

Pain Management and Provider Liability: No More Excuses

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Pain¹ is undertreated in the American health-care system at all levels: physician offices, hospitals, long-term care facilities.² The result is needless suffering for patients, complications that cause further injury or death, and added costs in treatment overall. The health-care system's failure to respond to patient pain needs corrective action. Excuses for such shortcomings are simply not acceptable any longer.

Physicians have long been accused of poor pain management for their patients.³ The term "opiophobia" has been coined to describe this remarkable clinical aversion to the proper use of opioids to control pain.⁴ If the professional mandate of the health-care professional is to relieve suffering, then physicians are falling far short of their obligations⁵ by accepting myths about the use of opioids in the face of evidence to the contrary.⁶

The possible reasons for health-care providers' failures to properly manage pain are many. First, physicians are poorly educated in medical school about narcotics and proper pain management, and they remain ignorant in practice about appropriate treatment choices for pain management,⁷ often rapidly absorbing professional norms that simply reflect a culture hostile to drug use.⁸ Second, threats of legal action loom large in providers' vision: criminal prosecution for use of controlled substances; sanctions involving the loss of hospital staff privileges for use of opiates; medical licensing board disciplinary action; and so on. Uncertainty about legitimate opioid use, coupled with a regulatory system that threatens sanctions, intimidates physicians.⁹ Third, patients, worried about tolerance and addiction to the opioids, receive little adequate information or education by providers.¹⁰ Patients suffer unnecessary pain as a result.¹¹ Fourth, lack of insur-

ance coverage may deny patients access to costly long-term pain management with its multiple modalities of treatment.¹²

Scholars have examined many of these barriers — restrictions on insurance reimbursement,¹³ Medicare and Medicaid limits,¹⁴ and criminal prosecutions — and their effect on the use of effective tools for pain control.¹⁵ It is clear that the legal and regulatory environment is a complicated one, with cross-currents that make it difficult for physicians to offer optimal care. What is missing is an external source of norms that articulate the values of pain relief and impose a penalty on providers for their shortcomings. Such a source of pressure can counteract the fears of criminal prosecution and the pressures of both inertia and restrictions on reimbursement that push physicians, hospitals, managed care organizations, and nursing homes to undertreat pain. Tort liability is a powerful external threat, and it can work in tandem with other constructive pressures in the environment to improve provider management of patient pain.

The threat of a malpractice suit for undertreatment of pain is presently quite low. Few judicial decisions discuss pain management and undertreatment. Pain as a component of a tort suit shows up primarily in pain and suffering awards for a physician's negligent treatment or diagnosis of a patient that leads to physical harm and accompanying pain; workers compensation claims for pain treatments; or a component of emotional distress claims. If, however, a physician's treatment of the patient's illness meets the medical standard of care, then the pain attendant on the normal course of illness has typically not been the object of tort damages. What is needed is recognition that the standard of care in treating patients includes pain management as much as it does treatment of the disease.

Treatment and management of pain by both physicians and institutional providers can be improved by the threat of tort litigation, which would spotlight providers' failures to

comply with an emergent standard of proper pain management. This threat of litigation can be a powerful incentive to change medical practices. This article will analyze existing and emerging liability theories and doctrines that should have an impact on the attitudes of physicians and institutional providers toward pain management.

I. THE NATURE OF PAIN: TOUGHING IT OUT

Pain is often viewed as an inevitable part of illness, as a necessary adjunct to disease and its treatment. Too often physicians simply force patients to tough it out, to cope with pain that is unnecessary and debilitating. Patients may also share an attitude that pain is normal and should simply be endured, although this is in contrast to patients with advanced diseases, who welcome pain management for their symptoms.¹⁶ Most pain can be treated and relieved, even though sadly it is too often untreated or poorly managed.¹⁷

A. Categories of pain

Pain is traditionally divided into acute and chronic pain. Acute pain may be the result of surgery, dental work, burns, or other somatic damage that results in pain of limited duration. Chronic pain may be divided into cancer pain and nonmalignant pain. For nonmalignant pain, palliative medicine is the therapeutic response, defined as “the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.”¹⁸ Such pain is also often termed “intractable,” to mean any condition or situation that is unmanageable or untreatable.¹⁹ While the disease or condition may be untreatable, the pain and symptoms most often can be treated. Chronic pain is usually viewed as appropriately treatable by opioid analgesics on a long-term basis.²⁰

Cancer pain is one of the largest categories of pain. Millions of cancer patients suffer pain that could be relieved and managed by proper treatment. One estimate is that more than 90 percent of cancer pain can be controlled with available treatment options.²¹ Analgesic drugs, in particular, are an effective approach to managing cancer pain; these include aspirin, codeine, morphine, and their substitutes.

The elderly, particularly in nursing homes, suffer high levels of pain — chronic and nonmalignant in many cases — that is poorly managed up to 70 percent of the time. According to clinical practice guidelines on the management of chronic pain in older persons, “For some conditions, chronic pain is defined as pain that exists beyond an expected time frame for healing. For other conditions, it is well recognized that healing may never occur. In many cases, chronic pain is understood as persistent pain that is not amenable to routine pain control methods. Because there are many differences in what may be regarded as chronic pain, the definition remains flexible and related to specific diagnoses or cases.”²²

The standard of practice for pain management is well articulated for cancer pain, for surgical pain, and for nonmalignant chronic pain. But medical practice has been slow to adopt this standard due to fear of addiction and a multiplicity of other factors.²³

B. Proper pain management

Pain management is defined in the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines as “a comprehensive approach to the needs of patients, residents, clients, or other individuals served who experience problems associated with acute or chronic pain.”²⁴ Proper assessment of pain, based on patient self-reporting, is at the heart of any organizational approach to pain management. Pain comes in many forms, but treatment of so-called “intractable” pain follows a generally agreed-upon pyramid of treatment, in which the non-steroidal anti-inflammatory drugs (NSAIDs) and other drugs in combination with patient training come first, and opioids are the final and effective treatment for all forms of pain that fail to respond to milder drugs. As Joranson and colleagues state, “the use of opioids in the class of morphine is the cornerstone of pain management.”²⁵ Yet patients and clinicians continue to be unduly concerned about addiction. Joranson and colleagues comment that “[h]ealth care professionals may be reluctant to prescribe, administer, dispense, or stock controlled substances for fear of causing addiction or contributing to the drug abuse problem.”²⁶ Addiction is viewed as an evil to be avoided even when its likelihood is low, leaving patients to a stoic absorption of pain that most cannot achieve. Recent studies confirm that abuse of opioid analgesics has remained low in spite of increases in their medical use.²⁷

Failure to properly manage pain — to assess, treat, and manage it — is professional negligence.²⁸ The problem from a malpractice perspective is one of establishing a standard of care based on a clear practice in favor of sophisticated pain management. The current versions of the ethical principles governing clinical practice — the Hippocratic Oath and the Code of Ethics of the American Medical Association (AMA) — and the statements of medical leaders do articulate the duty to relieve suffering. For example, the AMA’s Code of Medical Ethics states in pertinent part, “[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.”²⁹ Nurses likewise are admonished to “use full and effective doses of pain medication for the proper management of pain in the dying patient. The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified.”³⁰ But medical practice at all levels lags behind these ethical expressions of the duty to treat pain.

II. PHYSICIAN FAILURES TO TREAT PAIN: TORT AS A BEACON

A. Functions of tort liability

The rules developed by courts in malpractice suits serve a range of functions in altering medical practice. First, tort rules reinforce good medical practice. Case law is the voice of common law judges stating minimum principles of generally accepted medical practice. The cases typically defer to the medical consensus on a standard of practice without much judicial scrutiny of the standard. But case law is still an influencing force on medical practice nonetheless, as it imposes financial burdens on providers and their malpractice insurers for medical errors, ignorance of good practice, and tolerance of sloppy practice. A lawsuit inflicts a price on providers in insurance costs and defense costs. Providers, as consumers of lawyers and insurance, are at least somewhat sensitive to increases in price, heightening their sensitivity to bright-line rules of practice.

Second, tort rules give voice to patients who have been patronized, ignored, actively manipulated, or cruelly treated by physicians. Informed-consent doctrine has forced medical recognition of patients' informational needs; EMTALA has forced stabilizing treatment by hospitals inclined to simply push patients out the door; disclosure obligations have built on the physician's fiduciary duty toward patients.

Third, malpractice litigation drives institutional practices toward convergence on validated standards of practice. Lawyers can introduce evidence of emerging clinical practice guidelines as a way of arguing for a standard of care that the defendant failed to satisfy. Proof of malpractice thus slowly moves from elastic expert opinion toward more empirically validated clinical practices. This means that the defense has less wiggle room in the average malpractice case and, as a result, the law indirectly forces physicians toward heightened awareness of standards.

Fourth, tort law often articulates new duties of care for providers. Physicians not only must pay attention to emerging practices, but must also disclose risks to third parties created by a patient, candidly make a referral to a more skilled specialist, be honest with the patient, and watch out for the patient's interests over those of the provider. These new duties force providers to focus on the patient as primary.

These tort functions have implications for improving pain management. We have come to expect providers to master these new roles: provider of full information to patients as consumers of health care; protector of public health, through obligations to warn family members and third parties; stabilizer of patients even without a contractual relationship; and comforter and counselor of families. But current incentives in the health-care system push powerfully toward physicians' undertreating pain. As Ann Martino writes:

[S]trong rewards, both internal and external to the practice of chronic pain management, reinforce the principle in the ethic of under prescribing to say no. A practitioner who accepts that addiction is harmful and that assisting or hastening death is a wrong has a duty to prescribe drugs in a manner that will not result in either. Federal and state prescribing laws, societal norms about the dangers of drugs, and board rules and regulations reward practitioners who under prescribe by making saying yes a risky proposition — to practitioners' livelihood, reputation, and status in the practice community and under the law.³¹

The threat of malpractice litigation may offset these powerful forces, making anxious providers either overestimate the risk of suit or at least adjust their practice to a new assessment of the risk of suit. Surprisingly, most patients do not file a malpractice claim because of uncertainty as to the cause of their injury.³² This is true even though studies of medical error have concluded that "the burden of iatrogenic injury is large enduring, and an innate feature of hospital care in the United States."³³ Even for patients with major permanent injuries, it appears that only about one in six file suit.³⁴ However, the threat of tort litigation has a substantial psychological impact on physicians in excess of the diluted financial incentives created.³⁵ Physicians overestimate the risk of being sued and the size of feared judgments.³⁶ The sheer unpleasantness of being sued also deters, although it has been argued that the lack of clarity as to the locus of negligence in most cases does not provide useful feedback to providers.³⁷

Physicians clearly perceive a threat from the system, judging their risk of being sued as much higher than it actually is. The Harvard New York Study, surveying New York physicians, found that physicians who had been sued were more likely to explain risks to patients, to restrict their scope of practice, and to order more tests and procedures.³⁸ Malpractice insurers, particularly the physician-owned companies in many states, now engage in aggressive review of claims. These companies insure about 40 percent of physicians in active patient care. They routinely use physicians to review applications for insurance and to review the competence of those sued. Physicians with claims due to negligence, as assessed by the peer reviews, may be terminated, surcharged, or have restrictions on their practice imposed.³⁹ If a physician loses his malpractice insurance, he may quit, switch jobs, or go without insurance. He may also go to a surplus-lines insurance company that charges much higher premiums for coverage. Claims exposure can thus lead to a direct financial impact on the physician who is forced to carry such expensive insurance.⁴⁰

The litigation process is neither as arbitrary nor as unfair as critics suggest.⁴¹ The jury turns out to be a surprisingly reliable decision-making institution.⁴² Lawyers are good

screens for frivolous cases. A physician named as a defendant may, as a consequence, spend more time on exams or patient histories, invest in further training, increase support staff, or develop a more systematic approach to pain management. The few available studies have found that physicians who have been malpractice defendants often alter their practice as a result, even if they win the litigation. Perceived risk is thus important to physician conduct.⁴³ Hospitals have instituted risk management offices and quality assurance programs; informed-consent forms have become ubiquitous; medical record-keeping with an eye toward establishing proof of care at trial has become the rule. There is little doubt that the threat of malpractice litigation has had some effect on provider practices, and that increases in litigation over inadequate pain management would likely spur improvements at the individual provider and institutional levels.⁴⁴

B. The general malpractice rule

1. National standards of care

A liability analysis of pain management starts with the physician, since it is the physician who fails to prescribe proper medication or to assess and manage patient pain. The liability of physicians is governed by general medical malpractice principles. Malpractice is usually defined as unskillful practice resulting in injury to the patient, which constitutes a failure to exercise the “required degree of care, skill and diligence” under the circumstances.⁴⁵ A physician is not a guarantor of good results, nor is he or she required to exercise the highest degree of care possible. As one court said, “The physician will not be held to a standard of perfection nor evaluated with benefit of hindsight.”⁴⁶

The standard of care by which most state courts measure the conduct of both general practitioners and specialists is a national standard. A good statement of this standard is found in *Hall v. Hilbun*:

The duty of care ... takes two forms: (a) a duty to render a quality of care consonant with the level of medical and practical knowledge the physician may reasonably be expected to possess and the medical judgment he may be expected to exercise, and (b) a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonably available.⁴⁷

Most jurisdictions impose a national standard of care on physicians⁴⁸ because of concerns about a “conspiracy of silence,”⁴⁹ unfair limitations on the use of experts, and a recognition of the national character of medical education and practice.⁵⁰ Nonetheless, many jurisdictions allow evidence describing the practice limitations under which the defen-

dant labors.⁵¹ Some jurisdictions explicitly allow the trier of fact to consider the facilities, staff, and other equipment available to the practitioner in the institution where he or she is affiliated. This follows the general rule that courts should take into account the locality, proximity of specialists, and special facilities for diagnosis and treatment.⁵² The standard of care governs a physician’s conduct during the period when the patient was under his or her care; this includes follow-up care to ensure that a patient obtains medical records and information as requested.⁵³

Proving negligent pain management is difficult for the plaintiff in light of contemporary failures by the medical profession to practice pain management practices. Traditionally, tort law has allowed the medical profession to set the standards of practice, with the courts enforcing these standards in tort suits. Defendants trying to prove a standard of care normally present expert testimony describing the actual pattern of medical practice, historically without any reference to the effectiveness of that practice. Most jurisdictions give professional medical standards conclusive weight, so that the trier of fact is not allowed to reject the practice as improper.⁵⁴ On rare occasions, the courts have allowed the case to proceed in spite of agreement that the defendant satisfied the customary practice of his or her specialty because evidence was presented that the defendant was aware of the dangers in the standard practice.⁵⁵ Other more recent decisions have found that proof of “ordinary care” can prevail over a defense of compliance with custom.⁵⁶

The standard of care is not usually a bright-line rule. The standard in *Hall* for judging the defendant’s conduct was “minimally competent physicians in the same specialty.”⁵⁷ This minimal competence test seems less demanding than standard jury instructions in other states that require comparison to “the average practitioner in the class to which he or she belongs.”⁵⁸ “Average” suggests a midpoint in the range of practitioners, while “minimal” places the defendant’s conduct distinctly lower on a scale of practice. The standard of care must be at least in compliance with available technology at the time the diagnosis or treatment was offered to the patient, without the benefit of hindsight.⁵⁹ So the issue of what is known by a “minimally competent” practitioner, held to a national standard and assuming up-to-date education, is a classic jury question, leaving the trier of fact to resolve the dispute among sparring experts from either side.

a. Clinical practice guidelines

What a minimally competent practitioner must know has not traditionally been derived from an external authority, such as a government standard, but rather from medical standards developed through the interaction of leaders in the profession, professional journals and meetings, and networks of colleagues. Most clinical policies develop from an ongoing exchange in the literature, at meetings, and in peer dis-

ussions. Over a period of time, a clinical policy takes shape from this series of interactions. If it becomes generally accepted, it becomes "standard practice."⁶⁰

The development and proliferation of clinical practice guidelines has speeded the process by which good evidence-based medical practice becomes recognized and disseminated as such. In response to the rapid growth in medical research and published findings, these guidelines have become one of the transforming forces in current medical practice.⁶¹

Medical knowledge about evidence-based medicine has accumulated at a staggering rate. Between 1966 and 1995, the number of clinical research articles based on randomized clinical trials jumped from about 100 to 10,000 per year.⁶² American physicians and specialty groups have expended substantial effort on standard-setting in recent years, specifying treatments for particular diseases. Clinical practice protocols (also referred to as practice parameters or guidelines⁶³) have been developed by specialty societies such as the American Academy of Pediatrics; by the government, through the National Institutes of Health; and by individual hospitals in the clinical setting.

The development of practice standards and guidelines by national medical organizations has accelerated the process of moving all medical practice toward national standards.⁶⁴ Such guidelines provide a particularized source of standards against which to judge the conduct of the defendant physician, and the fact that they are produced by national medical specialty societies and the government means that they will be influential.⁶⁵

Such guidelines are sets of suggestions, described in decision rules, based on current medical consensus about how to treat a certain illness or condition. The Institute of Medicine has defined clinical guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." They are standardized specifications for using a procedure or managing a particular clinical problem. Such guidelines may be quality-oriented, reducing variations in practice while improving patient care;⁶⁶ they may also be cost-reducing, promoting a lower cost approach to care.

A clinical standard may be presumptive evidence of due care if expert testimony introduces the standard and establishes its sources and its relevancy.⁶⁷ The guidelines can also be used to impeach the opinion of a medical expert.⁶⁸ Clinical guidelines potentially offer an authoritative and settled statement of what the standard of care should be for a given treatment or illness. A court has several choices when such guidelines are offered into evidence. A guideline might be evidence of the customary practice in the medical profession. A doctor practicing in conformity with a guideline would be shielded from liability to the same extent as one who can establish that she or he followed professional custom. A guideline could also serve as a defense to a claim that the defen-

dant deviated from customary practice, insofar as it represents the practice of at least a "respectable" minority of the relevant profession.⁶⁹ The guideline acts like an authoritative expert witness or a well-accepted review article. Using guidelines as evidence of professional custom, however, is problematic if they are ahead of prevailing medical practice.

Guidelines have already had an effect on settlement patterns, according to surveys of malpractice lawyers.⁷⁰ Plaintiffs have used such guidelines to their advantage in malpractice cases, particularly the guidelines of the American College of Obstetricians and Gynecologists.⁷¹ Such guidelines provide a particularized source of standards against which to judge the conduct of the defendant physician. A widely accepted clinical standard may be presumptive evidence of due care, but expert testimony would still be required to introduce the standard and establish its source and relevancy. A guideline could thus be treated as negligence per se or at least a rebuttable presumption, which could then be countered with evidence.

Standards of care for pain management are increasingly well-established. Organizations such as the Agency for Health Care Policy and Research, the Agency for Healthcare Research and Quality, the American Pain Society, the American Academy of Pain Medicine, the American Geriatric Society, and the American Society of Anesthesiologists have promulgated pain control standards.⁷² The Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance have also been paying more attention to an institution's standards for pain management during the accreditation process.⁷³

The use of such guidelines in pain management litigation is therefore likely. Consider the Practice Guidelines of the American Society of Anesthesiologists.⁷⁴ These guidelines develop an interrelated set of approaches to proper pain management, with several levels: a comprehensive evaluation and treatment plan (history, physical examination, psychosocial evaluation, impression and differential diagnosis, and treatment plan); a diagnostic evaluation; counseling and coordination of care; periodic monitoring and measurement of clinical outcomes; and multidisciplinary, multimodal pain management. Multimodal therapy is "concomitant use of separate therapeutic interventions under the direction of a single practitioner to obtain additive beneficial effects or reduction of adverse effects." These interventions might include neural blockade with medications, rehabilitative therapies with neural blockade, and medications of varying strengths.

Pain management guidelines demand at least an initial diagnostic assessment of pain as a clear starting point and then attention to following the patient and using pain management strategies in a well-established hierarchical fashion. For physicians who work in hospital settings or depend on managed care organizations for the bulk of their patients, knowledge of and compliance with guidelines will become a

necessity. The guidelines provide the beginning of a bright-line test for measuring provider shortcomings in managing patient pain.

b. Web-based databases

The second force that reinforces the power of clinical practice guidelines is their easy availability on a range of Web sites.⁷⁵ Web sites have proliferated to help physicians gain efficient and user-friendly access to this even-greater proliferation of guidelines and other medical information.⁷⁶

The National Guideline Clearinghouse⁷⁷ is the best example of this; it offers free access to physicians and others to the current clinical practice guidelines, with instantaneous searches of the database. A search produces all guidelines on a given subject, along with an “appropriateness” analysis for each guideline.⁷⁸ The Clearinghouse also provides a standardized abstract of each guideline, and grades the scientific basis of its recommendations and the development process for each. Full text or links to sites with the guidelines are provided. Readers are given synopses to produce a side-by-side comparison of guidelines, outlining where the different sources of guidelines agree and disagree. Physicians can access electronic mail groups to discuss development and implementation.

To be included on the Web site, these guidelines must pass certain entry criteria: They must be current; contain systematically developed statements to guide physician decisions; have been produced by a medical or other professional group, government agency, health-care organization, or other private or public organization; and show that they were developed through a systematic search of peer-reviewed scientific evidence. The benefits of such a database are apparent. It has search features, comprehensiveness, and easy access through its Internet location, making it the most powerful tool for using guidelines to date.⁷⁹

Clinical practice guidelines have the power to influence the finding of a standard of care in a malpractice case, but are often ignored by busy physicians.⁸⁰ Physician adherence to guidelines appears to be hindered by inertia, lack of awareness, and external barriers, such as lack of time or difficulty of use.⁸¹ As Stephen Lande writes: “The reality of the system ... is that physicians will resist attempts to change treatment practices and will ultimately revert to their own way of thinking except when they are explicitly pressured.”⁸² Physicians who work within managed care systems, as most do today, need to have reminder and feedback systems in place to reinforce their attention to guidelines.

Resistance to pain management practices combines these forces of inertia with the provider’s additional fears about the extensive regulation of powerful opioids. However, Internet access to such guidelines in a quick and user-friendly way may hurry along the process of awareness and adoption of such guidelines and increase physicians’ comfort level with

better pain management practices. The location of current information on the Internet facilitates access for anyone with a computer, and the fact that the guidelines are linked to other commercial sites makes them easy to find, no matter what portal a physician uses to access medical information databases on the Web.⁸³

With the rapid clinical deployment of personal digital assistants (PDAs), which can download material from the Internet and store volumes of clinical reference information, physicians will be expected to be familiar with the appropriate clinical guidelines for the patients they treat. One company, docuCare, now offers a handheld device to document patient care at the bedside — to record vital signs, medications, the physician’s pain assessment, and the patient’s responses to a pain satisfaction survey.⁸⁴ The fact that a pain assessment survey is included with the device should emphasize to physicians the standard nature of taking such a survey.

A provider’s failure to access medical databases like the National Guideline Clearinghouse is likely to become an important piece of evidence in a malpractice suit, since it is evidence that a physician failed to stay current in his or her field of practice. A physician who displays ignorance of current treatment guidelines may be attacked by the plaintiff using the results of a computer search to display these guidelines and their relative ease of access.⁸⁵ Refusal to listen to a patient’s description of pain or to move to more effective drugs as needed, following the World Health Organization treatment pyramid or the pain management guidelines of various specialty organizations, will not be excused because of a claim that customary practice does not require it.

2. Other reasons to conform to the standard of care

A spectrum of liability doctrines are potentially available in situations where pain management is not given or is substandard.⁸⁶ The theoretical underpinning of all such theories is the same: failure to be aware of the standard of care for proper pain management or failure to conform to it.

The heart of any malpractice case is proof by the plaintiff that the defendant failed to meet the standard of care. If the physician provides pain management for a patient, it must be done properly. A claim for a failure to treat for pain is dependent on evidence that the standard of care requires proper pain management in the situation experienced by the plaintiff. A patient can expect proper treatment, defined by the emerging standards of care as encompassing a right to relief from pain.⁸⁷

Can a physician argue defensively that he or she was not trained in medical school as to proper pain management and that the customary practice among physicians is to undertreat pain? If a customary practice is a nonreflective and uninformed practice, it may be attacked by the plaintiff’s experts. A growing body of testimony by physicians who have

studied pain reflects a growing consensus on the proper treatment of pain — and you can bet that a plaintiff's pain is something about which every jury can understand and empathize.⁸⁸

The issue is whether the customary practice is a reflective one or the result of ignorance and inertia. Modern case law has at times instructed the trier of fact that customary practice need not always be an absolute defense — that evidence of good practice may be introduced. Judicial deference to customary practice is, in fact, weakening. The Wisconsin Supreme Court observed in *Nowatske v. Oserhoh*:⁸⁹

should customary medical practice fail to keep pace with developments and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care.... [W]hile evidence of the usual and customary conduct of others under similar circumstances is ordinarily relevant and admissible as an indication of what is reasonably prudent, customary conduct is not dispositive and cannot overcome the requirement that physicians exercise ordinary care.

The respectable minority defense allows a physician who wants to follow pain management guidelines to defend his or her practice in the face of a different customary practice. Pain management guidelines are already generally accepted and used as a reference in workers compensation cases in many states, since workers often claim both job-related disability and the pain that results from that disability.⁹⁰ The workers compensation judge often has to make findings as to whether a particular medical treatment is necessary. Statutes clearly allow compensation not only for curative treatment but also for palliative treatment, including aggressive pain management using opioids long term.

In *City of Jennings Police Department v. Dorr*, for example, the claimant suffered from chronic pain and depression due to a severe back injury. She had tried a variety of drugs, and her physician finally prescribed morphine sulphate for pain relief — specifically, 180 milligrams every eight hours, a dose usually reserved for chronically or terminally ill cancer patients. The court noted that the medical literature supported long-term treatment in certain cases with high dosages, although there was a split of opinion in the medical community. The court found that the level of drugs prescribed was not excessive and upheld the treatment plan of the physician as appropriate.⁹¹

Courts in a variety of cases — malpractice, workers compensation, and medical discipline, for example — apply a standard increasingly calibrated to proper pain management practices. As long as the physician can present evidence of a thoughtful program of pain management for a particular patient, the courts are willing to respect aggressive opioid use.⁹²

C. Other tort norms forcing pain management

1. Referrals to pain specialists

Multidisciplinary pain programs are acknowledged to provide cost-effective approaches to pain.⁹³ The ideal program includes specialists who can provide a range of services, including an anesthesiologist, a behavioral medicine specialist, a physical therapist, rehabilitative medicine specialist, and case managers to oversee and coordinate care.⁹⁴ Consequently, it is necessary for the primary care physician and other specialists to be familiar with the existence and expertise of a pain specialist. This is more than a statement of medical necessity for the patient; established tort principles require a physician to make a referral to the appropriate specialist when the physician lacks the knowledge or experience to properly treat the patient.⁹⁵

In *Freeman v. Cleveland Clinic Foundation*,⁹⁶ the plaintiffs' son committed suicide. They argued that the surgeon who was treating the young man for his knee injury negligently failed to refer him to a pain management clinic after he concluded that the patient would not benefit from further physical treatment of knee problems. The court held that failure to refer did not proximately cause the young man's death, a common judicial way of avoiding the imposition of liability for suicide. The court did not, however, reject the possibility of such a duty to refer. In a more typical malpractice case, where a patient is experiencing acute or chronic pain and the treating physician fails to treat it because of a lack of pain management knowledge, it is more likely that a duty to refer will be found. For instance, in *Johnson v. Kokemoor*,⁹⁷ a Wisconsin informed consent case, the court held that the physician's inexperience with a surgical procedure should have led him to offer the patient the choice of a referral to a nearby experienced surgeon.

The common law tort duty to refer is a well-established one. As the specialties of pain management mature, physicians who do not want to manage their patients' pain have a duty to refer. Patients with complicated pain imbedded in their disease process, like many cancer patients, require pain management as an integral part of their treatment. A pain management specialist must therefore be a part of the treatment team at a minimum. A physician who refuses either to treat the pain in conformity with current guidelines or to refer the patient is acting unethically. One could even argue that refusal to treat a pain patient is analogous to refusing to treat HIV-positive patients. The duty to refer must be carefully developed in light of the problem of pain, typically imbedded in the disease process for many patients. It can be argued that a primary care physician in particular must become familiar with pain management treatments, since referral may not always be possible — either because of insurer limitations or physical proximity. In such cases, the

duty of continued treatment binds the physician to learn about pain and its control, or risk an action for abandonment of the patient.

2. *Negligent or intentional infliction of mental distress*

Can a patient or the family as bystanders sue for infliction of emotional distress because of the patient's tangible suffering unrelieved by proper pain management? The family members of a post-operative patient, or a terminally ill patient, are vulnerable, worried, and anxious. Visible suffering, unrelieved by the tools of pain management, can predictably create emotional distress in family members. Witnessing a family member in a hospital or nursing home suffer from unrelieved pain is itself painful.

No case law exists to support such a duty toward family members, but it can be movingly and persuasively argued. Courts have allowed plaintiffs to sue health-care providers for the negligent infliction of emotional distress under particularly egregious circumstances. One example is *Oswald v. Legrand*.⁹⁸ The plaintiffs, a married couple, sued for mental injury as the result of a series of obstetric events. The wife was pregnant and began to have difficulties prior to her five-month check-up. She was admitted to the hospital, where she was treated rudely by physicians and staff and finally gave birth to a child who was presumed to be stillborn but turned out to be alive. The sequence of events was outrageous. The Oswalds claimed, among other things, severe emotional distress and mental anguish caused by witnessing the negligent treatment of their newborn infant. The court observed that tort law allows recovery for emotional distress when it is connected to physical injury or "where the nature of the relationship between the parties is such that there arises a duty to exercise ordinary care to avoid causing emotional harm. . . . [W]e think liability for emotional injury should attach to the delivery of medical services" (emphasis added).

Oswald focused on the vulnerability of the plaintiffs, coupled with the "crass insensitivity" of the medical staff. A similar case is *Wargelin v. Sisters of Mercy Health Corporation*,⁹⁹ where a series of obstetric disasters befell the plaintiffs. The obstetrician made only two visits during labor, even though a Caesarean section was indicated due to the plaintiff's lopsided uterus and the fact that the fetal monitor indicated distress. The staff failed to react, and an intern subsequently delivered the plaintiff's child, not breathing and blue in color, and placed it on the mother's stomach as if it were a healthy child. Realizing the child's condition, the obstetrician then grabbed the child and began to pound on her chest and administer electrical shocks to revive it. A call for a pediatrician to help went unanswered, and after fifteen minutes, the rescue attempt was abandoned. The Michigan court applied the bystander rule, which permits a family

member witnessing an injury to a third person to recover if the family member is present or suffers shock "fairly contemporaneous" with the accident. The court held that "the cumulative effect of all the events surrounding the stillbirth of the child, if proven to be negligent at trial, are sufficient to cause a parent to suffer emotional and mental distress."

In these cases, the courts have required observation of the disturbing events.¹⁰⁰ "Observation" has been liberally construed by some state courts to include a discussion with a physician about a loved one's deteriorating condition.¹⁰¹ Most courts, however, require some direct observation of the events causing the bad outcome, not just observation of the bad outcome itself.¹⁰²

Some jurisdictions are reluctant to allow observational distress, fearing a litigation explosion and difficulties of proof in such cases. In *Gray v. INOVA Health Services*,¹⁰³ a mother sued a hospital for negligent infliction of emotional distress after seeing her young daughter's physical reactions to an overdose of drugs during a medical test. The plaintiff alleged that she contemporaneously experienced extreme shock, blacked out, fell to the floor, vomited, and still suffers from mental anguish. The court affirmed a demurrer for the defendant on the grounds that the hospital owed no duty to the mother, only to the child who was the patient. However, *Gray* is distinguishable from the *Oswald* case, where active labor and its stresses involved both parents intimately in the birth process and where the staff's behavior was reprehensible. In *Gray*, the fault lay in a negligent dosage of drugs, not a cascade of rude and insensitive behaviors directed at vulnerable parties.

The doctrine of negligent infliction of emotional distress, therefore, has the potential to offer a remedy to vulnerable family members as they watch a loved one suffer needlessly in pain. The analogy to the labor and delivery cases is clear in the hospital or nursing home setting where the patient is obviously suffering. The doctrine is arguably applicable to any instances of intractable pain and its poor management in extreme cases.

3. *The doctrine of informed consent*

Can a plaintiff argue that informed-consent doctrine requires that pain management be disclosed as an alternative treatment to doing nothing for intractable pain, even if the physician does not want to use opiates or otherwise manage the pain? Such an obligation is connected to the duty to refer discussed above.

Physicians are required to disclose alternative methods of treatment — along with their risks and consequences, and their probability of success — if these methods of treatment are generally acknowledged within the medical community as feasible.¹⁰⁴ Physicians are obligated to discuss with patients the side-effects of drug treatments where

driving or other life activities might be impaired.¹⁰⁵ Some courts have held that alternatives should be disclosed even if the alternative is more hazardous¹⁰⁶ or the physician is not capable of performing the procedure or evaluating its risk.¹⁰⁷ The threshold is only that the alternative treatment be considered within the standard of care.¹⁰⁸ Such alternatives might include access to pain control programs or other specialty services.¹⁰⁹ Aggressive pain management through opioid prescription is, at present, at least a minority practice within the medical professions using comprehensive pain management strategies.

The definition of “treatment” for purposes of when “informed consent” is needed has been construed broadly to include diagnostic options and choices of hospitals for performing a procedure. Physicians must disclose diagnostic procedures that might assist patients in making an informed decision about treatment. In *Martin v. Richards*,¹¹⁰ the physicians failed to inform the parents of a minor patient of the availability of a CAT scan to detect intracranial bleeding and the unavailability of a neurosurgeon at the hospital to operate on the child. The court held that it was for the jury to decide whether these things caused the patient’s brain damage.

In *Vachon v. Broadlawns Medical Foundation*,¹¹¹ the plaintiff suffered severe multiple trauma injuries. The issue was whether the plaintiff’s transfer to a university hospital two hours away instead of to closer trauma hospitals was reasonable. The court held that the decision to transfer was part of the patient’s treatment and raised an issue of reasonable care. In *Johnson v. Kokemoor*,¹¹² the court included within a surgeon’s duty of disclosure an obligation to inform the patient of the proximity of experienced providers in a nearby clinical setting who would have been able to perform the operation at a lower risk.

The corresponding pain management issue is whether a physician should be sufficiently aware of choices — hospices for cancer patients, pain management programs for nonmalignant pain sufferers, or other physicians trained in modern pain management techniques — to be able to inform a patient of his or her options in treatment. It does not seem a stretch to require a duty to inform patients in such circumstances that a full range of pain therapies is available. Failure to discuss pain management options and the possibility of referral or transfer might well appear as a count in the patient’s malpractice complaint for pain mismanagement.

D. Proving pain as damages

Present and future pain and suffering is a legitimate component of a damages claim by a malpractice plaintiff. As Dobbs says, “[t]he pain for which recovery is allowed includes virtually any form of conscious suffering, both emotional and physical.”¹¹³ This can even include the pain of recalling past pain.¹¹⁴ Pain experts can testify about such pain, as can the

plaintiff; inferences about the degree of pain can also be drawn from the nature of the plaintiff’s condition and the kind of medical treatment needed. Pain includes the sensation of physical pain.

In the normal tort case, pain is the result of a bodily injury caused by the defendant. The court is willing to instruct juries on pain and suffering when the plaintiff has suffered tangible injury due to the defendant. In the medical setting, pain from a missed diagnosis and lost opportunity to treat can be part of damages. The pain management failures are more complicated: The physician or provider is responsible not for the patient’s condition, but for the mismanagement of pain, which is a by-product and symptom of an underlying disease. Pain, therefore, becomes the only component of damages, by analogy to the mental distress torts. The loss of enjoyment of life, as a corollary of the pain, may be allowed as a separate component of damages. The plaintiff’s reactions to the pain and his or her sense of loss as a result may also be compensable.¹¹⁵

III. INSTITUTIONAL FAILURES TO MANAGE PAIN: THOUGHTLESS SYSTEMS

Pain is ignored in the institutional setting as well as the physician’s office. The consequence of unrelieved pain, particularly cancer pain, is not only patient suffering and decreased quality of life. It has been estimated that “[b]etween 30 and 50 percent of cancer patients in active treatment and 70 to 90 percent of those with advanced disease experience moderate to severe pain. . . .”¹¹⁶ In surveys of surgical patients, it has been found that approximately half of all hospitalized post-operative patients failed to receive adequate pain relief. Patients reporting moderate to high levels of pain received less than half of the pain medication that was ordered.

The result of this undertreatment is decreased quality of life, functionality, activity, appetite, and productivity. The patient, having experienced such severe pain, can also become unwilling to continue treatment and become suicidal. At the MD Anderson Cancer Center in Texas, the annual hospital costs for pain admissions are estimated at \$4.7 million annually.¹¹⁷ Most of this pain can be managed by proper assessment of causes and treatment with opioid analgesics.¹¹⁸ And most of this pain is found in patients in institutional clinical settings — general medical, surgical, and oncology wards; burn units; emergency departments; and pediatric wards.¹¹⁹

Failures of pain management can have catastrophic consequences for patients and for health-care institutions. Undertreatment may also lead to patient suffering, surgical complications, and other negative treatment results. Pain is not just a background noise produced by a disease like AIDS or cancer, to be stoically ignored or endured; it is the cause of somatic failures and expensive hospitalization and of patient resistance to treatment. Lower back pain, as one ex-

ample, costs millions of dollars a year in loss work time. Pain, in other words, operates as an independent medical condition, and its continuation when modalities of treatment are available is iatrogenic — that is, injury that is provider-induced.¹²⁰

Malpractice tends to isolate the individual physician as the cause of patient injury and suffering. The evidence as to undertreatment suggests that while physicians may often be at fault, it is primarily the system of care that has failed to reorganize its resources to address the problem. Since educational approaches lack efficacy, the better approach is to affect the systems that influence physician behavior.

Treatment and management of pain by institutional providers can be fostered by the possibility of liability for failure to satisfy a standard of care for effective pain relief. These threats of litigation can be powerful incentives to counteract physician resistance to the adoption of sound pain management practices.

A. Hospitals: the mandate of pain management

In the hospital setting, unnecessary patient pain frequently imposes higher costs as the result of lost wages and higher health-care utilization, such as emergency room visits and unnecessary hospitalizations.¹²¹ The hospital system has not been designed to recognize pain as a valid indicator of suffering and track and treat it with the intensity with which a fever is treated in a hospital. “[R]eports of unrelieved pain do not invariably result in corrective measures; pain may not be visible at the coordinating centers of the ward, and physicians and nurses have not traditionally been held accountable for providing titrated analgesia.”¹²²

1. The general duty to manage complex systems

Hospitals have been slow to adopt pain management practices. Hospital staffs have not made pain relief a priority, and hospital organizational structures have failed to incorporate pain management support.¹²³ For instance, the SUPPORT Study in 1995 found that hospital treatment for dying patients involved poor communication between physicians and patients, overly aggressive treatments, and inattention to patient pain and suffering. It provided a discouraging indictment of the hospital system — namely, that it failed to treat patients with pain at the end of life. Critically ill patients were and continue to be bombarded with the newest medical technologies to extend their lives, even in the face of their stated wishes for a prompt relief of pain and suffering. A recent study of hospital palliative care concluded that lack of financial reimbursement is one of the reasons that end-of-life care is not a priority for hospitals.¹²⁴

Guidelines from the Agency for Health Care Policy and Research (AHCPR) provide for the minimization of the inci-

dence and severity of acute pain.¹²⁵ These guidelines were published in 1992, but “evidence suggests that suitable pain management programs have yet to be developed.”¹²⁶ This is despite the fact that the technologies are available, including intraspinal opioid administration, opioid infusion, and inhalational analgesia,¹²⁷ and that the organizational structures are well-defined.¹²⁸

Hospital-based clinical management has neglected post-operative pain. In the words of Blau and colleagues, “[r]ecent data suggest that many patients continue to fear severe pain after surgery, and many post-operative patients continue to have significant pain. Further improvements in the quality of pain control will not occur unless it is recognized as a priority by health care providers, and an institutional approach is taken to assure that high quality analgesic care is consistently provided.”¹²⁹ In spite of sound guidelines, “many health care institutions continue to lack any organized institutional approach for the management of acute pain.”¹³⁰

Yet the benefits of pain management are apparent. Surgical outcomes are improved by effective post-operative pain management, which may also reduce patient time in an intensive care unit, accelerate discharge readiness, and reduce the overall cost of hospitalization. These outcome benefits are based on inhibition of the metabolic stress response after surgery. Evidence shows that inadequate control of pain can also interfere more directly with recovery by impairing pulmonary function and movement and delaying the recovery of gastric and bowel function.¹³¹

Many medical disciplines are responsible for pain management. Pain management needs to be an institutional priority, supported with resources and leadership.¹³² A health-care institution, whether a hospital, nursing home, or clinic, is liable to its patients for negligence in maintaining its facilities, providing and maintaining medical equipment, hiring, supervising and retaining nurses and other employees, and failing to have procedures in place to protect patients.

Basic negligence principles govern hospital liability for injuries caused by something other than the negligent acts of the medical staff.¹³³ Hospitals are generally held to a national standard of care for hospitals of their size and treatment category. Where, however, a new technology of proven efficacy has been adopted by some hospitals, the standard may be used to measure the practice in all hospitals.¹³⁴

The professional duty of a hospital is to provide a safe environment for patient diagnosis, treatment, and recovery. If an unsafe condition on the hospital’s premises causes injury to a patient as a result of the hospital’s negligence, the hospital has breached its duty *qua* hospital.¹³⁵ The test is “whether the negligent act occurred in the rendering of services for which the health care provider is licensed.”¹³⁶ Hospitals must have minimum facilities and support systems to treat the range of problems and side effects that accompany the procedures they offer. Equip-

ment must be adequate for the services offered, although it need not be state of the art.¹³⁷

Pain management requires a systematic team approach. Much of the case law that has articulated hospital responsibility has come to focus on the administrative and treatment systems in place. For example, short staffing has been rejected as a defense where the available staff could have been juggled to achieve closer supervision of a problem patient.¹³⁸ Failure to provide an adequate twenty-four hour anesthesia service also may create liability.¹³⁹ A hospital and its contracting physicians may be liable for damages caused by inadequate or defective systems they develop and implement, particularly where emergency care is involved. Poorly designed systems can create harm just as readily as an incompetent staff member.¹⁴⁰ Hospital on-call systems must work properly,¹⁴¹ and systems for storing and supplying medications must function effectively.¹⁴² Another example of such an administrative failure is when a hospital fails to properly schedule a specialist consultation once it has been requested by a staff physician.¹⁴³

Hospitals will be liable for injuries caused by inadequacies in the internal programs that are mandated by statutes.¹⁴⁴ Once a hospital assumes a new responsibility, even a voluntary one, it is expected to properly implement that responsibility.¹⁴⁵

2. Corporate negligence

Courts have expanded the doctrine of corporate negligence for hospitals since the 1960s, recognizing that the hospital is no longer just a shell for the physician to use, but an active ring leader in providing care, support, and service. A hospital is thus directly liable for the failure of administrators and staff to properly monitor and supervise the delivery of health care within the hospital. A hospital has a non-delegable duty that extends directly to its patients, and it is liable for a breach of these duties. The liability arises from the hospital's action or inaction regarding its policies, rather than the specific negligent acts of one of its employees.¹⁴⁶

The courts have generally required hospitals to provide surveillance of the quality of patient care within the hospital.¹⁴⁷ Other courts have imposed on hospitals a duty to follow their own internal procedures¹⁴⁸ and to monitor the risks to patients created by poor treatment by staff physicians.¹⁴⁹

Corporate negligence imposes liability on health-care institutions for their failure to protect patients from the harms the institution could have controlled. The doctrine's best recent formulation is found in *Thompson v. Nason*, decided by the Pennsylvania Supreme Court.¹⁵⁰ The court held that corporate negligence is a doctrine imposing liability on a hospital if it fails to uphold the standard of care to "ensure the patient's safety and well-being while at the hospital." Four areas of liability are involved:

- a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;¹⁵¹
- a duty to select and retain only competent physicians;
- a duty to oversee all persons who practice medicine within its walls as to patient care; and
- a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients.

This articulation of the doctrine of corporate negligence by the Pennsylvania Supreme Court is broader than that of other state courts considering the issue; these other courts have often limited the doctrine to the duty to select and monitor physicians and allied health-care professionals. *Thompson* expands the scope of the doctrine to encompass the hospital's general duty to ensure quality of care for patients. This recognizes the complexity of the modern health-care institution and the need to impose a patient-centered approach to doing business. The fourth duty articulated — to formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients — is directly relevant to pain management. If a standard of care is established by accreditation standards, then a hospital can be expected, independent of accreditation, to follow such standards.

a. Duty to properly select and retain medical staff

Most jurisdictions have held hospitals to a duty to take reasonable steps to ensure the competence of its medical staff.¹⁵² The monitoring and retention of hospital staff have led to expanded duties to detect incompetence. A properly designed utilization review process within an institution will produce data as to unnecessary procedures, high error rates, and other early warnings of problems with a staff physician. The existence of such a process will give a hospital actual notice of possible incompetence, exposing it to liability if it fails to act to deal with the problem.¹⁵³

In addition to determining which staff physicians are incompetent to handle certain procedures, the hospital must detect any concealment by its staff of medical errors.¹⁵⁴ While some courts have limited this duty to only those situations where a hospital has learned of physician insufficiencies,¹⁵⁵ others have talked of "negligent supervision" in terms of an affirmative duty to detect problems.¹⁵⁶ The few cases that reject a hospital's duty to monitor are increasingly outside mainstream jurisprudence on hospital responsibility.¹⁵⁷

Pain management obligations should be shouldered by physicians, with continuous feedback and attention to the level and quality of such management by the hospital. A failure to provide training and feedback and to detect physician reluctance to use proper techniques provides an argument of corporate negligence.

b. *Duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care*

The broad statement of this fourth duty of hospitals, as articulated in *Thompson v. Nason*, properly defines the role of corporate negligence in addressing institutional management of all dimensions of patient care. The regular charting of pain should be treated as a “fifth vital sign” along with the other vital signs of temperature, pulse, respiration, and blood pressure.¹⁵⁸ Pain management is now a dimension of hospital administration in light of the new JCAHO standards. The duty to monitor patient care to ensure that staff physicians are properly treating patients must now include proper pain management.

i. *JCAHO standards and pain management as a priority*

Hospitals are regulated by their states, and state regulation typically defers to the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The standard of care applied by courts in malpractice actions also reflects a baseline mandated by JCAHO standards, including its peer reviews through internal committee structures. Courts have consistently allowed evidence of JCAHO standards, state hospital licensure laws, and the hospital’s own by-laws, which the trier of fact is entitled to accept or reject, as creating a permissive inference of negligence¹⁵⁹ or a rebuttable presumption.

Failure to follow new JCAHO standards for pain management can thus lead to liability, with such standards being admissible as evidence of the standard of care once they are implemented for the hospital’s accreditation.¹⁶⁰ The standards force integration of pain management into a hospital’s overall care of a patient. A team approach to medical practice, incorporating pharmacists and other providers, is likely to further reduce risks. The standards developed by JCAHO and the National Committee on Quality Assurance need to rapidly incorporate the current findings of the Institute of Medicine report, *To Err Is Human: Building a Safer Health System*, and increase the pressure on individual and institutional health-care providers to redesign their systems to reduce risk.

Only within the last few years have JCAHO standards finally addressed pain management in hospitals and the need for proper organizational structures to promote such management. In 1991, JCAHO mandated that pain be routinely assessed and outcomes of care be routinely documented for terminally ill patients, but not for other patient populations experiencing acute or chronic pain. By 1995, JCAHO had written pain management into its guidelines. Finally, with the 2000 and 2001 editions of the JCAHO accreditation manuals, JCAHO now requires surveyors inspecting hospitals to include in their surveys a systematic look at pain as-

essment and management; the surveyors must determine whether the hospital has integrated compliance with the pain management standards with the overall care of patients.¹⁶¹

If proper pain management is now part of the hospital accreditation process, then corporate negligence suits will use such accreditation guidelines, along with common law decisions that generally impose a duty of institutional responsibility for patient care, to establish the hospital’s standard of care.

ii. *Emergency Medical Treatment and Labor Act (EMTALA)*

The Emergency Medical Treatment and Labor Act,¹⁶² or EMTALA, provides another source of liability that particularizes the standard of care expected of hospitals that participate in the federal Medicare program¹⁶³ and have emergency departments. The Act requires covered hospitals to provide a medical screening examination¹⁶⁴ to any patient coming into the emergency department¹⁶⁵ of the hospital.

The question from the perspective of pain management is twofold: Is pain an emergency medical condition that requires stabilization before transfer is possible? *and* Is avoidable or treatable pain a material deterioration of the patient’s condition? The control of avoidable physical pain is a significant obligation of medical treatment. Severe physical pain that could have been avoided with appropriate medical care is arguably a material deterioration of the patient’s condition.¹⁶⁶

If an emergency medical condition¹⁶⁷ is present, the hospital must provide treatment to stabilize¹⁶⁸ the patient’s medical condition unless the patient requests the transfer in writing, or a physician certifies that the benefit of the transfer to the patient outweighs the risk.¹⁶⁹ If the hospital transfers the patient,¹⁷⁰ the transport support provided must meet the statutory standards for adequacy of equipment and personnel, the receiving facility must agree to accept the transfer, and the transferring hospital must provide all medical records to the receiving facility.¹⁷¹ Patients may refuse treatment, may refuse to consent to the transfer, and may request transfer.¹⁷²

EMTALA provides for a private cause of action for violation of the statute. Any individual suffering harm as a “direct result” of a hospital’s violation of the statute has a cause of action against the hospital.¹⁷³ The statute also provides for civil monetary penalties against the hospital and against the “responsible” physician for violations of the Act.¹⁷⁴ The statute provides that civil damages¹⁷⁵ for a hospital’s violation of the Act shall be “those damages available for personal injury under the law of the State in which the hospital is located.”¹⁷⁶ Although claims under EMTALA are not claims for medical malpractice, plaintiffs usually claim both a violation of EMTALA and medical malpractice.

The Act provides that “if any individual . . . comes to the emergency department,”¹⁷⁷ it is the hospital’s duty to assess whether the patient has an emergency medical condition.¹⁷⁸

The claim of failure to provide an appropriate medical examination requires that the patient be physically present in the emergency department, but some courts have held that a claim of transfer in an unstable condition does not require that the patient enter the hospital through the emergency room.¹⁷⁹

Courts interpreting EMTALA's medical screening requirement have generally adopted a standard of differential treatment and not professional standards. Plaintiffs must prove that the hospital's policy is to conform with professional standards. To the extent that the hospital has established written guidelines or has followed consistent practices in emergency medical examinations, it is, of course, essential for plaintiffs to prove their content.¹⁸⁰ The patient's examination may be so cursory or inadequate as to amount to no examination at all, resulting in a finding that EMTALA was violated.¹⁸¹

A hospital violates the Act if it fails to provide an "appropriate medical screening examination" to the patient arriving in the emergency room. If the hospital provides an appropriate examination that detects an emergency condition or if the patient's emergency condition is otherwise known to the hospital, the hospital is liable under the Act if it transfers or discharges the patient in an unstable medical condition. Courts have required the plaintiff to prove that the hospital actually knew of the plaintiff's emergency condition in order to trigger the duty to stabilize prior to transfer or discharge.¹⁸² Where the hospital lacks actual knowledge of the patient's emergency condition as a result of a statutorily inadequate medical screening examination, the hospital would be liable at least for violating the examination requirement of the Act.¹⁸³

Courts look at several factors in deciding whether a patient was stable before transfer or discharge. If the hospital actually admitted and treated the patient for a significant amount of time, this is some evidence of stability.¹⁸⁴ Patient stabilization must be judged from the perspective of professional standards rather than standards established by each hospital.¹⁸⁵ The Act explicitly defines "stabilized" as a condition in which "no material deterioration of the condition is likely, *within reasonable medical probability*, to result from or occur during the transfer."¹⁸⁶

The EMTALA action is a small piece of the liability package for pain mismanagement. No case law has yet developed such a theory with regard to pain. But recognition of the importance of pain management in the new JCAHO pain management guidelines means that hospitals that seek JCAHO accreditation will need to develop policies for assessing and treating patient pain, including emergency admissions. This then sets a standard that must be followed in screening patients and stabilizing them. EMTALA then offers a statutory basis for suit in emergency admissions when patients are not properly screened or stabilized for pain.

B. Managed care organizations: paying for pain relief

Managed care organizations undertake to "manage" the care of subscribers. For outpatient conditions, such as lower back pain or other kinds of disability that can result in chronic intractable pain, it is arguable that a managed care organization should be responsible for designing and paying for institutional approaches to proper pain management. If clinical guidelines describe an ideal approach to pain, then the individual or institutional health-care provider is responsible for implementing such a strategy. Cost-sensitive managed care organizations, however, may resist.

For example, emergency room treatment for pain is likely to be resisted by utilization reviewers, arguing that it is too subjective and will impose excessive costs on the plan. Likewise, hospice care for cancer or other patients at the end of life is not provided consistently by all managed care organizations.¹⁸⁷ Nonmalignant chronic pain, such as that experienced by nursing home residents or those with other disabilities, can be expensive to treat with some of the new treatment approaches and is often neglected because of difficulty in defining it.¹⁸⁸ The complex sources of chronic nonmalignant pain make diagnosis and management difficult. As a result, patients with such pain may need extensive diagnostic tests and referral to specialists or multidisciplinary centers.¹⁸⁹

Managed care plans are worried about the costs of proper pain management, and with some justification. Susan Wolf notes:

Just as research on pain is in its infancy, research on how well or poorly MCOs [managed care organizations] do in treating pain similarly seems to be at an early point. It is clear that "HMOs' outpatient prescription drug benefits frequently are subject to restrictions . . . such as generic substitution, therapeutic substitution, and [limited] formularies." Moreover, these benefits may be available in some HMOs only by subscriber purchase of an extra "rider" to the coverage contract, and coverage affects access to pain-relieving drugs. Much remains to be determined about the effectiveness of MCOs in addressing pain, however, especially for patients at the end of life.¹⁹⁰

Managed care organizations and insurers are reluctant, in large part, because they feel that many of the pain management guidelines are not based on extensive clinical studies.¹⁹¹

Until recently, courts have held that ERISA (the Employee Retirement Income Security Act) preempted most litigation against managed care organizations for medical errors. But this position has been deteriorating in the face of

quality-of-care abuses by managed care organizations. At bottom, managed care organizations are businesses. They market their care to potential employers and subscribers in a competitive marketplace for health care. They recruit and organize their physicians through their networks. They design a corporate system in which health care is delivered. And they must administer this system in a safe fashion that avoids injury to subscribers caused by the negligence of plan physicians and other providers. Malpractice claims based on vicarious liability, corporate negligence, negligence per se, and intentional infliction of mental distress may be allowed to proceed against managed care organizations under the current law as quality-of-care issues outside the scope of an ERISA claim for benefits (i.e., quantity-of-care, or coverage, issues).¹⁹²

1. Agency doctrine

Under theories of agency, managed care organizations may be on the hook for the liability of the physicians and other providers who work for them. Such vicarious liability has been upheld by the majority of courts, having considered the question of liability not to be preempted by ERISA.¹⁹³ The reason is that the managed care organization's plan is irrelevant to the claim, since the claim of agency does not rise and fall with the plan.¹⁹⁴ Rather the claim is established by reference to the parties' reliance and representations, a question of fact not involving the interpretation of an ERISA plan.¹⁹⁵ If, however, the underlying claim against the treating physician is a failure to treat — a denial of benefits — then it relates to the benefits plan, and the claim could not be resolved without reference to a determination on benefits. In such a situation, one circuit court has held that ERISA completely preempts the agency claim.¹⁹⁶

2. Substandard plan design and administration

Claims of negligent design and administration of the delivery of health-care services have been allowed in recent cases.¹⁹⁷ A negligence claim against a plan for providing contractual benefits in "such a dilatory fashion that the patient was injured are intertwined with the provision of safe care."¹⁹⁸ In *Pappas v. U.S. Healthcare*, the issue was a delay in transporting the plaintiff to a specialty trauma unit for care. The delay arguably was caused by the utilization review process of the managed care organization, which did not allow transport to the best hospital unit in the area for spinal injuries. The case appears to involve both a system-induced delay and a benefits question as to which hospitals were available to the plaintiff. The case was remanded by the U.S. Supreme Court for reconsideration in light of its decision in *Pegram v. Herdrich*. Absent ERISA preemption as a defense, the doctrine of corporate negligence could be held to apply.¹⁹⁹

A claim that a ERISA managed care plan is "substandard" and has led to patient injury as a result has been allowed to avoid ERISA preemption. In *Moreno v. Health Partners Health Plan*,²⁰⁰ the District Court held that there was "no relation between an action for medical malpractice and the recovery of benefits or the clarification of rights to future benefits under an ERISA plan."²⁰¹ An action for negligent supervision of plan physicians has been allowed by courts to proceed as a quality issue and has not been deemed preempted by ERISA.²⁰² Likewise, a plan decision to discharge a patient from the hospital to her home rather than a skilled nursing facility has been considered a "quality" issue, not suitable for preemption.²⁰³

Where a plan is responsible for the continuum of care and it proves to be inadequate — even if that means it refuses to cover a benefit at a rehabilitation hospital or other facility — courts have found this to be a complaint of substandard care and thus not preempted by ERISA.²⁰⁴ If a plan is negligent in failing to provide appropriate screening tests and studies, this, too, could be viewed as a negligent provision of benefits and not a denial of benefits, thus subject to ERISA.²⁰⁵ The U.S. Supreme Court's recent decision in *Pegram v. Herdrich*²⁰⁶ further opens the door to state tort litigation against managed care organizations on all the theories that hospitals are subject to, by refusing to interpret ERISA as imposing a fiduciary duty on physicians making "mixed eligibility decisions."

The problem with managed care organization liability is that pain management is still in its infancy. The field lacks clinical practice guidelines that are well-grounded in clinical studies. The practitioners of pain management are credentialed by different organizations and the lack of a consensus as to the gold standard for accreditation means that managed care medical directors are properly uncertain about to whom patients should be referred. Evidence of fraud in hospice billing in some cases has exacerbated managed care organization reluctance. As Diane Hoffmann writes:

additional resources and attention need to be devoted to developing guidelines for treatment of various types of pain and ... more research needs to be conducted on the effectiveness and cost effectiveness of various pain treatment modalities and palliative care.... Additionally, there needs to be broader recognition of what constitutes a pain specialist and when a referral to a pain specialist is appropriate.... [U]ntil more widespread consensus develops on what constitutes effective treatment of pain, especially chronic pain, or agreement on credentials for certification of pain providers, we can expect insurers and MCOs to be reluctant to approve coverage of some forms of pain treatment and continuing variation across plans in the way they deal with this issue.²⁰⁷

Managed care plans should be expected to be a market for effective pain management practices, since the use of the “substandard” test by the federal courts suggests not only an ERISA preemption defense for plaintiffs, but the emergence of a corporate negligence test that applies directly to managed care organizations.

A set of standards by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance will push managed care organizations in the direction of better pain management, both through market pressure and through the provision of a standard of care in tort actions. The law, after all, usually reflects the maturing and solidification of medical practice, demanding of practitioners and institutions that they measure up to standards set by their own institutions. NCQA has not yet provided specific standards for pain management, while JCAHO’s new guidelines indicate that the field is maturing. NCQA should be urged to develop a standard that reinforces JCAHO’s guidelines, thereby acknowledging the central importance of pain management in the care of patients.

C. Long-term care facilities: pain and quality of life

Nursing homes are increasingly the final stop before death. It has been estimated that half of the Americans who live to the age of 65 will live in a nursing home before they die.²⁰⁸ In 1996, there were over 1.56 million nursing home residents in the United States.²⁰⁹

The elderly in nursing homes are often undertreated for pain.²¹⁰ Improper pain management in nursing homes can lead to high levels of chronic pain. Most nursing home residents are chronically, rather than acutely, ill. The average length of stay for nursing home patients is much longer than the average length for patients in acute-care hospitals. More than 84 percent of nursing home residents receive help with three or more activities of daily living, including eating, dressing, bathing, toileting, and transferring from one location to another.²¹¹ Pain is often the companion for these residents.

The elderly, the primary residents of such long-term care facilities, are poorly treated. The elderly also have lacked effective tort remedies: Causation may be hard to establish, given multiple diseases, and damages are hard to prove, with the exception of pain and suffering. The primary case to date that has imposed a duty to treat for pain is *Estate of Henry James v. Hillhaven Corp.*²¹²

In this case, James was admitted to a nursing home with prostate cancer that had metastasized to his left femur and spine. Upon admission, it was estimated that he had about six months more to live. His personal physician prescribed 7.5 cc’s of oral morphine elixir every three hours, as needed for pain. A nurse at the nursing home countermanded this order, after assessing James as addicted. She implemented a

pain management plan using a mild tranquilizer and delaying or withholding analgesics.

The court found that James experienced physical pain and suffering and mental anguish, described as “inhuman treatment” inflicted “without regard to the consequences and without care as to whether or not the patient received analgesic relief and without care that the result and procedures were torture of the human flesh.”²¹³ During the trial, medical and nursing experts testified about the standard of care for opioid analgesics and morphine for intractable pain. A nurse also testified that proper quality assurance in nursing homes requires proper pain management.²¹⁴ Thus, the issue again becomes the role of well-established clinical practice guidelines, JCAHO accreditation standards, and other sources to which a court can turn for a standard in evaluating the failures of a physician or nurse in a long-term care setting or the failure of the facility to detect and correct negligent treatment.²¹⁵

1. Damages and causal problems with nursing home litigation

The nursing home population, in contrast to the typical hospital patient, will have more difficulty in succeeding in private litigation to remedy harms suffered as a result of breaches of established standards of care.²¹⁶ Physical injuries such as broken bones and bruises in very frail elderly persons may be caused either by ordinary touching or by poor care or abuse. Causation, therefore, is difficult to prove. The mental impairment of many nursing home patients makes them poor witnesses, since they are unable to testify as to their experiences of pain. Their limited lifespan and their disabilities minimize legally recognizable damages for injury or death. They do not suffer lost wages. Their access to private attorneys has been limited because small damage awards discourage contingent fee arrangements and because of the isolation of institutionalization. Because of these limitations, several states have enacted statutes providing for private rights of action for nursing home residents. These statutes generally provide a cause of action for breach of statutory standards and may provide for enhanced damages and attorney’s fees.²¹⁷

2. False Claims actions under OBRA

The newest approach to poor quality of care in nursing homes is the False Claims Act under the Omnibus Reconciliation Act of 1987 (OBRA ’87).²¹⁸ OBRA deals with (1) service requirements for those facilities in the Medicare and Medicaid programs; (2) a survey and certification process; and (3) enforcement and sanctions. OBRA requires a thorough assessment of each resident’s functional capacity, to be used in developing a written care plan; specialized rehabilitation; a requirement that homes use less restrictive measures before turning to physical restraints; a prohibition of “unnecessary”

drugs; and an explicit statutory basis for residents' rights. The goal of OBRA is to address a nursing home resident's condition so that he or she can achieve and maintain the "highest practicable physical, mental, and psychosocial well-being."²¹⁹

The False Claims Act ²²⁰ provides a statutory source, either used by the government or in a Qui Tam action by a private party, for using OBRA as setting the minimum standard for quality of life in a nursing home. A prima facie case need only allege that (1) the defendants presented or caused to be presented to an agent of the United States a claim for payment; (2) the claim was false or fraudulent; (3) the defendants knew the claim was false or fraudulent; and (4) the United States suffered damages as a result of the false or fraudulent claim.

The False Claims Act was initially used for overbilling or billing for unnecessary services. Its use by U.S. Attorneys against nursing homes has been based on allegations of billing for unrendered, yet necessary services, leading to a poor quality of care for residents. Providers claiming reimbursement under the federal Medicare and/or Medicaid programs implicitly certify compliance with all applicable federal regulations pertaining to program eligibility. When providers, either knowingly or recklessly, fail to render the appropriate regulated levels of care, they may be susceptible to liability under the False Claims Act, having falsely certified compliance.²²¹

The False Claims Act has potential for extreme violations and obvious misconduct in nursing homes, such as bed sores and major sanitary problems with fragile elderly patients. Undertreatment of pain, absent an extreme case such as the facts in *Henry James* and absent an aggressive and protective family, will continue to be difficult to prove, even with this new weapon. But the specter of a large judgment based on a patient's pain is one additional source of pressure on nursing home operators to incorporate effective pain management into their care of residents.

CONCLUSION

Pain management is evolving as critics clamor for improvement in patient care. Progress, however, has been surprisingly slow — the result of continued uncertainty by providers as to appropriate opioid use, lack of institutional attention to pain management, and inattention by medical schools.

A convergence of forces is now building pressure on health-care providers to incorporate pain management into their practices. First, JCAHO's new statement of *Pain Assessment and Management* establishes a new standard of pain as the "fifth vital sign," which must be monitored and treated by hospitals for continued accreditation. Second, pain management clinical practice guidelines are now readily found through the Internet for easy access by health-care providers.

One can only hope that medical school education will also incorporate a contemporary version of pain management into its curriculum.

Tort liability can now build on this convergence in pain management standards. It can reflect this convergence in medical practice and amplify the message so that providers hear it and change their practices accordingly. Patients suffer from too much pain — it is time for our hospitals, nursing homes, and doctor's offices to reduce this suffering.

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3. See, for example, AMA Department of Young Physicians Services, *Pain Management: Resources for Physicians* (visited July 20, 2000) <<http://www.texnet.net/paincare/acute.htm>> (stating that "[d]espite good intentions and genuine concern for patients' comfort on the part of physicians, repeated evaluations of the state of pain therapy over the past 20 years suggest that many patients receive inadequate pain relief"); Committee on Care at the End of Life, *Approaching Death: Improving Care at the End of Life*, M.J. Field and C.K. Cassel, eds. (Washington, D.C.: National Academy Press, 1997): at 5. See J.J. Bonica, *Effective Pain Management for Cancer Patients* (St. Paul: SIMS Deltec, Inc., 1994) (eleven reports, involving nearly 2,100 patients, found that 70 percent of patients managed with opioids and other drugs have unrelieved pain until their death. See also R. Bernabel, C. Gatsonis, and V. Mor, "Management of Pain in Elderly Patients with Cancer," *JAMA*, 279 (1998): 1877–82 (reporting on a study of over 10,000 nursing home residents with cancer which found that, although pain is common among such residents, it is often untreated); R. Oden, "Acute Postoperative Pain: Incidence, Severity and the Etiology of Inadequate Treatment," *Anesthesiology Clinics of North America*, 7 (1989): 1–15; K. Sriwatanakul, O.F. Weis, J.L. Alloza et al., "Analysis of Narcotic Usage in the Treatment of Postoperative Pain," *JAMA*, 250 (1983): 926–29.

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5. K.M. Foley, "The 'Decriminalization' of Cancer Pain," in *Advances in Pain Research & Therapy*, vol. 11, C.S. Hill, Jr., and W.S. Fields, eds. (New York: Raven Press, 1989): 5, at 15 (describes "rampant opiophobia" among health-care professionals and concludes that "most physicians lack sufficient knowledge of the clinical pharmacologic approaches" that would be necessary for them to assume responsibility "to manage acute and chronic pain in medical illness effectively.") See also R. Melzack, "The Tragedy of Needless Pain," *Scientific American*, 262 (1990): at 27.

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47. 466 So. 2d 856, 872-73 (Miss. 1985). *Hall* was followed in *Turner v. Temple*, 602 So. 2d 817 (Miss. 1992).

48. See, e.g., *Bahr v. Harper-Grace Hospitals*, 528 N.W.2d 179 (Mich. 1995).

49. See, e.g., *Trull v. Long*, 621 So. 2d 1278 (Ala. 1993). Some courts require that the plaintiff prove such a conspiracy of silence in the particular case before an instruction will be allowed. See, e.g., *Thibodeaux v. Aetna Casualty & Surety Co.*, 216 So. 2d 314 (La. Ct. App. 1968).

50. See, e.g., *Bates v. Meyer*, 565 So. 2d 134 (Ala. 1990).

51. *Vergara v. Doan, M.D.*, 593 N.E.2d 185, 187 (Ind. 1992) ("availability of facilities may be considered").

52. See *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970); Restatement (Second) of Torts, § 299A cmt. g (1977) ("Allowance must be made also for the type of community in which the actor carries on his practice. A country doctor cannot be expected to have the equipment, facilities, experience, knowledge or opportunity to obtain it, afforded him by a large city.")

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56. See *Nowatske v. Osterloh*, 543 N.W.2d 265 (Wis. 1996),

where the court noted that "customary conduct is not dispositive and cannot overcome the requirement that physicians exercise ordinary care.... We recognize that in most situations there will be no significant difference between customary and reasonable practices. In most situations physicians, like other professionals, will revise their customary practices so that the care they offer reflects a due regard for advances in the profession. An emphasis on reasonable rather than customary practices, however, insures that custom will not shelter physicians who fail to adopt advances in their respective fields and who consequently fail to conform to the standard of care which both the profession and its patients have a right to expect."

57. *Hall*, 466 So. 2d at 871.

58. *Zintek v. Perchik*, 471 N.W.2d 522, 530 (Wis. Ct. App. 1991).

59. See *Klisch v. Meritcare Medical Group, Inc.*, 134 F.3d 1356 (8th Cir. 1998), where the patient sued for negligent performance of surgery. The Court of Appeals held that (1) a jury instruction in which the jury was asked to consider the state of medical technology at time of the allegedly negligent surgery was appropriate; and (2) under Minnesota law, the jury in a medical malpractice action should weigh information available to physicians at the time of treatment and without benefit of hindsight.

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62. M.R. Chassin, "Is Health Care Ready for Six Sigma Quality?," *The Milbank Quarterly*, 76 (1998): 565, at 574.

63. See, e.g., Rosoff, *supra* note 61, at 369.

64. The Agency for Health Care Policy and Research (AHCPR) within the Health Care Financing Administration, for example, has the responsibility of developing guidelines for clinical practice through the administration's Medical Treatment Effectiveness Program. This program supports research, data development, and other activities to develop and review clinically relevant guidelines, standards of quality, performance measures, and medical review criteria in order to improve the quality and effectiveness of health-care services. See Pub. L. No. 101-239 (1990).

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67. See generally Kinney and Wilder, *supra* note 65; M.J. Mehlman, "Assuring the Quality of Medical Care: The Impact of

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68. See *Roper v. Blumenfeld*, 706 A.2d 1151, 1156 (N.J. Super. App. Div. 1998) (defendant allowed to use a 1992 edition of *Parameters of Care for Oral and Maxillofacial Surgery: A Guide of Practice, Monitoring and Evaluation* to examine his expert and cross-examine the plaintiff's expert; the textbook established that the injury suffered by the plaintiff was a known complication of the procedure).

69. See generally A.L. Hyams, D.W. Shapiro, and T.A. Brennan, "Medical Practice Guidelines in Malpractice Litigation: An Early Retrospective," *Journal of Health Politics, Policy & Law*, 21 (1996): 289. The respectable minority defense allows a defendant physician to defend by arguing that her practice is followed by at least a respectable minority of other physicians in that practice area or specialty.

70. *Id.*

71. See, e.g., *Miles v. Tabor*, 443 N.E.2d 1302 (Mass. 1982) (obstetrician's failure to initiate resuscitation of infant immediately after delivery violated American College of Obstetricians and Gynecologists guidelines); *Green v. Goldberg*, 630 So. 2d 606 (Fla. Dist. Ct. App. 1993) (American College of Obstetricians and Gynecologists bulletin on breast cancer treatment used to support expert testimony); *Basten v. U.S.*, 848 F. Supp. 962 (M.D. Ala. 1994) (involving American College of Obstetricians and Gynecologists guidelines requiring that alpha-fetoprotein screening be offered and that acceptance or rejection be documented). See generally Hyams et al., *supra* note 69, at 296-99.

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74. These guidelines can be found on-line at <http://www.asahq.org/practice/chronic_pain/chronic_pain.html>.

75. J.P. Kassirer, "Patients, Physicians, and the Internet," *Health Affairs*, 19 (2000): 115 (noting that physicians access medical information on-line, even though older physicians are slower to adopt more wide-ranging uses for the medium).

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79. See P.G. Shekelle and D.L. Schriger, "Evaluating the Use

of the Appropriateness Method in the Agency for Health Care Policy and Research Clinical Practice Guideline Development Process," *Health Services Research*, 31, no. 4 (1996): 453.

80. "Passive dissemination of guidelines (such as via publication or the World Wide Web) is a weak way of modifying physician behavior." D.L. Schriger et al., "Implementation of Clinical Guidelines Using a Computer Charting System: Effect on the Initial Care of Health Care Workers Exposed to Body Fluids," *JAMA*, 278 (1997): 1585, at 1589. The studies conclude that some form of active implementation of guidelines at the local level is needed in order to involve physicians. In one study, in a hospital emergency department in a university hospital, patients were health-care workers exposed to blood. A computer charting system provided real-time information regarding history and recommendations for laboratory testing, treatment, and disposition based on rules derived from clinical guidelines. The study found that documentation and compliance improved. Compliance with testing guidelines increased from 63 percent to 83 percent during the intervention phase and decreased to 52 percent when the computer system was removed. Real-time application of a computer-based system that provides practice guidelines literally "at the physician's fingertips" may be an effective method to improve the quality of patient care. "The fusion of electronic charting, computer databases, and clinical guidelines may offer the best hope for efficiently guiding, monitoring and improving the quality of ambulatory medicine." *Id.* at 1590. See also I. Ray-Coquard et al., "Impact of a Clinical Guidelines Program for Breast and Colon Cancer in a French Cancer Center," *JAMA*, 278 (1997): 1591; K. Elam et al., "Impact of a Worker's Compensation Practice Guideline on Lumbar Spine Fusion in Washington State," *Medicare Care*, 35 (1997): 417 (through use of guidelines for elective lumbar fusion as part of inpatient utilization review program, tied to reimbursement limitations, lumbar fusion rate declined 26 percent compared with a 3 percent decline for all lumbar operations over five years).

81. See M.D. Cabana et al., "Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement," *JAMA*, 282 (1999): 1458.

82. S.D. Lande, "The Problem of Pain" (Chapter 2), in *Managed Care and Pain*, S.D. Lande and R.J. Kulich, eds. (Glenview, Illinois: American Pain Society, 2000): 28.

83. Internet-based physician-oriented Web sites are available on a commercial basis. One example is MDConsult, a commercial database available by subscription that provides easy access to hundreds of medical textbooks and treatises, as well as clinical practice guidelines. Another example is Medscape, which provides a full range of on-line resources.

84. See <<http://www.docuare.net/>>.

85. See *Warrick v. Giron*, 290 N.W.2d 166 (Minn. 1980).

86. See B.A. Rich, "The Emerging Standard of Care for Pain Management," *William Mitchell Law Review*, 26 (2000): 1; R.S. Shapiro, "Health Care Providers' Liability Exposure for Inappropriate Pain Management," *Journal of Law, Medicine & Ethics*, 24 (1996): 360 (general malpractice discussion).

87. *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989), where a quadriplegic incapable of spontaneous respiration sought court approval for discontinuation of his respirator. The Georgia Supreme Court affirmed his right to refuse medical treatment and to receive proper sedation as well: "Mr. McAfee's right to be free from pain at the time the ventilator is disconnected is inseparable from his right to refuse medical treatment. The record shows that Mr. McAfee has attempted to disconnect his ventilator in the past, but has been unable to do so due to the severe pain he suffers when deprived of oxygen. His right to have a sedative (a medication that in no way causes or accelerates death) adminis-

tered before the ventilator is disconnected is a part of his right to control his medical treatment." *Id.* at 652.

88. See S.H. Walzer et al., "The Physician's Responsibility Towards Hopelessly Ill Patients: A Second Look," *N. Eng. J. Med.*, 320 (1989): 844, at 847 ("To allow a patient to experience unbearable pain or suffering is unethical medical practice."); E.D. Pellegrino, "Emerging Ethical Issues in Palliative Care," *JAMA*, 279 (1998): 1521, at 1521 ("not to relieve pain optimally is tantamount to moral and legal malpractice"); M. Angell, "The Quality of Mercy," *N. Eng. J. Med.*, 306 (1982): 98, at 99 ("the treatment of severe pain in hospitalized patients is regularly and systematically inadequate.... Pain is soul destroying. No patient should have to endure intense pain unnecessarily.").

89. 543 N.W.2d 265, 272 (Wis. 1996).

90. Shapiro, *supra* note 86.

91. 736 So. 2d 366 (C.A. La. 1999).

92. Most of the legal discussion of substandard practice is not found in malpractice cases, but in medical discipline actions. For example, in *Holladay v. Louisiana State Board of Medical Examiners*, the Louisiana State Board of Medical Examiners imposed sanctions on a physician for prescribing controlled substances in a substandard way. He had prescribed controlled drugs in the absence of any treatment plan and medical examinations for up to eight months. He had also failed to check on the substance abuse record of his patients. According to the testimony of experienced physicians, the physician had breached the standard of care for proper pain management given these omissions.

93. *Managed Care and Pain*, S.D. Lande and R.J. Kulich, eds. (Glenview, Illinois: American Pain Society, 2000): at 30.

94. Shapiro, *supra* note 86, at 361.

95. See *Corley v. State*, 749 So. 2d 926 (La. 1999); *Johnson v. Kokemoor*, 545 N.W.2d 495, 508-09 (Wisc. 1996).

96. 713 N.E.2d 33 (1998).

97. 546 N.W. 495 (Wis. 1996).

98. 453 N.W.2d 634 (Iowa 1990).

99. 385 N.W.2d 732 (Mich. Ct. App. 1986).

100. *Johnson v. Ruark Obstetrics and Gynecology Associates, P.A.*, 395 S.E.2d 85 (N.C. 1990) (expectant parents of a stillborn fetus sued the physicians for the negligent infliction of mental distress, alleging that they had observed events surrounding the death of the fetus; the North Carolina Supreme Court allowed negligent infliction of emotional distress based on a test of reasonably foreseeable consequences).

101. See, for example, *Frame v. Kothari*, 515 A.2d 810 (N.J. Super. Ct. App. Div. 1985) (defendant physician's misdiagnosis of a cerebella hemorrhage and acute hydrocephalus due to blunt trauma to the skull was held to be an event perceived by the parents; first, the parents' discussion with the defendant about their son's deteriorating condition was an "observation"; and second, their distress was foreseeable after the doctor was informed of the condition and failed to properly treat it). See also *Ochoa v. Superior Court of Santa Clara County*, 216 Cal. Rptr. 661, 703 P.2d 1 (Cal. 1985) (mother suffered distress after visiting her son who was receiving "woefully inadequate" medical care in a juvenile detention home).

102. See, for example, *Smelko v. Brinton*, 740 P.2d 591 (Kan. 1987) (parents waiting outside the operating room for their baby to undergo surgery; baby is negligently burned during the surgery and they discover the burn when he is brought out; court held that merely seeing the bad result is not sufficient for recovery). But see *Martinez v. Long Island Jewish Hillside Medical Center*, 518 N.Y.S.2d 955, 512 N.E.2d 538 (N.Y. 1987) (physician negligently diagnosed a pregnant woman's condition as requiring an abortion; the woman aborts the fetus and then discovers the abortion was not needed; recovery allowed).

103. 514 S.E.2d 355 (Va. 1999).
104. See, e.g., *Teilhaber v. Greene*, 727 A.2d 518 (N.J. Super. Ct. 1999); *Moore v. Baker*, 989 F.2d 1129 (11th Cir. 1993).
105. Case law requires physicians to warn third parties about, or take steps to protect them from, patients who are taking medication. These steps might include warning the patient about the effects of medication, or even refusing to prescribe the medication if the patient might still drive. See *Welke v. Kuzilla*, 375 N.W.2d 403 (Mich. Ct. App. 1985); *Myers v. Quesenberry*, 193 Cal. Rptr. 733 (Cal. Ct. App. 1983) (physician failed to warn his patient, a diabetic, of the dangers of driving); *Calwell v. Hassan*, 908 P.2d 184 (Kan. Ct. App. 1995) (physician treated patient for sleep disorder, failed to warn him not to drive).
106. *Gemme v. Goldberg*, 626 A.2d 318, 326 (Conn. App. Ct. 1993).
107. See *Holt v. Nelson*, 523 P.2d 211 (Wash. Ct. App. 1974).
108. See *Morris v. Ferriss*, 669 So. 2d 1316 (La. Ct. App. 4th 1996) (physician did not have to advise patient that psychiatric treatment was an alternative treatment for epileptic partial complex seizures since it was not accepted as feasible); *Lienhard v. State*, 431 N.W.2d 861 (Minn. 1988) (managing pregnancy at home rather than in hospital not a choice between alternative methods of treatment; therefore, disclosure was not required).
109. *Martin v. Richards*, 531 N.W.2d 70 (Wis. 1995) (failure to inform parents of patient that a CT scanner was available to diagnose head injuries and that facility lacked neurosurgeon to treat intracranial bleeding).
110. 500 N.W.2d 691 (Wis. Ct. App. 1993).
111. 490 N.W.2d 820 (Iowa 1992).
112. 545 N.W.2d 495 (Wis. 1996).
113. Dan B. Dobbs, *Law of Torts* 1050 (2000).
114. *Sears, Roebuck & Co. v. Hartley*, 160 F.2d 1019 (9th Cir. 1947).
115. Dobbs, *supra* note 113, at 1052. See also 2 Dan B. Dobbs, *Law of Remedies* § 8.1(4) (2nd ed. 1993).
116. *Id.*
117. *Id.* at 224.
118. *Id.* at 225–226 (“most cancer pain can be managed by the appropriate assessment of the causes of pain and treatment with non-invasive opioid analgesics. However, despite recent progress in the management of cancer pain, many patients experience severe pain due to inadequate analgesia.”).
119. American Pain Society Quality of Care Committee, “Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain,” *JAMA*, 274 (1995): 1874. The Committee offered several Guidelines: First, recognize and treat pain promptly by charting patient self-reporting; commit to continuous improvement of outcome variables; and document outcomes. Second, make information about analgesics available. Third, promise patients attentive analgesic care. Fourth, define explicit policies for use of advanced analgesic technologies. Fifth, maintain a commitment to continuous improvement.
120. The most important work to date addressing the broad issue of medical error is the Institute of Medicine report, *To Err Is Human: Building a Safer Health System*. The report is groundbreaking in its emphatic recognition, finally, that health care is a complex technological system prone to error. The report calls for “a comprehensive approach to improving patient safety,” noting that “[m]ost errors and safety issues go undetected and unreported both externally and within health care organizations.” With the exception of anesthesia, where the recognition that systems factors cause errors has led to a fail-safe system and better training to reduce such errors, health care has yet to implement any larger mechanism to detect errors based on system deficiencies and individual errors.
121. S. Chandler and R. Payne, “Economics of Unrelieved Cancer Pain,” *American Journal of Hospice & Palliative Care*, 15, no. 4 (July/August 1998): 223.
122. *Id.* at 1875.
123. For an early acknowledgment of this problem, see generally S.Y. Fagerhaugh and A.L. Strauss, *Politics of Pain Management: Staff-Patient Interaction* (Reading, Massachusetts: Addison-Wesley, 1977). A more recent review of the literature is found at Morgan, *supra* note 4.
124. C.K. Cassel, J.M. Ludden, and G.M. Moon, “Perceptions of Barriers to High-Quality Palliative Care in Hospitals,” *Health Affairs*, 19 (2000): 166.
125. *Acute Pain Management*, *supra* note 72. See generally P.C. Crowley, “No Pain, No Gain? The Agency for Health Care Policy & Research’s Attempt to Change Inefficient Health Care Practice of Withholding Medication from Patients in Pain,” *Journal of Contemporary Health Law & Policy*, 10 (1993): 383.
126. J.A. Dalton et al., “Changing Acute Pain Management to Improve Patient Outcomes: An Educational Approach,” *Journal of Pain and Symptom Management*, 17 (1998): 277, at 278.
127. B.R. Ferrell and H. Griffith, “Cost Issues Related to Pain Management: Report from the Cancer Pain Panel of the Agency for Health Care Policy and Research,” *Journal of Pain and Symptom Management*, 9 (1994): 221, at 222 (“Development of technology for pain treatment has flourished. In essence, pain management has become a growing health-care business. The technology of patient-controlled analgesia has been adapted from postoperative use to widespread use in cancer pain management.”).
128. E.H. Miller et al., “Institution-wide Pain Management Improvement through the Use of Evidence-Based Content, Strategies, Resources, and Outcomes,” *Quality Management in Health Care*, 7 (1999): 28.
129. Blau, Dalton, and Lindley, *supra* note 73.
130. *Id.*
131. *Id.* at 467.
132. E.C. Devine et al., “AHCPR Clinical Practice Guideline on Surgical Pain Management: Adoption and Outcomes,” *Research in Nursing & Health*, 22 (1999): 119, at 128.
133. *Sisters of Charity of the Incarnate Word v. Gobert*, 992 S.W.2d 25 (Tex. App. 1997) (negligent failure of hospital to monitor patients’ room, allowing a sexual assault to occur); *Lamb v. Candler General Hospital, Inc.*, 413 S.E.2d 720 (Ga. 1992) (hospital negligent in failing to use proper replacement parts in a medical instrument).
134. *Washington v. Washington Hospital Center*, 579 A.2d 177 (D.C. Cir. 1990) (defendant had not yet placed end-tidal carbon dioxide monitors, which allow for early detection of insufficient oxygen in time to prevent brain injury, in their operating rooms; plaintiff’s injuries would have been prevented by the early detection that such monitors make possible).
135. See, e.g., *Pearce v. Feinstein*, 754 F. Supp. 308 (W.D.N.Y. 1990); *Murillo v. Good Samaritan Hospital*, 160 Cal. Rptr. 33 (Cal. Ct. App. 1979).
136. *Id.* at 57.
137. See *Emory University v. Porter*, 120 S.E.2d 668, 670 (Ga. Ct. App. 1961); *Lauro v. Travelers Insurance Co.*, 261 So. 2d 261 (La. Ct. App. 1972), *cert. denied*, 262 So. 2d 787 (La. 1972).
138. *Horton v. Niagara Falls Memorial Medical Center*, 380 N.Y.S.2d 116 (N.Y. App. Div. 1976).
139. *Herrington v. Hiller*, 883 F.2d 411 (5th Cir. 1989).
140. *Air Shields, Inc. v. Spears*, 590 S.W.2d 574 (Tex. Civ. App. 1979).
141. *Marks v. Mandel*, 477 So. 2d 1036 (Fla. Dist. Ct. App. 1985).

142. See *Habuda v. Trustees of Rex Hospital*, 164 S.E.2d 17 (N.C. Ct. App. 1968) (hospital liable for inadequate rules for handling, storing, and administering medications); *Herrington v. Hiller*, 883 F.2d 411 (5th Cir. 1989) (failure to provide for adequate twenty-four hour anesthesia service).

143. *Decker v. St. Mary's Hospital*, 619 N.E.2d 537 (Ill. App. Ct. 1993). Such a duty was rejected by the Maine Supreme Judicial Court in *Gafner v. Down East Community Hospital*, 1999 WL 605619 (Me. 1999) (refusing to recognize corporate liability action against hospitals for failing to have explicit policies in place to control the actions of independent physicians).

144. Fla. Stat. Ann. § 768.60 (West 2001).

145. See, e.g., *Johnson v. University of Chicago Hospital*, 982 F.2d 230 (7th Cir. 1992), on remand, 1994 WL 118192 (N.D. Ill. 1994) (holding that hospital that provided telemetry communications to ambulance paramedics, directing them to the proper hospital in the system, could be liable for negligent operation of the system).

146. *Moser v. Heistand*, 681 A.2d 1322 (Pa. 1996).

147. The case most identified with corporate negligence is *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965). The Illinois Supreme Court relied upon several sources of standards to establish the standard of care for the hospital, including standards by the Joint Commission on Accreditation of Healthcare Organizations for hospital accreditation, the state licensing regulations, and the defendant's bylaws. All of these sources mandated that a hospital assume certain responsibilities for the care of the patient. The court allowed the jury to use these standards to evaluate the failure of both the nursing staff and administrators to blow the whistle on the defendant's handling of the case.

148. See, e.g., *Williams v. St. Claire Medical Center*, 657 S.W.2d 590 (Ky. Ct. App. 1983).

149. See, e.g., *Strubhart v. Perry Memorial Hospital Trust Authority*, 903 P.2d 263 (Okla. 1995) (adopts doctrine of independent corporate responsibility, requiring hospitals to ensure that only competent physicians have staff privileges; also requires hospitals to take reasonable steps to ensure patient safety when it knows or should know that physicians have displayed incompetence); *NKC Hospitals, Inc. v. Anthony*, 849 S.W.2d 564 (Ky. Ct. App. 1993).

150. 591 A.2d 703 (Pa. 1991).

151. Such a duty was rejected by the Maine Supreme Court in *Gafner v. Down East Community Hospital*, 1999 WL 605619 (Me. 1999).

152. *Welsh v. Bulger*, 698 A.2d 581 (Pa. 1997). See generally R.L. Griffith and J.M. Parker, "With Malice Toward None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation," *Texas Tech Law Review*, 22 (1991): 157.

153. See, e.g., *Cronic v. Doud*, 523 N.E.2d 176 (Ill. App. Ct. 1988).

154. *Cronic v. Doud*, 523 N.E.2d 176 (Ill. App. Ct. 1988); *Corleto v. Shore Memorial Hospital*, 350 A.2d 534 (N.J. Super. Ct. Law Div. 1975).

155. *Strubhart v. Perry Memorial Hospital Trust*, 903 P.2d 263 (Okla. 1995) (noting that twenty-two states have adopted some form of the corporate negligence doctrine); *Albain v. Flower Hospital*, 553 N.E.2d 1038 (Ohio 1990).

156. *Oehler v. Humana Inc.*, 775 P.2d 1271 (Nev. 1989).

157. See *St. Luke's Episcopal Hospital v. Agbor*, 952 S.W.2d 503 (Tex. 1997) (holding that hospitals were immune from liability under the Texas Medical Practice Act for negligent credentialing absent a showing of malice); *Hull v. North Valley Hospital*, 498 P.2d 136 (Mont. 1972).

158. See B.R. Ferrell et al., "An Institutional Commitment to Pain Management," *American Pain Society Bulletin* (April/May 1994): at 16.

159. *Decker v. St. Mary's Hospital*, 619 N.E.2d 537 (Ill. App. Ct. 1993).

160. The new JCAHO Pain Management standards must be satisfied by hospitals, home care agencies, nursing homes, behavioral health facilities, outpatient clinics, and health plans. These standards include:

1. the right of patients to appropriate assessment and management of pain;
2. assessing the nature and intensity of pain in all patients;
3. recording the results in a way that allows regular reassessment and follow up;
4. determining and assuring staff competency in pain assessment and management, including in the orientation of all new staff;
5. establishing policies and procedures to support appropriate prescription or ordering of effective pain medications;
6. educating patients and families about effective pain management; and
7. addressing patient needs for symptom management in the discharge planning process.

These new standards will be scored for compliance in 2001. They explicitly note that pain is a co-existing condition with a number of diseases and injuries, and it requires explicit attention. For example, a patient with breast cancer should be treated effectively not only for the actual illness, but also for any associated pain.

161. *Pain Assessment and Management*, *supra* note 24.

162. This Act is also often referred to as "COBRA" for the budget reconciliation act of which it was a part, or as the "Anti-Dumping Act."

163. 42 U.S.C.A. § 1395dd(e)(2); Interim Final Rule with Comment Period, 59 Fed. Reg. 32,086 (1994).

164. The statute requires that the hospital "provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists." 42 U.S.C.A. § 1395dd(a).

165. 42 U.S.C.A. § 1395dd(a).

166. But see *Wey v. Evangelical Community Hospital*, 833 F. Supp. 453 (M.D. Pa. 1993).

167. The statute defines this term as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C.A. § 1395dd(e)(1). This section also defines the term for women in labor.

168. The statute defines the terms "to stabilize" and "stabilized" with reference to the potential for material deterioration in the patient's condition, i.e., "no material deterioration of the condition is likely, within reasonable medical probability" resulting from or occurring during the transfer. 42 U.S.C.A. § 1395dd(e)(3)(A) and (B).

169. 42 U.S.C.A. § 1395dd(c)(1).

170. The statute includes discharge of the patient within the definition of "transfer." 42 U.S.C.A. § 1395dd(e)(4).

171. 42 U.S.C.A. § 1395dd(c)(2).
 172. 42 U.S.C.A. § 1395dd(b)(2) and (3) and (c)(1)(A)(i).
 173. 42 U.S.C.A. § 1395dd(d)(2)(A).
 174. 42 U.S.C.A. § 1395dd(d)(1)(A) and (B).
 175. The statute also provides that a plaintiff in a civil action under the Act may receive "such equitable relief as is appropriate." Few reported cases thus far have issued equitable relief, but see *Owens v. Nacogdoches County Hospital District*, 741 F. Supp. 1269 (E.D. Tex. 1990).
 176. 42 U.S.C.A. § 1395dd(d)(2)(A).
 177. The statutory language requires that the patient request examination or treatment, but the request for treatment in the emergency room has generally not been the subject of dispute. However, see *Stevison v. Enid Health Systems*, 920 F.2d 710 (10th Cir. 1990).
 178. 42 U.S.C.A. § 1395dd(a).
 179. *McIntyre v. Schick*, 795 F. Supp. 777 (E.D. Va. 1992).
 180. But see *Collins v. DePaul Hospital*, 963 F.2d 303 (10th Cir. 1992), in which the court "accept[ed] as true counsel's assertion that ordinarily" such a patient would have had a certain diagnostic procedure and that the hospital staff had thought the procedure had been done even though in fact it had not. The court upheld summary judgment for the defendant because the statute did not "require a hospital to determine ... all of the emergency medical conditions from which a particular individual may be suffering." The applicability of this statement should be limited to the facts of *Collins*: the patient was transported to the emergency room with multiple injuries, including a fractured skull, and he stayed at the hospital for nearly a month recovering from his injuries. A fractured hip was not detected.
 181. See, e.g., *Baber v. Hospital Corporation of America*, 977 F.2d 872 (4th Cir. 1992); *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990).
 182. See, e.g., *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990); *Baber v. Hospital Corporation of America*, 977 F.2d 872 (4th Cir. 1992); *Deberry v. Sherman Hospital Association*, 769 F. Supp. 1030 (N.D. Ill. 1991); *Urban v. King*, 834 F. Supp. 1328 (D. Kan. 1993).
 183. See *Abercrombie v. Osteopathic Hospital Founders Association*, 950 F.2d 676 (10th Cir. 1991), for jury instructions on liability for violation of each of the requirements of the Act.
 184. See, e.g., *Collins v. DePaul Hospital*, 963 F.2d 303 (10th Cir. 1992); *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990).
 185. See, e.g., *Burditt v. United States*, 934 F.2d 1362 (5th Cir. 1991); *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993); *Green v. Touro Infirmary*, 992 F.2d 537 (5th Cir. 1993).
 186. 42 U.S.C.A. § 1395(e)(3)(A) (emphasis added).
 187. See generally Hoffmann, *supra* note 12.
 188. According to clinical practice guidelines on the management of chronic pain in older persons, "[f]or some conditions, chronic pain is defined as pain that exists beyond an expected time frame for healing. For other conditions, it is well recognized that healing may never occur. In many cases, chronic pain is understood as persistent pain that is not amenable to routine pain control methods. Because there are many differences in what may be regarded as chronic pain, the definition remains flexible and related to specific diagnoses or cases." AGS Panel on Chronic Pain in Older Persons, *supra* note 22 and accompanying text on the four types of pain, at 635-36.
 189. See M. Caudill et al., "Decreased Clinic Use by Chronic Pain Patients: Response to Behavioral Medicine Intervention," *Clinical Journal on Pain*, 7 (1991): 305-10.
 190. S.M. Wolf, "Physician-Assisted Suicide in the Context of

- Managed Care," *Duquesne Law Review*, 35 (1996): at 471.
 191. See R.N. Jamison, "Comprehensive Pretreatment and Outcome Assessment for Chronic Opioid Therapy in Nonmalignant Pain," *Journal of Pain and Symptom Management*, 11 (1996): at 231 ("no empirical studies have been conducted to substantiate these guidelines"); accord D. Justins, Book Review, "Pain Medicine: A Comprehensive Review" (Book Review), *Lancet*, 347 (1996): 814.
 192. *Herrera v. Lovelace Health Systems, Inc.*, 35 F. Supp. 2d 1327 (D.C.N.M. 1999); *Hoose v. Jefferson Home Health Care, Inc.*, 1998 WL 114492 (E.D. Pa. 1998) (with claims of vicarious liability and negligence in post-operative care, selection of therapists, and overall supervision of care, the court noted that "this case is nothing more than a medical malpractice case" and refused to uphold ERISA preemption).
 193. *Harris v. Deaconess Health Services Corp.*, No. 4:99-CV-701 CAS (E.D. Mo. 1999); *Herrera v. Lovelace Health System, Inc.*, 35 F. Supp. 2d 1327 (D.N.M. 1999); *Visconti v. U.S. Healthcare*, 1998 WL 968473 (E.D. Pa. 1998); *Petrovich v. Share Health Plan of Illinois, Inc.*, 1999 WL 773524 (Ill. 1999); *Dykema v. King*, 959 F. Supp. 736 (D.S.C. 1997); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D.C. Maryland 1996); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Gilbert v. Sycamore Municipal Hospital*, 622 N.E.2d 788 (Ill. 1993).
 194. *Eaccarino v. Canlas*, 1998 WL 195875 (E.D. Pa. 1998) (agency theory is a "garden variety" tort not preempted by ERISA).
 195. See *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995).
 196. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996).
 197. See *McDonald v. Damian*, 1999 WL 500133 (E.D. Pa. 1999) (claim for inadequacies in the delivery of medical services).
 198. *Pappas v. Asbel*, 724 A.2d 889, 893 (Pa. 1999).
 199. *Shannon v. McNulty*, 718 A.2d 828 (Pa. Super. Ct. 1998).
 200. 4 F. Supp. 2d 888 (D.C. Ariz. 1998).
 201. *Id.* at 893.
 202. *Hoyt v. Edge*, 1997 WL 356324 (E.D. Pa. 1997).
 203. *Miller v. Riddle Memorial Hospital*, 1998 WL 272167 (E.D. Pa. 1998).
 204. *Snow v. Burden*, 1999 WL 387196 (E.D. Pa. 1999).
 205. *Newton v. Tavani*, 962 F. Supp. 45 (D.C.N.J. 1997).
 206. 120 S. Ct. 2143 (2000).
 207. Hoffmann, *supra* note 12, at 283-284.
 208. J. Zerzan, S. Stearns, and L. Hanson, "Access to Palliative Care and Hospice in Nursing Homes," *JAMA*, 284 (2000): 2489, at 2489.
 209. N.A. Krauss and B.M. Altman, "Characteristics of Nursing Home Residents — 1996," (visited February 28, 2001) <<http://www.meps.ahrq.gov/papers/99-0006/99-0006.htm>>.
 210. *Id.* at 2490. See also B.A. Ferrell et al., "Pain in the Nursing Home," *Journal of the American Geriatrics Society*, 38 (1990): 409; P.R. Mobily et al., "An Epidemiological Analysis of Pain in the Elderly: The Iowa 65+ Rural Health Study," *Journal of Aging & Health*, 6 (1994): 139.
 211. Hoffmann, *supra* note 12, at 283.
 212. Super. Ct. Div. No. 89-CVS64, Hertford County, N.C. (Nov. 20, 1990) (cited in Shapiro, *supra* note 86, at 361).
 213. R. Angarola, "Inappropriate Pain Management Results in High Jury Award" (Letter), *Journal of Pain & Symptom Management*, 6 (1991): 407.
 214. D.Q. Haney, "Control of Pain Gains Priority in Cancer Treatment Centers; Medicine: More and More Doctors are Paying Attention to Patients' Discomfort," *L.A. Times*, March 15,

1992, at A-1 (noting that patient's family was awarded \$15 million from the nursing home).

215. In *Bergman v. Chin*, the family of an elderly hospital patient filed suit after the state medical board failed to act against the treating physician. The daughter said: "We found that the care was grossly inadequate to my father, that they did not provide adequate pain medication or relief to him while he was in the hospital or when he was discharged to our home to have hospice care." California's Elder Abuse Act has no cap like that for medical malpractice claims. Punitive damages and attorneys fees are recovered, and pain and suffering survives death and can accrue to the estate. "The goal of the family in this case and of Compassion in Dying is that this kind of accountability will motivate physicians and other providers to be more attentive and aggressive in caring for pain." V. Foubister, "Doctor Faces Charges for Allegedly Undertreating Pain," *AMA News* (March 20, 2000).

216. J.B. Stern, "Malpractice in the Managed Care Industry," *Creighton Law Review*, 24 (1991): 1285; J.P. Ludington, *Licensing and Regulation of Nursing or Rest Homes*, 53 A.L.R.4th 689 (1993); L.B. Frantz, *Patient Tort Liability of Rest, Convalescent, or Nursing Homes*, 83 A.L.R.3d 871, 875 (1993) (discussing the general standard of care for nursing homes as the "degree of care, skill, and diligence used by such homes generally in the community"); *Stogsdill v. Manor Convalescent Home, Inc.*, 343 N.E.2d 589 (Ill. App. Ct. 1976) (holding that usual or customary care did not necessarily preclude a finding of negligence). See M.B. Kapp, "Malpractice Liability in Long-Term Care: A Changing Environment," *Creighton Law Review*, 24 (1991): 1235; M.B. Kapp, "Nursing Home Restraints and Legal Liability: Merging the Standard of Care and Industry Practice," *Journal of Legal Medicine*, 13 (1992): 1.

217. See, e.g., *Stiffelman v. Abrams*, 655 S.W.2d 522 (Mo. 1983) and *Harris v. Manor Healthcare Corp.*, 489 N.E.2d 1374 (Ill. 1986), both interpreting state statutes creating private rights of action. See also *Stewart v. Bernstein*, 769 F.2d 1088 (5th Cir. 1985);

Chalfin v. Beverly Enterprises, 741 F. Supp. 1162 (E.D. Pa. 1989), holding no private right of action under "pre-OBRA 1987" federal statutes. But see *Roberson v. Wood*, 464 F. Supp. 983 (E.D. Ill. 1979), holding that a private right of action existed. Despite these earlier cases, one could argue that there is an implied private right of action under the current federal statute. The Medicaid and Medicare statutes provide that the statutory remedies "are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." 42 U.S.C.A. § 1395i-3(h)(5); 42 U.S.C.A. § 1396r(h)(8). Legislative history indicates some support for a Congressional intent to allow a private right of action on the part of nursing home residents. The House Energy and Commerce Committee explained the intent of the above provision by stating that it would include "private rights of action to enforce compliance with requirements for nursing facilities." H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 472. See *Martin v. Voinovich*, 840 F. Supp. 1175 (S.D. Ohio 1993), holding that there is a private right of action under the OBRA provisions, enforceable through 42 U.S.C.A. § 1983. Residents may also have a statutory right to initiate sanctions. See, e.g., 210 Ill. Comp. Stat. 45/3-503, allowing residents to petition for receivership; *Kizer v. County of San Mateo*, 279 Cal. Rptr. 318, 806 P.2d 1353 (Cal. 1991), discussing right of private party to bring an action if the agency does not assess a fine.

218. OBRA '87, 42 U.S.C. § 1396r (involving the enhancement of quality of life and the psychosocial needs of residents).

219. 42 U.S.C. §§ 1395i-3(a)-(h), 1396r(a)-(h) (1988). See generally T.S. Edelman, "The Nursing Home Reform Law: Issues for Litigation," 24 *Clearinghouse Rev.* 545, at 545-49 (1990).

220. 31 U.S.C.A. §§ 3729-33.

221. See M. DuBois Krohn, "The False Claims Act and Managed Care: Blowing the Whistle on Underutilization" (Comment), *Cumberland Law Review*, 28 (1998): 443, at 458.