillhaven Corp., No. 89CVS64 (N.C. Super. Ct. N.C. Jan. 15, 1991)). In Estate of Henry James, a North Carolina jury awarded the estate of a prostate cancer patient $15 million. Id. Although the hospital physician prescribed morphine to alleviate James’ pain, a nurse at the defendant nursing home independently assessed the patient as “addicted to morphine.” Id. Staff at the facility then withheld the morphine, and substituted it with less effective pain medication or placebos. Faison v. Hillhaven Corp., No. 89CVS64 (N.C. Hertford Super. Ct. Nov. 1991) (LPR Jury), 1991 WL 453508. The nursing home was found guilty of failing to adequately treat the patient’s cancer pains. Id.
84 Bergman, 46 TRIALS DIG. 4TH at 2, 2001 WL 1517376, at *2; Tom Troy, New Type of Suit: Pain Treatment, Calif. Verdict Against Doctor is Based on Law Against Abuse of the Elderly, 23 NAT’L. L.J. A5, A5 (July 5, 2001).
86 Id.
emergency room physician initially prescribed morphine, Dr. Wing Chin, the attending physician at the hospital, changed the prescription to Demerol, with instructions to administer the pain medication “PRN” (as needed). During the five days Bergman remained hospitalized, records indicated that on numerous occasions he complained of severe pain ranging from levels 7 to 10, with 10 being the worst pain imaginable. Yet, no other type of medication was prescribed. At the time of discharge Bergman reported level 10 pain. Despite the fact that Bergman was known to have difficulty swallowing, he was prescribed an oral form of Vicodin. Only after the plaintiff requested stronger medication for her father did Dr. Chin prescribe a shot of Demerol and a fentanyl patch.

Two days after discharge, a hospice nurse found Bergman in “out of control” pain. After attempting to contact Dr. Chin for one and a half hours, the nurse was told that the patient was no longer under his care. Bergman’s regular physician then re-prescribed liquid morphine and two additional patches, which effectively relieved the pain. Bergman died the next day.

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87 Berry, supra note 79.

88 Id.; Bergman, 46 TRIALS DIG. 4TH at 2, 2001 WL 1517376, at *1. Demerol is a narcotic (opioid) analgesic similar to morphine, used to treat moderate to severe pain. PHYSICIAN’S DESK REFERENCE, supra note 12, at 3014-15.

89 Bergman, 46 TRIALS DIG. 4TH at 2, 2001 WL 1517376, at *1.

90 Id.


93 Id.

94 Id.

95 Tucker, supra note 71, at 19.

96 Bergman, 46 TRIALS DIG. 4TH at 2, 2001 WL 1517376, at *1.
1. Bringing a claim under California’s Elder Abuse and Dependent Adult Civil Protection Act

Because California’s malpractice law did not provide for survival of an action for pain and suffering, the plaintiffs in Bergman asserted a cause of action under the state’s Elder Abuse and Dependent Adult Civil Protection Act. Not only did the “elder abuse statute” allow for survival of pain and suffering claims, but also provided for recovery of attorneys’ fees, avoided the cap on damages in malpractice cases, and allowed heightened remedies. The basis for the plaintiffs’ claim was that the defendant’s failure to establish an adequate pain management plan was reckless, resulted in severe injury (excruciating pain), and was therefore a violation of the state’s “elder abuse statute.” This meant, however, that the plaintiffs needed to meet a higher burden of proof. While California’s malpractice laws required proof of negligence by a preponderance of the evidence, the “elder abuse statute” required proof that conduct rose to the level of “recklessness” through clear and convincing evidence. Thus, the plaintiffs needed to show that the defendant acted with “deliberate disregard of the high probability that an injury [would] occur[,]” and that the conduct constituted “a conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.”

97 Id.


101 Elder Abuse: Undertreating Pain Can Amount to Elder Abuse, PAIN & CENTRAL NERVOUS SYSTEM WEEK, 22-23 (Feb. 14, 2000).

102 See Berry, supra note 79; see CAL. WELF. & INST. CODE § 15657 (West 2001).

103 Bergman, No. A091386 at 3 (citation omitted in original) (citing Delaney v. Baker, 20 Cal.4th 23, 31-32 (1999)).
2. Proving reckless negligence and establishing a standard of care

Under traditional medical malpractice schemes, the plaintiffs did not have a recognized cause of action. Defense experts testified that Dr. Chin’s conduct fell within the standard of care, and asserted, “what [he] did, 95 percent of doctors would do[.]” Under a claim of reckless neglect, however, state pain policies and guidelines were allowed as evidence to establish notice of the defendant’s duty to provide attentive and aggressive pain treatment. Among other things, the plaintiffs introduced California’s Intractable Pain Treatment laws, Pain Guidelines adopted by the state’s medical board, a policy statement made by the board encouraging aggressive pain care, clinical practice guidelines issued by the Agency for Health Care Policy and Research (“AHCPR”) that were mailed to all California physicians in 1994, California’s Pain Patient’s Bill of Rights, and numerous medical literature addressing the issue.

To prove that the defendant’s conduct rose to the level of recklessness, Plaintiffs’ expert described how specific actions by the defendant grossly departed from the standard of care laid out by the AHCPR guidelines. Among those departures, the expert pointed out that while the guidelines recommended around-the-clock pain medication for intractable pain, with additional medication for breakthrough pain, Dr. Chin prescribed 25-milligrams of Demerol (one quarter the manufacturer’s recommended dose) on an “as needed” basis. Despite reports of level 10 pain at the time of discharge, Dr. Chin merely prescribed Vicodin, the

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104 See Berry, supra note 79.

105 Tucker, supra note 71, at 19.

106 See CAL. BUS. & PROF. CODE § 2241.5 (West 2003).

107 CAL. HEALTH & SAFETY CODE § 124960-124961 (West 2004).

108 Tucker, supra note 71, at 19.

109 Id.

medication Bergman had been taking prior to hospitalization. In addition, Dr. Chin prescribed an oral form of the medication, knowing that the patient had difficulties swallowing. A shot of Demerol and an additional fentanyl patch were later prescribed, but only after the patient’s daughter demanded it. According to the expert, “the care and treatment provided . . . was consistently below the standard of care and demonstrated an indifference and deliberate disregard for Mr. Bergman’s continued and severe pain and suffering.”

The jury ultimately found that through the numerous policies, guidelines, and medical literature, Dr. Chin was “on notice of his duty to treat pain attentively and aggressively.” In light of this, his failure to treat Bergman’s pain aggressively constituted recklessness rather than plain negligence. Although the $1.5 million award for pain and suffering was later reduced to $250,000 due to California’s Medical Injury Compensation Reform Act, Dr. Chin was also ordered to pay attorney fees, which the court enhanced by a multiplier available in cases significant to the public interest resulting in a total of 150 percent of actual fees.

**B. Tomlinson v. Bayberry Care Center—A Shift in Perspective**

Following the Bergman verdict, defense attorneys in California attempted to calm stunned medical and malpractice communities by stating, “If you had the same fact pattern, and ran it by a different jury,
you would have a different result.”

They further declared, “This is not . . . ‘the new tort’.”

Two years later, California’s second pain case was successfully brought under the state’s “elder abuse statute.”

Lester Tomlinson, 85, suffered from mesothelioma, an incurable form of lung cancer.

Similar to the facts in Bergman, Tomlinson was admitted into a hospital; records indicated that pain was experienced “all the time,” which at times reached level 10; and pain relief was only sporadically provided.

After being transferred to a nursing home, Tomlinson frequently reported pain.

Around-the-clock pain control was never provided, however, and medication was only administered after Tomlinson’s family researched various pain medications on their own then requested it.

Follow-up assessments were never made.

Despite the fact that Tomlinson had an advance directive expressly stating his wishes to aggressively treat his pain, the days prior to his death were characterized as “twenty days of unremitting agony.”

After reading about the Bergman case, Ginger Tomlinson filed a lawsuit claiming, *inter alia*, that improper pain management of her terminally ill father’s pain constituted reckless neglect under California’s

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118 Berry, *supra* note 79 (quoting David Lucchese of Walnut Creek’s Anderson, Galloway & Lucchese, Malpractice attorney).

119 *Id.* (quoting Ralph Lombardi, Defense Attorney in Oakland).

120 *See generally* TOPICS, *supra* note 77.


122 *Id.*

123 *Id.*

124 *Id.*

125 *See generally* id.

126 *Id.*
Elder Abuse and Dependent Adult Civil Protection Act.\textsuperscript{127} The hospital, the attending physician at the hospital, the nursing care facility, and the physician at the facility, all settled for undisclosed amounts and agreed to participate in continuing education classes.\textsuperscript{128}

While the settlements by all of the defendants were caused in part by the Bergman verdict, the overriding cause was a shift in perspective in the medical and health care communities.\textsuperscript{129} An affirmative duty to provide adequate pain management now appears firmly established.\textsuperscript{130} Illustrative of this shift are the disciplinary actions taken by the California Medical Board, and the pursuance of fraud charges by the Centers for Medicare and Medicaid Services (“CMS”). In Bergman, the California Medical Board refused to pursue disciplinary action despite finding inadequate care on the part of the defendant.\textsuperscript{131} In Tomlinson, however, not only did the board file an accusation with the state attorney general, but it also issued a public reprimand of Dr. Eugene B. Whitney.\textsuperscript{132} Of equal significance, CMS launched an investigation and is considering pursuing federal fraud charges.\textsuperscript{133} The premises of the charges would be that adequate pain management is the standard of care, and billing for treatment that falls short of the standard constitutes fraud.\textsuperscript{134}


\textsuperscript{129} See Topics, supra note 77.

\textsuperscript{130} Id.

\textsuperscript{131} Id.

\textsuperscript{132} Id.; see In re Eugene B. Whitney, M.D., Medical Board of Cal., Case No. 12-2002-133376 (Dec. 15, 2003).


\textsuperscript{134} Id.
As a result of this shift in perspective, nursing home residents (or their estates) nation-wide are now provided effective remedies for asserting the right to adequate pain treatment. With inadequate management recognized as substandard care, a cause of action may now exist under a state’s “elder abuse statute,” where the quality-of-care given falls below acceptable standards. In addition, or in the alternative, a cause of action may also exist under medical malpractice statutes, where substandard care constitutes professional negligence.

IV. APPLYING THE NEW THEORY TO EXISTING HAWAI‘I STATE LAWS

Under the theory that inadequate pain relief constitutes both elder abuse and professional negligence, existing Hawai‘i State laws are sufficient to provide for the established standard of care. With inadequate management constituting abuse, nursing home residents are now able to utilize various elderly services to initiate immediate intervention and/or protective proceedings. In addition, the State’s attorney general can pursue civil or criminal charges for abuse of a dependent adult. Although residents (or estates) are not provided private causes of action for abuse, under the theory that inadequate management constitutes professional negligence, they are provided various causes of action under State medical malpractice laws. Thus, a variety of State laws now offer elderly nursing home residents and their estates, effective tools and remedies to assert the right to adequate pain treatment.

Abuse or neglect of a dependent elderly nursing home resident can be addressed in various ways: formally or informally, administratively, judicially, or privately between a resident and a facility. This Comment focuses on the types of proceedings made available to a resident or an estate under the new theory. There are three main types of proceedings: 1) protective proceedings, 2) civil causes of action, and 3) criminal prosecution. Each type serves a different purpose. As a result, more

135 Throughout this section the author uses the term “resident” to refer to a nursing home resident, designated legal representative, court appointed guardian, or legal surrogate.

than one type of proceeding may apply in a particular situation.\footnote{137} This Comment discusses the first two types in depth, and only briefly touches upon the third.

A. Protective Proceedings

When an individual is suffering from inadequate pain relief, immediate intervention is paramount. Protective proceedings are an appropriate alternative, and include investigation of reports of alleged abuse, findings, and issuance of protective orders.\footnote{138} Under the theory that inadequate pain treatment constitutes elder abuse, nursing home residents are now afforded recourse through Hawai‘i’s statewide elderly service delivery network. Resources available to facilitate immediate intervention include: Dependent Adult Protective Services, the Long-Term Care Ombudsman Program, the Department of Commerce and Consumer Affairs, the Medicaid Investigations Division of the Office of the Attorney General, and Hawai‘i’s Uniform Health-care Decisions Act.

1. Dependent Adult Protective Services

Although Hawai‘i does not have an “elder abuse statute,” there are other laws and resources in place to protect elderly nursing home residents. The most cogent law is Hawai‘i’s Dependent Adult Protective Services Act.\footnote{139} The purpose of this law is to protect adults who are at a high risk of abuse, neglect, and financial exploitation, due to their dependency on others.\footnote{140} To benefit from this law, an individual must be at least 18 years old, have a mental or physical impairment, and be “dependent upon another person, a care organization, or a care facility for personal health, safety, or welfare,” due to the impairment.\footnote{141}

\footnote{137} Id.


\footnote{139} HAW. REV. STAT. § 346-221 to -253 (1993).

\footnote{140} HAW. REV. STAT. § 346-221 (1993).

\footnote{141} HAW. REV. STAT. § 346-222 (1993).
The statute defines “abuse” as “actual or imminent physical injury, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment.” Applicable situations include those when “[a]ny dependent adult is not provided in a timely manner with adequate . . . physical care, medical care, or supervision[,]” or when “[t]here has been a failure to exercise that degree of care toward a dependent adult which a reasonable person with the responsibility of a caregiver would exercise, including, but not limited to, failure to . . . [p]rovide necessary health care, access to health care, or prescribed medication[.]” For conduct to qualify as abuse under the statute, however, two criteria must be met: the abuse has occurred, and further abuse is imminent unless protective action is taken.

Intervention may be initiated by a complaint to the Department of Human Services’ Adult Intake. The complaint may be made by a victim, family member, facility staff member, or any interested party. If the “abuse” criteria are met, the report is sent to Adult Protective Services (“APS”) for investigation. APS must have the consent of the victim, or the representative of the victim, however, before an investigation or protective action can commence. If there is probable cause to believe

142 Id. (emphasis added).


145 HAW. REV. STAT. § 346-223 (1993); see HAW. REV. STAT. § 346-222 (1993) (stating that “[i]mminent abuse” exists where there is reasonable cause to believe that abuse will occur or recur within the next ninety days).

146 HAW. REV. STAT. § 346-224 (1993); Telephone Interview with David Tanaka, Supervisor, Adult Protective Services (Feb. 28, 2004) [hereinafter “Tanaka Interview”].


that the dependent adult lacks the capacity to make such decisions and has no designated representative, a court may issue a protective order\(^\text{151}\) and appoint a guardian ad litem to represent the victim’s interests.\(^\text{152}\) Even after an investigation has begun, APS may at any time, intervene to protect the victim. If the agency finds probable cause that a dependent adult is in danger of imminent abuse, it may undertake informal resolution with the facility, seek an order for immediate protection, seek a temporary restraining order, or file a petition with the court seeking any protective or remedial actions authorized by law.\(^\text{153}\) Under the statute, “abuse” is demonstrated by a preponderance of the evidence.\(^\text{154}\) If the court determines that abuse has taken place, a protective order will be issued.\(^\text{155}\) In addition, “[t]he court may . . . order the appropriate parties to pay or reimburse reasonable costs and fees of the guardian ad litem and counsel appointed for the dependent adult.”\(^\text{156}\)

\(^{150}\) HAW. REV. STAT. § 346-231(b) (1993). The statute provides that a finding of probable cause may be based in whole or in part upon hearsay evidence when direct testimony is unavailable. Id.

\(^{151}\) HAW. REV. STAT. § 346-231 (1993).

\(^{152}\) HAW. REV. STAT. § 346-234 (1993).

\(^{153}\) HAW. REV. STAT. § 346-228 (1993). Where injury is imminent, an order for immediate protection may be obtained orally or in writing by the department, without notice to the defendant and without a hearing. HAW. REV. STAT. § 346-231(a), (e) (1993). If an order is issued orally, it must be reduced to writing within twenty-four hours, and the department must file a petition with the court within twenty-four hours. HAW. REV. STAT. § 346-231(e) (1993). A hearing to show cause why an order should be continued will take place within seventy-two hours of the issuance of a written order. HAW. REV. STAT. § 346-232(a) (1993). If cause is shown, the court is required to schedule an adjudicatory hearing “as soon as it is practical.” HAW. REV. STAT. § 346-232(c) (1993).

\(^{154}\) HAW. REV. STAT. § 346-240(b) (1993).

\(^{155}\) HAW. REV. STAT. § 346-241 (1993). The statute provides that if the defendant fails to comply with the protective order, “[t]he court may apply contempt of court provisions and all other provisions available under the law[.]” HAW. REV. STAT. § 346-246 (1993).

\(^{156}\) HAW. REV. STAT. § 346-234 (1993).
Thus, in cases where a dependent adult remains in severe pain despite requests for pain medication, a resident or family member can petition a court for help. They can petition a court to order the facility to immediately administer the medication, or to transfer the patient to a willing facility, pending an adjudicatory hearing. Initiation of protective proceedings does not preclude the use of any other criminal, civil, or administrative remedies.  

2. **Mandated reporting**

Adult Protective Services may also receive complaints through mandated reporters. Under the Dependent Adult Protective Services Act, certain “persons who, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse[,]” are required to promptly file an oral report with the Department of Human Services. These mandated reporters include licensed or registered professionals of healing arts, physicians, nurses, pharmacists, employees or officers of any public or private agency or institution providing medical services, law enforcement, and employees or officers of any adult residential care home or similar institution. Thus, reporting abuse can be as straightforward as calling the police.

A person mandated to make a report who knowingly fails to do so, or who willfully prevents another from reporting the abuse, will be guilty of a petty misdemeanor. Thus, if a staff member is aware of inadequate treatment and does not report it, that individual will also be held liable. On the other hand, immunity is granted to anyone making a report in good faith, who might otherwise have incurred liability.

3. **Long-term Care Ombudsman Program**

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159 Id.


The Long-term Care Ombudsman Program (“Program”) is another valuable resource available to residents in public or private nursing homes. As part of the statewide elderly services network, the Program’s main purposes are to facilitate assessment and prevention of elder abuse in long-term care facilities, and to advocate improvement of the quality of care received. In cases of institutional mistreatment, defined by the statute as “acts which may adversely affect the health, safety, welfare, and rights of residents[,]” complaints can be made to a State ombudsman (investigator). Those entitled to assistance under the Program include all elderly residents of long-term care facilities, intermediate care facilities, nursing homes, or similar adult care facilities. A report of mistreatment can be filed by a victim, or by any other person on behalf of the victim. Complaints can be made to an area agency on aging by phone, in writing, or in person, or to an ombudsman during unannounced visits to the nursing home. Complaints can also be made to certified Long-term Care Ombudsman volunteers, during their regular meetings with residents.

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164 Id.


166 HAW. REV. STAT. § 349-12(a) (1993).


168 See 2003 ANNUAL REPORT, supra note 65, at 6-7.

169 See HAW. REV. STAT. § 321-15.6(a) (Supp. 2003) providing:

The department [of health] shall conduct unannounced visits, other than the inspection for relicensing, to every licensed adult residential care home and expanded adult residential care home on an annual basis and at such intervals as determined by the department to ensure the health, safety, and welfare of each resident.

170 See 2003 ANNUAL REPORT, supra note 65, at 6-7.
volunteers are available to advise interested parties about issues such as resident rights and informal and formal remedies, and can refer a resident to appropriate services and agencies.  

All complaints received are immediately investigated. With the written consent of the victim or victim’s representative, the ombudsman can access all patient records and files. All reports are kept confidential. Where an individual lacks sufficient capacity, a court may order disclosure. In the event abuse or neglect is found, the ombudsman will inform the victim of their possible options. Again, consent is required before the findings can be forwarded to appropriate agencies (including law enforcement) capable of taking corrective action. Any act of retaliation by a facility or its employees is a misdemeanor. Each act of retaliation is considered a separate incident, and each day that an act continues constitutes a separate offense.

A significant benefit provided by the program is the continued advocacy for quality care. In situations where the abuse does not meet the criteria set out under the Dependent Adult Protective Services Act (i.e., evidence is insufficient to show abuse has occurred and is imminent), or where residents or their agents refuse for whatever reason to pursue legal or administrative action, program volunteers attempt to continue weekly visits with the resident. Where inadequate pain management persists,

See id.


HAW. REV. STAT. § 349-14(b) (1993).


Telephone Interview with John McDermott, State LTC Ombudsman, Executive Office on Aging (Feb. 29, 2004).
the volunteer will continue to advise a resident or family member about alternative ways for obtaining relief. This includes consulting facility staff about current pain standards, filing a complaint with the Joint Commission (“JCAHO”) or the Department of Commerce and Consumer Affairs, or arranging for the resident to be transferred to another facility. The ombudsman, however, does not have the authority to assist residents in private tort litigation.

4. Department of Commerce and Consumer Affairs

All nursing facilities in Hawai‘i must be licensed by the State Department of Commerce and Consumer Affairs (“Department”). If a facility fails to “substantially . . . conform to the required [licensing] standards[,]” the license will be revoked or suspended. Currently, all facilities are required to have a written policy prohibiting the mistreatment, neglect, or abuse of a resident. Therefore, intervention can be initiated by filing a complaint with the Department. All reports will be investigated and appropriate action will be taken when violations of the licensing standards are found. Any person found in violation of the standards will be fined “not more than $500 for a first offense[,]” and “not more than $1000, or imprisonment not more than one year, or both.” Remedies or penalties are cumulative to those available under other State laws, unless otherwise provided.
5. Medicaid Investigations Division

Yet another way intervention can be initiated is by making a report with the Medicaid Investigations Division of the Department of the Attorney General of the State of Hawai‘i (“Division”). Under State law, the Division has the power to investigate alleged abuses occurring in any state nursing facility. When findings of abuse, neglect, or exploitation of a dependent adult are made, the Division has the authority to criminally prosecute the nursing facility involved. Claims pursued by the Division, however, must prove that conduct rises to the level of criminal intent. This is an extremely high standard that is rarely met in dependent adult abuse cases. As mandated reporters under the Dependent Adult Protective Services Act, however, even when conduct does not reach criminal levels, Medicaid investigators are required to forward the report to the Department of Human Services.

6. Advance health care directives

Another option is available to residents who have advance health care directives. Under the Hawai‘i Uniform Health-care Decisions Act (modified), a health care provider must follow an individual’s health care directive, a reasonable interpretation of the directive by a guardian, a guardian appointed by a court, or a reasonable interpretation of an individual instruction or a power of attorney for health care.

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191 Id.

192 Id.

193 Mike Gordon, Elder Abuse Bills Take Spotlight, HONOLULU ADVERTISER, Feb. 27, 2003, at Hawaii: B. Between 1999 and February 2003, the Attorney General for the state of Hawaii prosecuted only four cases of abuse and neglect, with only one case rising to the level of a felony. Id.


195 HAW. REV. STAT. § 327E-2 (Supp. 2003) (defining an “advance health-care directive” as “an individual instruction or a power of attorney for health care”).

agent or surrogate, or a health-care decision made by a guardian, agent or surrogate.\textsuperscript{197} If the provider is aware of a patient’s wishes but refuses to comply, a family member or interested person can petition a court to direct a health care instruction, or to transfer the patient to a facility that will comply.\textsuperscript{198} Thus, if a patient has a directive instructing that pain relief be given despite any secondary effects such as the hastening of death, any person can petition a court to order the administration of pain medication in accordance with the directive.\textsuperscript{199} If there are family members who oppose the decision, however, this vehicle may not provide an immediate remedy. Relief may also be delayed where the decision to administer pain medication is not contained in a written directive, but is made by a guardian, agent, or surrogate.

B. \textit{Civil Cause of Action Based on Abuse of a Dependent Elder}

The second type of proceeding made available by the new theory is civil causes of action. Under current State law, however, only the attorney general has a statutory cause of action for “dependent elder abuse” occurring in a long-term care facility.\textsuperscript{200}

1. \textit{The Elder Justice Act}

Until recently, the attorney general could only bring criminal charges against health care facilities in cases of abuse or neglect.\textsuperscript{201} This proved problematic when dealing with dependent elderly nursing home residents. One of the primary problems faced in litigation involving elderly residents is proving causation.\textsuperscript{202} A majority of the residents are in the homes due to mental or physical incapacities, thus communication presents a significant problem. Many residents are unable to explain what

\textsuperscript{197} \textsc{Haw. Rev. Stat.} § 327E-7 (Supp. 2003).

\textsuperscript{198} \textsc{Haw. Rev. Stat.} § 327E-14 (Supp. 2003).

\textsuperscript{199} \textit{Id}.

\textsuperscript{200} \textsc{Haw. Rev. Stat.} § 28-94(a) (Supp. 2003).

\textsuperscript{201} See discussion \textit{infra} Part IV.A.5.

\textsuperscript{202} See Furrow, \textit{supra} note 31, at 42; Tanaka Interview, \textit{supra} note 146.
happened to them, recall specific times and events, or identify the person who inflicted the injury.\(^{203}\) There are also problems of multiple illnesses, and natural physical frailties such as thin skin that bruises easily or broken bones caused by ordinary touching.\(^{204}\) Due to these obstacles, criminal intent is rarely proven and conviction rates remain low.\(^{205}\) Under a recently enacted law, however, the attorney general now has the option to pursue civil action in cases of institutional abuse of dependent elders.

The Elder Justice Act, which took effect in 2003, authorizes the attorney general to pursue a civil action against any caregiver found guilty of abusing\(^{206}\) a dependent elder, on behalf of the State.\(^{207}\) The action can be for the purposes of prevention, restraint, or remedy.\(^{208}\) The statute defines neglect as “the reckless disregard for the health, safety or welfare of a dependent elder . . . that results in injury[.]”\(^{209}\) To illustrate the range of actions that constitute neglect, the statute reads: “‘Neglect’ includes, but is not limited to . . . [f]ailure to provide or arrange for necessary . . . health care; except when such failure is in accordance with the dependent elder’s [health care] directive[.]”\(^{210}\) If a dependent elder lacks sufficient capacity to communicate a responsible decision, abuse occurs when the individual is “exposed to a situation or condition which poses an imminent risk of death or risk of serious physical harm[.]”\(^{211}\)

In the event that abuse or negligence is found, a mandatory civil penalty will be ordered in an amount “not less than $500 nor more than

\(^{203}\) See Furrow, supra note 31, at 42; Tanaka Interview, supra note 146.

\(^{204}\) See Furrow, supra note 31, at 42; Tanaka Interview, supra note 146.

\(^{205}\) See Furrow, supra note 31, at 42.

\(^{206}\) HAW. REV. STAT. § 28-94(a) (Supp. 2003). The statute defines abuse as “actual or imminent physical injury, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment.” HAW. REV. STAT. § 28-94(b) (supp. 2003).

\(^{207}\) HAW. REV. STAT. § 28-94(a) (Supp. 2003).

\(^{208}\) Id.

\(^{209}\) HAW. REV. STAT. § 28-94(b) (supp. 2003) (emphasis added).

\(^{210}\) HAW. REV. STAT. § 28-94(b) (Supp. 2003).

\(^{211}\) HAW. REV. STAT. § 28-94(b)(5) (Supp. 2003).
$1,000 for each day that the abuse occurred . . . [plus] costs of investigation.” The statute does not specify a maximum amount. The law provides limited protection, however, and to qualify, a resident must be sixty-two years of age or older, have a mental or physical impairment, and be dependent upon another for personal health, safety, or welfare due to the impairment. Those who can be held liable as caregivers include “any person who has undertaken the care, custody, or physical control of, or who has a legal or contractual duty to care for the health, safety, and welfare of a dependent elder, including . . . owners, operators, employees, or staff of . . . [l]ong-term care facilities[.]” A significant benefit of claims brought by the attorney general is a statutory exemption excluding State actions from a statute of limitation.

2. Bringing a claim under the act

Assuming both resident and caregiver fall within the purview of the statute, the basis for a claim brought under the Elder Justice Act would be that the defendant’s failure to provide necessary and adequate pain treatment showed reckless disregard for the health, safety, and welfare of the resident, resulted in injury (unrelieved pain), and therefore constituted neglect of a dependent elder. The first step would be to establish the duty of adequate and aggressive pain treatment owed to the patient, and the defendant’s notice of this duty. Under the new theory, a plaintiff would introduce the newly enacted “Pain Patient’s Bill of Rights,” as well as the Joint Commission on Accreditation of

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212 HAW. REV. STAT. § 28-94(a) (Supp. 2003).

213 Id.

214 HAW. REV. STAT. § 28-94(b) (Supp. 2003).

215 Id.

216 HAW. REV. STAT. § 657-1.5 (1993).


218 See Act of July 9, 2004, Ch. 189, 23rd Leg., Reg. Sess. (Haw. 2004); see discussion supra Part II.C.
Healthcare Organization’s pain assessment and management standards. The standards mandate, among other things, for accredited facilities to: recognize a patient’s right to adequate pain management; provide training for staff members on an ongoing basis; educate patients and family members about their rights upon admission; perform proper assessment and reassessment; record results of assessments in a way that facilitates regular reassessment and follow-up; and address patient needs for symptom management in the discharge planning process. The standards also mandate use of “pain as the 5th vital sign.” This means that in addition to the routine monitoring and recording of a patient’s blood pressure, pulse, respiration and temperature, health care providers are now required to routinely monitor pain. Routine inquiry entails recording of pain location, intensity, duration, quantity, and quality. While accreditation by the Joint Commission is not required, some nursing homes and all hospitals in Hawai‘i are accredited. Therefore, the pain assessment and management standards in place at all hospitals and accredited nursing facilities, in effect, become the standard of care in the community. As seen in Tomlinson, courts are generally willing to extend the duty of adequate pain management to nursing facilities.

The next step would be to establish the standard of care by which to measure the defendant’s conduct. The general rule followed by Hawai‘i
courts is that “the question of negligence must be decided by reference to relevant medical standards of care, which plaintiff carries the burden of proving through expert medical testimony.” 226 Under the new theory, clinical practice guidelines and standards would be allowed as evidence to establish the standard of care owed to the resident. A plaintiff would need to retain an expert to explain the Joint Commission pain management standards and their relevancy to the defendant, and to testify how the provider’s conduct deviated from those standards.

Lastly, a plaintiff would need to prove that an injury occurred, and that the injury or damage was caused by the reckless negligence of the defendant. 227 The burden would be on the plaintiff to prove this by clear and convincing evidence. 228 “Clear and convincing” means that the evidence must “produce in the mind of the trier of fact a firm belief or conviction as to the allegations sought to be established, and requires the existence of a fact be highly probable.” 229 To reach the level of “recklessness,” a plaintiff must show that the defendant “has intentionally done an act of an unreasonable character in disregard of a risk known to or so obvious that he [or she] must be taken to have been aware of it, and so great as to make it highly probable that harm would follow.” 230 In both the Bergman and Tomlinson cases, the plaintiffs used medical records indicating various levels of pain to show that an injury had occurred, and that the defendants were aware of the injuries. 231 Thus, a plaintiff would retain an expert to testify that the victim’s pain could have been effectively relieved or controlled by pain medication. Medical records could be

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226 Craft v. Peebles, 78 Hawai‘i 287, 298, 893 P.2d 138, 149  (1995) (involving a medical malpractice action where the plaintiff brought claims against her physician for professional negligence after the rupture of her silicone breast implants).

227 Id.

228 Iddings v. Mee-Lee, 82 Hawai‘i 1, 14, 919 P.2d 263, 276 (1996) (holding that the clear and convincing standard of proof must be applied to all civil claims alleging willful and wanton misconduct).

229 Id. at 13, 919 P.2d at 275 (citations omitted).

230 Id. at 11, 919 P.2d at 273 (quoting Thompson v. Bohlken, 312 N.W.2d 501, 185 (Iowa 1981)).

231 Thomson American Health Consultants, supra note 133, at 49.
introduced to show the defendant was aware of the risk of injury to the patient, but due to an intentional disregard for the patient’s health, safety, and welfare, failed to treat the pain adequately. As a result, the patient suffered unnecessarily. In Bergman, clinical practice guidelines and state pain policies were introduced as evidence of the environment in which the defendant practiced, and to show that he was on notice of his duty to treat pain aggressively. Based on this theory, the absence of comprehensive State pain policies, the reluctance by Hawai’i’s Medical Board to adopt pain guidelines, and the lack of serious disciplinary action in cases of professional negligence all present potential problems. However, a plaintiff could introduce into evidence, among other things, the massive number of articles addressing adequate pain management published in medical and health journals, the Bergman case and its progeny, the Joint Commission standards, and the abundance of clinical practice guidelines offered over the Internet.

If a civil judgment is entered against the defendant, the final step would be to prove damages. This would include proving when the neglect began, as well as the amount spent in litigating the case.

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232 Tucker, supra note 71, at 19. “Plaintiffs were able to convince the jury that the physician had been reckless because the physician was shown to be practicing in an environment where he had been barraged with information about his duty and responsibility to treat pain aggressively and attentively.” Id.

233 See 2001 ANNUAL REVIEW, supra note 57, at 2.

234 See Public Citizen’s Health Research Group, supra note 59.


237 HAW. REV. STAT. § 28-94(a) (Supp. 2003) provides in relevant part: Any caregiver against whom a civil judgment is entered on a complaint alleging that the caregiver committed abuse against a dependent elder, shall be subject to a civil penalty of not less than $500 nor more than $1,000 for each day that the abuse occurred, and the costs of investigation.
found to rise to the level of recklessness, there is a high probability that other claims will be filed and fines assessed against the institution. As illustrated by the Tomlinson case, The Centers for Medicare and Medicaid Services now considers inadequate treatment substandard care and a basis for fraud, and state boards are beginning to take disciplinary action.\textsuperscript{238} State departments in charge of licensing will have to take disciplinary action for substandard care, and victimized residents or their estates will most likely institute private medical malpractice suits seeking among other things, punitive damages.\textsuperscript{239} Clearly, nursing homes can no longer afford to ignore residents' pain.

C. Civil Causes of Action Under Hawai'i's Medical Malpractice Laws

After a resident is protected from further harm, or in situations where an estate desires compensation for past abuses, civil remedies provide another alternative. Although residents are not provided a private cause of action for dependent elder abuse, State law allows for the survival of an action arising out of neglect.\textsuperscript{240} Thus, under the theory that inadequate pain management constitutes professional negligence, a resident or estate is provided several causes of action under traditional medical malpractice laws.\textsuperscript{241} Such claims can be pursued in addition to judicial, administrative, or protective actions taken by the attorney general,

\textit{Id.} (emphasis added).

\textsuperscript{238} See Thomson American Health Consultants, \textit{supra} note 133, at 51; \textit{In re} Eugene B. Whitney, M.D., Medical Board of Cal., Case No. 12-2002-133376 (Dec. 15, 2003). In a decision effective January 14, 2004, the California Licensing Board became only the second board to discipline a physician for the undertreatment of pain. \textit{Id.}

\textsuperscript{239} See discussion \textit{infra} Part IV.C.

\textsuperscript{240} HAW. REV. STAT. § 663-7 (1993).

\textsuperscript{241} Throughout this section, the author uses the term “resident” to refer to a nursing home resident or a resident's legal surrogate, guardian, or estate. A "legal surrogate" is defined as an agent designated in a power of attorney for health care or surrogate designated or selected in accordance with chapter 327E. HAW. REV. STAT. § 671-3(e) (Supp. 2003). A “guardian” is defined as a judicially appointed guardian having authority to make a health-care decision for an individual.” HAW. REV. STAT. § 327E-2 (Supp. 2003).
Department of Health, Department of Consumer Affairs, Medicaid Investigations Divisions, or Adult Protective Services.

A "medical tort" is defined as “professional negligence, the rendering of professional service without informed consent, or an error or omission in professional practice, by a health care provider, which proximately causes death, injury, or other damage to a patient.” A plaintiff would be required to take all steps necessary in a typical malpractice case, however, including filing a claim with the medical claim conciliation panel before instituting a lawsuit. The claim would be subject to a two-year statute of limitation, and damages awarded for pain and suffering would be subject to the $375,000 cap for tort claims.

1. Professional negligence

In professional negligence actions, the burden is on the plaintiff to show the “duty owed by a defendant to the plaintiff, a breach of that duty, and the causal relationship between the breach and the injury suffered[.]” Thus, a plaintiff bringing a cause of action under traditional malpractice laws would proceed the same way as with a claim.

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244 See HAW. REV. STAT. § 671-12(a) (1993).

245 See HAW. REV. STAT. § 671-16 (Supp. 2003) (providing that a claimant may institute litigation based upon the claim in an appropriate court only after a party to a medical claim conciliation panel hearing rejects the decision of the panel, or after the twelve-month period under section 671-18 has expired.


brought under the Elder Justice Act. However, several significant differences exist. A plaintiff would need to meet the lower standard of negligence, rather than reckless neglect. Also, a preponderance of the evidence standard would apply, meaning that a plaintiff would only need to prove “whether the existence of [a] contested fact is more probable than its nonexistence.” In establishing the standard of care by which to measure the defendant’s conduct, expert medical testimony is again generally necessary. Expert testimony would also be needed to prove how the defendant’s conduct deviated from the standard.

2. Negligent failure to obtain informed consent

In addition, a plaintiff may be able to assert a claim of negligent failure to obtain informed consent. Under State law, a health care provider is required to obtain the informed consent of a patient before administering medical care. Among the requirements for informed consent is that the patient be made aware of the condition being treated, and of recognized possible alternative forms of treatment. Thus, with

249 See discussion infra Part IV.B.1.

250 Masaki v. General Motors Corp., 71 Haw. 1, 14, 780 P.2d 566, 574 (1989), reconsideration denied, 71 Haw. 664, 833 P.2d 899 (1989) (holding that “[i]n most civil proceedings . . . the plaintiff must show by a ‘preponderance of the evidence’ that his or her claim is valid. . . . The preponderance standard directs the factfinder to decide ‘whether the existence of contested fact is more probable than its nonexistence.’” (quoting E. CLEARY, MCCORMICK ON EVIDENCE, section 339, 957 (3d ed. 1984)).


252 See Bernard, 79 Hawai‘i at 378, 903 P.2d at 683.


254 Id.

aggressive treatment now a recognized alternative, the basis for a claim could be that the option of aggressive treatment was never provided, and therefore professional service was rendered without informed consent. If a plaintiff could show that demands for aggressive treatment were made and not met, or if medical records indicate continuing pain yet medication that could have provided effective relief was not offered, informed consent will be deemed not to have been obtained.

3. Failure to comply with health care instructions

Where a resident lacks sufficient capacity\(^{256}\) to make health care decisions, the defendant’s conduct may rise to the level of recklessness, or even criminal intent, if an advance health care directive\(^{257}\) exists but is not complied with.\(^{258}\) Under Hawai‘i’s Uniform Health-Care Decisions Act (modified),\(^{259}\) a health care institution must comply with a health care instruction made by a patient, designated agent, judicially appointed guardian, or legal surrogate.\(^{260}\) The institution may decline to comply under certain situations,\(^{261}\) but must inform the decision-maker of the

\(^{256}\) HAW. REV. STAT. § 327E-2 (Supp. 2003) (defining "Capacity" as “an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.”).

\(^{257}\) Id. (defining an "Advance health-care directive" as “an individual instruction or a power of attorney for health care.”).

\(^{258}\) See HAW. REV. STAT. § 327E (Supp. 2003). The statute provides in relevant part:

(a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity.

\(^{259}\) HAW. REV. STAT. § 327E-3 (Supp. 2003).

\(^{260}\) HAW. REV. STAT. § 372E-7 (Supp. 2003).

\(^{261}\) Id.
refusal and of a provider willing to comply. In addition, the provider must assist the resident in a transfer if one is so desired, and provide continuing care until the transfer is completed. If a plaintiff can prove that the institution knew about an advance directive but failed to comply, this could be used to prove reckless negligence and failure to obtain informed consent. Hawai‘i courts have consistently imposed an affirmative duty on health care providers to protect patient autonomy through informed consent. Thus, by consciously choosing not to comply with a directive, the provider is recklessly disregarding patient autonomy and violating the duty of informed consent. A failure to comply would then be grounds for pain and suffering damages, and depending on the mental state of the defendant, could also be grounds for punitive damages. In addition, if a violation of the law is found, statutory damages including actual damages and reasonable attorney fees will be awarded to the resident or estate.

This presents a potentially significant liability issue for Hawai‘i health care providers, since Hawai‘i has a higher than average rate of elderly residents with advance directives. In 2000, 48.5 percent of all residents in nursing homes in Hawai‘i had formal advance directives; 55.4 percent of terminally ill residents had formal advance directives; 40.7

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262 HAW. REV. STAT. § 327E-7(g)(1) (Supp. 2003).

263 HAW. REV. STAT. § 327E-7(g)(1) (Supp. 2003).


265 See Masaki v. General Motors Corp., 71 Haw. 1, 6, 780 P.2d 566, 570 (1989), reconsideration denied, 71 Haw. 664, 833 P.2d 899 (1989). The court held that “[i]n determining whether an award of punitive damages is appropriate, the inquiry focuses primarily upon the defendant's mental state, and to a lesser degree, the nature of his conduct.” Id. (citation omitted).

266 See HAW. REV. STAT. § 327E-10 (Supp. 2003).

267 See HAWAII STATE PROFILE, supra note 54.
percent of residents with severe cognitive impairment had formal advance directives.\textsuperscript{268}

4. **Damages**

Proving damages presents another common problem in suits involving dependent elders. Recognizable damages are usually minimal due to limited lifespan, existence of one or more disabilities, and no loss of wages.\textsuperscript{269} Consequently, not many attorneys are willing to take these cases. Damages in these types of suits, therefore, should mainly focus on pain and suffering,\textsuperscript{270} mental anguish, and loss of quality of life.\textsuperscript{271} A plaintiff should consider:

1) Necessary and reasonable medical expenses; 2) Actual past expenses for physician, hospital, nursing and laboratory fees, medications, prosthetic devices, etc.; 3) Anticipated future expenses; 4) Harm from conditions caused by prolonged immobilization; 5) Pain and suffering from physical injuries; 6) Pain and suffering reasonably likely to occur in the future; 7) ‘Phantom pain’ and other subjective pain that may not be readily apparent to others; 8) Mental anguish; 9) Harm from loss of sleep; [and] 10) Past and future impairment of the ability to enjoy life.\textsuperscript{272}

\textsuperscript{268} *Id.* The corresponding national averages are as follows: 36.1 percent of all residents; 45 percent for terminally ill residents; and 36.9 percent for residents with severe cognitive impairment. *Id.*

\textsuperscript{269} Furrow, *supra* note 31, at 42.

\textsuperscript{270} Haw. Rev. Stat. § 663-8.5(b) (1993). “Pain and suffering is one type of noneconomic damage and means the actual physical pain and suffering that is the proximate result of a physical injury sustained by a person.” *Id.*


\textsuperscript{272} *Id.*
Damages may also be recoverable by surviving spouses and children, including damages for loss of companionship, mental anguish and grief, and funeral and burial expenses.\textsuperscript{273} Hawai‘i law allows for survival of claims for punitive damages.\textsuperscript{274} Thus, in some situations, punitive damages may also be appropriate.\textsuperscript{275} Hawai‘i courts have consistently held that “[w]here clear and convincing evidence exists, one circumstance . . . that warrants an award of punitive damages is when ‘there has been some wilful misconduct or that entire want of care which would raise presumption of a conscious indifference to consequences.’”\textsuperscript{276} If a plaintiff could prove that a provider’s conduct rises to the level of recklessness under the new theory, punitive damages may be available. In situations where health care providers have inadequately managed the pain of terminally ill patients, juries generally appear willing to award punitive damages.\textsuperscript{277}

\textsuperscript{273} Id.

\textsuperscript{274} Jenkins v. Whittaker Corp., 551 F. Supp. 110 (D. Haw. 1982), cert. denied, 479 U.S. 918 (1986) (holding that “because the decedent would have had an action for punitive damages had he survived, . . . his estate representative [was] entitled to recover for punitive damages under HAW. REV. STAT. § 663-7.”).

\textsuperscript{275} Masaki v. General Motors Corp., 71 Haw. 1, 6, 780 P.2d 566, 570 (1989), reconsideration denied, 71 Haw. 664, 833 P.2d 899 (1989). The court held that “[p]unitive or exemplary damages are generally defined as those damages assessed in addition to compensatory damages for the purpose of punishing the defendant for aggravated or outrageous misconduct and to deter the defendant and others from similar conduct in the future.” Id. (quoting D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES, § 3.9, at 204 (1973)).


\textsuperscript{277} See supra note 83 and accompanying text (discussing jury award of $15 million, including $7.5 in punitive damages, against nursing home for inadequate pain treatment); see also TOPICS, supra note 77 (discussing punitive damages in the Bergman case. The jury in Bergman voted eight to four to award punitive damages. This was only one vote short of California’s requirement of a nine to three vote for awarding punitive damages).
D. Other Possible Causes of Actions Under the New Theory

With inadequate pain treatment now recognized as substandard care, a plethora of additional claims exist to encourage victims and attorneys to pursue action. Possible claims include breach of contract, fraud, intentional or negligent infliction of emotional distress, unfair business practices, and violations of consumer protection.

V. RECOMMENDATIONS FOR FURTHER ACTION

With a standard for pain management established, education becomes the next priority. This means educating health care providers as to what constitutes adequate care, and educating residents about their right to receive adequate treatment. In addition, with inadequate treatment now constituting elder abuse, individuals involved in the elderly services delivery network must also be made aware of the established standard of care.

A. Educating Health Care Providers

One recommendation for further improvement in managing pain is the inclusion of “pain as the 5th vital sign” in the Department of

\(^{278}\) FindLaw, Nursing Home Abuse & Injuries–Overview, supra note 135 (explaining that a claim for breach of contract exists if a provider’s conduct violates a promise made in the facility’s admissions contract regarding adequate care of the resident).

\(^{279}\) See supra Part III.B. (discussing possible fraud charges against Dr. Eugene Whitney by the Centers for Medicare and Medicaid Services).

\(^{280}\) See Berry, supra note 79. According to Robert Slattery, attorney for the defendant in the Bergman case, the claim lacked legal basis because unfair business practice applies to contract disputes rather than malpractice disputes. Id.; but see text accompanying note 278.

\(^{281}\) See Deanne Morgan, From the Front Lines: Pain Treatment Failures, Nursing Home Law & Litigation Report (Feb. 2004), available at http://www.compassionindying.org/tomlinson/index.php#9 (on file with Compassion in Dying Federation) (on file with author). The claims listed here are theoretically possible under the new theory. Further analysis is beyond the scope of this Comment.
Commerce and Consumer Affair’s licensing requirements. A major factor contributing to the inadequate treatment of pain in the institutional setting is poorly trained staff.\textsuperscript{282} Thus, it is imperative that each facility implement administrative procedures facilitating proper pain management. Equally as important is the implementation of effective performance measurement processes and methods.\textsuperscript{283}

One method for ensuring frequent pain assessment and proper continuing care is utilization of “pain as the 5th vital sign.”\textsuperscript{284} This method requires pain to be measured and recorded with each evaluation of the patient’s temperature, pulse, respiration, and blood pressure.\textsuperscript{285} Using these regular assessments as starting points, staff would then follow the facility’s established pain management strategies. Since all hospitals are required to use this method pursuant to the Joint Commission pain assessment standards,\textsuperscript{286} adoption of the method as a uniform practice in facilities would provide accurate and useful data for comparative studies of facilities statewide.

Another recommendation is the adoption of an “intractable pain statute.” To further encourage adequate pain management, states such as California have enacted these statutes to assure physicians that no litigation or disciplinary action will be taken for justifiable, aggressive treatment of intractable pain.\textsuperscript{287} Thus, to expedite improvement in the area of pain management, the Hawai‘i State Legislature should adopt an “intractable pain statute.”

Since facility staff are required to report abuse of a dependent adult under state law,\textsuperscript{288} it is important for all staff members to know that


\textsuperscript{283} Furrow, supra note 31, at 31.

\textsuperscript{284} “Pain as the 5th Vital Sign” is an initiative by the American Pain Society. The purpose of the initiative is to offer health care organizations a pain management improvement strategy, focusing on need to assess pain regularly. NAT’L PHARM. COUNCIL, INC., supra note 21, at 77.

\textsuperscript{285} Id.

\textsuperscript{286} See discussion supra Part IV.B.2.

\textsuperscript{287} See, e.g., CAL. BUS. & PROF. CODE § 2241.5 (West 1994).

\textsuperscript{288} HAW. REV. STAT. § 346-224 (1993).
inadequate pain management is now seen as abuse. Thus, “inadequate pain management” should be added to the definition of “abuse” under the Dependent Adult Protective Services Act, as well as to the definition of “neglect” contained in the Elder Justice Act. In addition, each facility in Hawai‘i should be required to include inadequate and untimely pain relief as an enumerated action constituting mistreatment, in individual facility policies.

B. Educating the Public

Since residents are now able to utilize services dealing with elder abuse to obtain immediate pain relief, another recommendation is the utilization of these services to educate residents and family members about the resident’s right to adequate pain relief, as well as options available when that right is violated. This means that individuals involved in these services must also be made aware of the established standard of care. Volunteers and employees in the network must receive training regarding a resident’s right to aggressive treatment, conduct that constitutes adequate treatment, and options available to a resident or family member when adequate treatment is not given. They must also learn how to recognize situations in which an elderly resident is being neglected. Thus, another recommendation is that signs and symptoms relating to unrelieved pain be added to training materials, brochures, pamphlets, and guides provided to volunteers and employees, as well as to material distributed to the public.

C. Amending the Elder Justice Act to Provide Private Causes of Action

Another recommendation is to amend the Elder Justice Act to provide victims and estates private causes of action for abuse of a


292 See, e.g., Executive Office on Aging & Dep’t of Human Services, Guidelines for Mandated Reporters Dependent Adult Abuse and Neglect (Feb. 2003).
dependent elder, as well as treble damages. By allowing residents to assert claims only under traditional medical malpractice law, victims are not being compensated for their injuries. Medical malpractice suits are extremely expensive and time consuming, and most terminally ill residents will not live long enough to see a case to the end. In addition, many residents and families who lack financial resources to institute malpractice claims will remain unprotected. Due to factors such as limited lifespan, physical or mental impairment, and terminal illness, a lack of enhanced penalties means damages awarded to residents or estates will generally remain low. Only where the most egregious facts exist will the attention of attorneys be drawn. The possibility of enhanced damages would provide a greatly needed incentive for attorneys to represent elderly residents. To safeguard institutions against a landslide of frivolous claims, however, language should also be added making litigation costs payable by the plaintiff where claims are found to be frivolous.

An earlier draft of the Elder Justice Act provided private causes of action for residents and their estates, treble damages, and an exemption of damages awarded under the section from the $375,000 cap. S.B. No. 78, 2003 Leg., 22nd Sess. (Haw. 2003). Due to concerns over the provisions’ impact on health care providers’ general liability insurance, however, the provisions were omitted from the final version. 2003 Haw. House J. 817, 859-61 (daily ed. Apr. 8, 2003).

Telephone Interview with Thomas Grande, Partner, Davis Levin Livingston Grande (Apr. 26, 2004) [hereinafter “Grande Interview”].

See Kevin B. Dreher, Book Note, Enforcement of Standards of Care in the Long-Term Care Industry: How Far Have We Come and Where Do We Go from Here?, 10 ELDER L.J. 119, 143-144 (2002).

Grande Interview, supra note 294; see Lindy Washburn, Elderly find their malpractice cases aren’t worth lawyers’ time, N. N.J. Rec., Oct. 6, 2002, at A-1 (stating that as a result of the low potential for damages in cases involving the elderly, victims or survivors seldom file malpractice suits due to inability to find representation).

Ellen J. Scott, Punitive Damages in Lawsuits Against Nursing Homes, 23 J. LEGAL MED. 115, 128 (Mar. 2002). “To provide a disincentive for frivolous lawsuits, such statutes should include a provision awarding defense attorney’s fees if it could be established that the plaintiff acted in bad faith in bringing the case.” Id.
VI. Conclusion

Under a theory emerging from a line of California elder abuse cases, a standard of care for pain management has been established, ambiguities surrounding pain medication prescription removed, and an affirmative duty to aggressively treat pain recognized. As a result, existing Hawai‘i State laws provide residents sufficient remedies to assert their right to adequate pain management. With inadequate relief now constituting elder abuse, Hawai‘i’s dependent elderly residents and their families are provided an entire network of protective services to exhaust. In addition, the attorney general has a recognized cause of action for abuse of a dependent elder, and can pursue either civil or criminal charges. Where State law fails to provide residents and estates a cause of action to hold providers liable for dependent elder abuse, State medical malpractice laws fill the gap by providing a cause of action for professional negligence.

Substandard pain management has remained the prevailing practice in the community for so long, that changes undoubtedly will take time. As demonstrated by the events unfolding in California, pain guidelines and state policies have only a limited effect. Sometimes, external pressures such as the threat of litigation are necessary to effectuate timely improvements. While Hawai‘i residents wait for these changes, however, alternatives now exist to protect them when violations occur.

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298 Furrow, supra note 31, at 30 (stating that “[t]he threat of malpractice litigation may offset [the powerful forces influencing practioer’s] to improperly manage pain] . . . making anxious providers either overestimate the risk of suit or at least adjust their practice to a new assessment of the risk of the suit.”).