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Nursing Home Contracts: Is It Time for Bad Faith to Come Out of Retirement?

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NURSING HOME CONTRACTS: IS IT TIME FOR BAD FAITH TO COME OUT OF RETIREMENT?

I. INTRODUCTION ..................................................61
II. DEVELOPMENT OF THE TORT OF BAD FAITH BREACH OF CONTRACT ....................................................62
III. EXTENSION OF THE TORT TO THE HEALTH CARE INDUSTRY ................................................64
IV. IS A NEW CAUSE OF ACTION NECESSARY? .................70
   A. Negligence ..................................................70
   B. Contract ....................................................73
   C. State Regulation ...........................................73
   D. Federal Regulation .........................................74
   E. Other Theories of Liability ................................77
V. BAD FAITH BREACH OF CONTRACT ....................................78
VI. TERMS OF THE CONTRACT ......................................79
   A. The Nursing Home Contract ................................79
   B. Advertisement .............................................80
   C. State Statutes .............................................81
   D. Federal Statutes ...........................................82
VII. THIRD PARTIES AND BAD FAITH BREACH .....................83
VIII. DAMAGES ........................................................84
   A. Consequential Damages ....................................84
   B. Punitive Damages ...........................................85
IX. STATUTE OF LIMITATIONS ......................................86
X. CONCLUSION ....................................................86

I. INTRODUCTION

For certain types of contracts, the remedy for the breach of the implied duty of good faith and fair dealing has been found to lie in tort. Until the Supreme Court's ruling in *Pilot Life Ins. Co. v. Dedeaux*,¹ courts were rapidly extending the application of the tort of bad faith breach of contract into areas beyond the traditionally accepted realm of insurance contracts.² Most significant for the purposes of this note was the expansion into the area of health care services, specifically health maintenance organizations.³ Perhaps because of the chilling effect *Pilot Life* has had upon this form of litigation,⁴ bad faith breach of contract has yet to be explored as

⁴ Although a discussion of the Supreme Court's decision in *Pilot Life* concerning the ERISA pre-emption of state statutory and common law actions is beyond the scope of this note, some understanding of the case is necessary to appreciate the recent loss of interest in the tort of bad faith breach of contract.
a means of addressing a major health problem in the United States: the plight of the nursing home resident. In this note an attempt is made to redefine the elements of the tort and examine the justification of extending it to the nursing home contract, the disadvantages of current remedies for the nursing home resident, and the advantages recognition of the tort of bad faith breach of contract would afford the resident/plaintiff.

II. DEVELOPMENT OF THE TORT OF BAD FAITH BREACH OF CONTRACT

The notion that every contract contains within it an implied covenant of good faith and fair dealing is well established in American law. It can be traced back to at least the turn of the century and has been codified in several sources. Its application as a tort to expand the traditional rule

Application of the provisions of the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. 55 1001-1461, to common law bad faith and insurance code claims has sharply limited the exposure of insurers to liability. ERISA covers both employee funded pension plans and employee welfare benefit plans. It is the latter, which include health care, disability and life insurance benefits, which has most significantly affected bad faith actions.

ERISA provides that the remedies found in the statute supersede all state laws. Federal courts have interpreted this as a pre-emption of all common law and state statutory remedies. Pilot Life involved a plaintiff's tortuous breach of contract claim against an insurance company's alleged bad faith denial of benefits under an employer-provided policy. The Supreme Court held that the action, regardless of the name attached to it, was pre-empted because the state law involved "related to" an employment benefit plan. See generally Bishop & Denney, Hello ERISA, Goodbye Bad Faith: Federal Pre-Emption of DTPA, Insurance Code, and Common Law Bad Faith Claims, 41 BAYLOR L. Rev. 267, 268-69 (1989).

Since very few employers offer plans which cover nursing homes, ERISA pre-emption should have little or no effect on bad faith actions brought by nursing home residents. Since most bad faith actions have been brought in the area of insurance law, the pre-emption may have caused many litigators to ignore bad faith breach of contract as a cause of action.

Abuse in both the living conditions in nursing homes and the business practices of the homes has been well documented by the federal government. The substandard conditions include improper and unhygienic handling of food, laundry, and medicines, filthy conditions in resident rooms, hallways, bathrooms and kitchens, residents left unbathed despite incontinence, and inferior quality food. Special Problems in Long-Term Health Care: Hearing Before the Subcomm. on Health and Long Term Care of the Select Comm. on Aging, 96th Cong., 1st Sess. 2 (1979). Improper business practices have included misappropriation of residents' funds, undisclosed and arbitrary discharges of residents, inadequate protection of residents' property, inadequate disclosures of charges, and the use of unfair and deceptive contract provisions. Donna Meyers Ambrogi, Legal Issues in Nursing Home Admissions, 18 LAW. MED. & HEALTH CARE 254 (citing Taylor, Draft Report: Unnamed Nursing Home Investigation (Seattle: Federal Trade Commission, 1981)).


For a good view of the historical development of the notion of a covenant of good faith being found in every contract, see Charles M. Louderback & Thomas J. Jurika, Standards for Limiting the Tort of Bad Faith Breach of Contract, 16 U.S.F. L. Rev. 187, 194 n. 34 (1982).

Id. at 190. Good faith and fair dealing have been incorporated into the Uniform Commercial Code, Uniform Sales Act, Robinson-Patman Act, and the Bankruptcy Act, in addition to the Restatement 2d of Contracts.
of Hadley v. Baxendale\(^9\) took root in insurance law. Through a series of cases, the California Supreme Court held that for certain types of contracts, the breach of the covenant of good faith and fair dealing was a tort for which consequential and even punitive damages could be recovered.\(^10\)

In the seminal case of Comunale v. Traders & Gen. Ins. Co.,\(^11\) the court held that an insurer's refusal to defend the insured in a third party suit or accept a reasonable settlement was a breach of the implied covenant to act in good faith present in every contract and was answerable in tort. Despite this finding, the court used a contract remedy for damages.

Subsequently, in Crisci v. Security Ins. Co.,\(^12\) the court distinguished insurance contracts from ordinary commercial contracts by focusing on the nature of the expectations of the insured. The court found it significant that the insured party to an insurance contract seeks "peace of mind in addition to commercial advantage."\(^13\) This emphasis on the special quality of the relationship between the insurer and the insured is reminiscent of the breach of public duty that, at common law, the practitioners of "common callings"\(^14\) were liable far beyond the extent of their contracts with their clients.\(^15\) In these cases, the practitioner, in holding himself out as a purveyor of the particular calling, was charged with a public interest by nature of his monopoly position in the field. A violation of this duty was redressable in either contract or tort.\(^16\)

This use of the bad faith breach of contract was extended by the same court to cover refusals by insurers to honor payments to first-party insureds in Gruenberg v. Aetna Ins. Co.\(^17\) In Gruenberg, the court clearly defined the extra-contractual nature of the bad faith breach of contract. In speaking of the duty to deal in good faith, the court stated:

> It is the obligation deemed to be imposed by law under which the insurer must act fairly and in good faith in discharging its contractual responsibilities. Where it fails ... such conduct may give rise to a cause of action in tort for the breach of the implied covenant of good faith and fair dealing.\(^18\)

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\(^9\) Hadley v. Baxendale, 156 Eng. Rptr. 145 (1854). This rule limited the compensatory damages available in contract to those which were foreseeable at the time of the formation of the contract.

\(^10\) See Cohen, supra note 2, at 1326.

\(^11\) 328 P.2d 198 (Cal. 1958).

\(^12\) 426 P.2d 173 (Cal. 1967).

\(^13\) Id. at 179.

\(^14\) These "common callings" traditionally included the blacksmith, the food-seller, the innkeeper, the common carrier, and the surgeon. See John, supra note 2, at 2044.

\(^15\) For an indepth discussion of the history and development of the extra-contractual duties of those dealing in services or products involved with the public interest, see Charles K. Burdick, The Origins of the Peculiar Duties of Public Service Companies, 11 COL. L. REV. 514 (1911).

\(^16\) See, John, supra note 2, at 2043-45.

\(^17\) 510 P.2d 1032 (Cal. 1973).

\(^18\) Id. at 1037. The plaintiff in Gruenberg claimed that the insurance company wrongly accused him of arson to avoid paying for the destruction of his restaurant by fire.
The opinion goes on to state that the duty is non-consensual rather than consensual.19

Applying this idea of the extra-contractual duty of the insurer, the same court saw fit to extend the doctrine to allow for punitive damages in Egan v. Mutual of Omaha Ins. Co.20 In finding that the insurance company's conduct merited punitive damages, the court stated "[i]n an action for the breach of an obligation not arising from contract, where the defendant has been guilty of oppression, fraud, or malice, express or implied, the plaintiff, in addition to actual damages may recover damages for the sake of example and by way of punishing the defendant."21

Significantly, the court elucidated the public policy underlying its decision in stating that the purpose of the use of punitive damages in such a context was to discourage objectionable corporate practices.22 The tort of bad faith breach of contract can then be seen conceptually as a form of corporate intentional tort, replete with punitive damages.

III. EXTENSION OF THE TORT TO THE HEALTH CARE INDUSTRY

That the tort of bad faith breach of contract could be extended to the health care industry was predicted by Stearns in her article Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?23 Stearns draws the analogy between the HMO-member relationship and the insurer-insured relationship. She emphasizes the dual nature of the health maintenance organization ("HMO") as both insurer and provider of care for the subscriber, thereby making the HMO liable both for the refusal to administer benefits and the quality of the care received.

In her rationale for the application of the tort, Stearns points out a number of features which characterize not only the HMO-subscriber and insurer-insured relationship but the nursing home-resident relationship as well. These cases are hallmarked by an inequality of bargaining power in which the weaker party is presented with an adhesion contract and cannot bargain over terms.24 This is especially the case for the nursing home resident who is most likely both mentally and physically impaired25 and for whom available alternatives to the nursing home may be extremely limited.26 Stearns points out the need for the tort in such situ-

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19 Id. at 1038.
21 Id. at 457. In this case the court found that the insurance company had failed to make a good faith effort to investigate the plaintiff's claim.
22 Id. at 487.
23 See John, supra note 2, at 911.
24 Id. at 915.
25 Stiffelman v. Abrams, 655 S.W.2d 522, 529 (Mo. 1983) (en banc).
ations to insure that the weaker party can realize the benefit of his bargain, especially where the contract is not made for commercial advantage but for "peace of mind and security".27

The potential for emotional and physical suffering is much greater in the HMO-subscriber relationship than in the insurer-insured relationship. The HMO determines not only what care is covered but what care is appropriate, who shall administer that care, when it will be administered, and the quality of the care. This is even more the case in the nursing home-resident relationship where the resident is literally dependent upon her nursing home, not only for her basic medical care (at least in the case of skilled nursing facilities), but for all the necessities (food, shelter, and even access to assistance for bodily elimination) of life. The potential for corporate abuse which forms the rationale for the tort in insurance cases is present a fortiori in both the nursing home and HMO contracts.

Stearns also relies on the quasi-public nature of the services provided by both the HMO and the insurance company.28 As noted in the previous section, this forms one of the bases for the application of the tort and relates back to the liability in tort at common law of the common callings. She notes in this regard that health maintenance organizations are subject to even more public regulation than the insurance industry. Again, the same reasoning applies to nursing homes which are the subject of extensive state and federal regulation.

There is additional justification in support of the application of the tort which is distinctly found in the nursing home and HMO setting. Because of the control both organizations maintain over their members' access to essential services, bad faith denials can result in emotional damages which exceed those normally generated by the breach of a commercial insurance contract. These types of emotional damages do not fit the conventional negligence model, which is traditionally based upon pain and suffering arising from a physical injury resulting from a specific act of negligence.

Although at the time of Stearn's writing no bad faith breach of contract suit against an HMO had reached the appellate stage,29 time bore out

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28 "The insurers' obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements. ... [A]s a supplier of a public service rather than a manufactured product the obligations of an insurer go beyond meeting reasonable expectations of coverage." Egan v. Mutual of Omaha Ins. Co., 598 P.2d 452, 457 (Cal. 1979) (citing Goodman & Seaton, Foreword: Ripe for Decision, Internal Workings & Current Concerns of the California Supreme Court, 62 CAL. LL. REV. 309, 346-47 (1947)).

29 See John, supra note 23, at 914-15.
Stearn's prediction. In *Williams v. Healthamerica*,\(^{30}\) the Ohio court of appeals recognized the analogy between the insurance and the HMO contract and held that the plaintiff had presented a cognizable form of action under Ohio law for bad faith breach of contract. The court overturned a lower court decision that the plaintiff's claim was actually for malpractice and upheld the validity of her claim that the HMO physician violated her contract by denying her the health care benefits she was promised through the HMO. In addition, the court, in analogizing to insurance law, allowed the plaintiff to seek relief for emotional damages under a bad faith breach of contract theory.

In *Rederscheid v. Comprecare*,\(^{31}\) the Colorado court of appeals found that a bad faith breach of contract action against an HMO was valid despite a Colorado statute which stated, "[T]he provisions of the insurance law . . . shall not be applicable to any health maintenance organization."\(^{32}\) In so finding, the court held that "[b]oth the tort of bad faith failure to exercise due care in the discharge of a contractual duty and the granting of damages for mental anguish caused by a willful and wanton breach of contract are grounded in basic common law, and not solely in the area of insurance law."\(^{33}\) The court thus recognized the application of the tort without resorting to the fiction that it was based solely on the HMO as insurer.

As a result of the Supreme Court's decision in *Pilot Life Ins. Co. v. Dedeaux*,\(^{34}\) there has been a sharp decline in the litigation brought against HMOs for bad faith breach of contract. As the vast majority of HMO subscribers join through plans provided by an employer, their contracts fall under the scope of ERISA. Since the primary advantage of bad faith breach of contract as a cause of action is the availability of tort damages including both damages for emotional distress and punitive damages, both of which are excluded in a contract action under ERISA, interest in the tort, especially in the area of health care, has understandably declined.

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\(^{30}\) 535 N.E.2d 717 (Ohio App. 1987). The plaintiff in this case was a member of a health plan provided by the defendant HMO. The plaintiff alleged that she had presented her primary care physician with a complaint of abdominal pain. The physician treated her with a variety of medications to no avail. Despite her repeated requests to be evaluated by an OB-GYN specialist, the physician refused to grant her a referral. The plaintiff complained to the HMO administration that she was being denied treatment that was due her but was informed that the decision to refer was up to the primary physician. The physician continued to treat her for one year without improvement in her condition when the plaintiff, despite a refusal of approval from the HMO, was seen at a local emergency room where a gynecologist diagnosed endometriosis. The plaintiff subsequently underwent surgery and included in her suit against the HMO a claim for bad faith breach of contract.

\(^{31}\) 667 P.2d 766 (Colo. 1983).

\(^{32}\) *Id.* at 767. (emphasis in original)

\(^{33}\) *Id.*

\(^{34}\) 481 U.S. 41 (1987).
NURSING HOME CONTRACTS

It may well be that the Supreme Court's holding represents a government policy decision to protect employers and their insurers, especially HMOs, from liability. This would protect employer-funded health insurance and relieve some of the growing demand for socialized medicine. However, no such policy concern exists for nursing homes. Rather, the federal government has shown increasing concern over the lack of effective controls over nursing home quality in the face of well documented nursing home abuse of residents.35

Although it is tempting to base extension of the tort of bad faith breach of contract to the nursing home contract merely by analogy, it is essential to determine distinct criteria which define those contracts to which the tort can be applied and then determine if nursing home contracts conform to those standards.

The most widely accepted criteria for the application of the tort was elucidated by Louderback and Jurika in their article Standards for Limiting the Tort of Bad Faith Breach of Contract.36 Louderback and Jurika attempt to distill from the insurance cases, where the tort has been recognized, those aspects of the insurance contract which make the tort applicable and thus serve as standards to which other types of contractual relationships can be measured.37 That they succeeded in this attempt is evidenced by the number of courts which have adopted their criteria as a standard for application of the tort.38

35 "[In 1974] the United States Senate Special Subcommittee on Aging called the system of long-term care for the elderly 'the most troubled and troublesome component of our entire healthcare system.' The committee found that at least half of the nation's nursing homes were substandard, due to the presence of life threatening conditions. The committee also found that many patients received inadequate health care, poor food, and were often subjected to unsanitary conditions. The most startling finding was that nursing home patients frequently suffer from neglect or are the targets of intentional abuse which sometimes results in injury or death." Joyce D. Slocum, Comment, A Critical Analysis: The Patient Abuse Provisions of the Missouri Omnibus Nursing Home Act, 24 ST. LOUIS U. L. J. 713, 713-14 (1981) (citing THE SUBCOMM. ON LONG-TERM CARE, SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. Rep. No. 93-1420, 93d Cong., 2d Sess. 111 (1974), and citing STAFF OF SUBCOMM. ON LONG-TERM CARE, SENATE SPECIAL COMM. ON AGING, 93d Cong., 2d Sess., — NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY: SUPPORTING PAPER NO. 1, THE LITANY OF NURSING HOME ABUSES AND THE ROOTS OF THE CONTROVERSY 205 (Comm. Print 1974)).

36 Louderback & Turica, supra note 7, at 194.

37 If anything, Louderback and Jurika's criteria have been criticized as too restrictive in that they exclude most contracts other than insurance contracts. See STEVE ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES § 11.03 (1986 and Supp. 1987). Nursing home contracts seem to fit, however, even judged by these relatively strict standards.

Most notable amongst these cases is *Seaman's Direct Buying Service v. Standard Oil*. The court, relying on the standards set by Louderback and Jurika, saw fit to extend the application of the tort to the realm of commercial contracts. Subsequently, based on the criteria outlined in *Seaman's*, courts have extended the bad faith breach of contract tort to the banking-depositor relationship and the employer-employee relationship.

Louderback and Jurika identified four basic criteria common to those insurance cases which have permitted the tort of bad faith breach of contract:

1) One of the parties to the contract enjoys a superior bargaining position to the extent that it is able to dictate the terms of the contract; 2) the purpose of the weaker party in entering into the contract is not primarily to profit but rather to secure an essential service or product, financial security or peace of mind; 3) the relationship of the parties is such that the weaker party places its trust and confidence in the larger entity; 4) there is conduct on the part of the defendant indicating an intent to frustrate the weaker party's enjoyment of the contract right.

The applicability of the first three criteria in the context of the nursing home are not difficult to establish. Nursing home residents, usually weak and debilitated to begin with, must often take any nursing home bed available. Waiting periods of up to one year are not unusual. Since the
residents can no longer manage the simple activities of daily life and usually have no one willing to care for them, they literally have no other option. They have neither the economic nor mental leverage necessary to bargain over contract terms. Once admitted they are totally dependant on the largesse and good will of the nursing home for their subsistence.\textsuperscript{45} The nursing home resident obviously does not enter into the nursing home contract for purposes of commercial enrichment and has little choice but to place her trust in the larger entity.

Interpretation of the fourth criteria as to what constitutes an “intent to frustrate the weaker party’s enjoyment of the contract rights”\textsuperscript{46} is more difficult. Owen has delineated three mental states which suffice to support punitive damages in this context: deliberate, evaluative and inadvertent.\textsuperscript{47} Deliberate conduct will hinge upon the lack of a valid business reason for the conduct. Evaluative conduct is seen where a party realizes the probable results of its actions but, for business reasons, engages in them anyway. Inadvertent action may exist where a party negligently or consciously avoids the knowledge of the probable results of its actions.

While a nursing home may be guilty of any of the three states, the most common (and easiest to prove) would be the latter two. John suggests that:

in such cases, an award of punitive damages may be equally appropriate when the institution has made a decision that fails to comport with expectations of the public regarding a quasi-public fiduciary. This is especially true . . . when the institution has adopted a policy which systematically fails to take the rights of these individuals into account.\textsuperscript{48}

John modifies Owen’s intents into an objective standard of “oppression, which focuses on the actual abuse of bargaining power,”\textsuperscript{49} for corporate defendants such as nursing homes.

This type of analysis reinforces the view of bad faith breach of contract as a form of corporate intentional tort. What is surprising is the ease with which the nursing home contract fits the above criteria. The vast amount of scrutiny of bad faith breach of contract, both by courts and writers, has been in its application to commercial settings and its validity as an alternative to traditional contract damages; i.e., imposing an extrcontractual tort duty upon what had been traditionally viewed as solely a contractual relationship.

\textsuperscript{45} “Residents of nursing homes are literally captive and at the mercy of the institutions wherein they reside; unless they can move to another facility - not always possible with current bed shortages and lack of relatives or friends to assist.” Patricia A. Butler, \textit{A Long Term Health Care Strategy for Legal Services, 14 Clearinghouse Rev.} 613, 641 (1980).

\textsuperscript{46} See supra note 42.


\textsuperscript{49} Id.
The nursing home contract, as is the case with the HMO contract, is, however, less of a commercial contract than the insurance contract, the standard against which other contracts have been measured. Further, the majority of suits brought against nursing homes by residents have not been in contract but in negligence. Many courts have viewed nursing home resident suits as variations of the medical malpractice model requiring expert testimony as to nursing practices and community standards of medical care.

Bad faith breach in the context of the nursing home resident relationship must be seen then as an alternative to a negligence model rather than as a contract model. Bad faith breach arises from an amalgam of contract theory and tort theory, much the same as strict product liability. Such an amalgam theory has been applied where the traditional theories fail to conform to economic or social reality. Problems with adequacy of recovery (failure to make the plaintiff whole), and difficulties of proof, combined with some sense of violation of the public good seem to justify a form of action which combines the most advantageous aspects of both contract and tort. The underlying rationale for bad faith breach thus differs little from that offered by Justice Traynor in explanation for the creation of strict product liability, with its merging of tort damages and strict warranty liability. A blending of tort and contract theory may better address certain problems which are inadequately addressed by either theory alone.

IV. IS A NEW CAUSE OF ACTION NECESSARY?

A. Negligence

Despite the well documented, widespread abuse which has been found in nursing homes, the majority of cases which have been brought by nursing home residents have been based in negligence, usually involving a fall. The comparison which must be made then is between negligence and bad faith breach as remedies for the nursing home patient. This involves an examination of the barriers which have arisen for nursing home residents in pursuing negligence actions.

Not unlike Aristotle's dramatic unities, the paradigm of a negligence action involves the unities of person and event; i.e., the ideal negligence suit involves the single negligent action of one person which results in injury to another person. In order to conform to economic realities, the

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50 See Butler, supra note 45, at 641.
51 See Butler, supra note 45, at 642.
54 See Butler, supra note 45, at 641.
law has had to adopt the fiction of respondeat superior to expand the unity of person, thus extending liability to a party better able to absorb the cost. Unity of event, however, is still the rule in negligence law. Negligence actions are best suited to incidents where a specific act of negligence can be identified, and damages can be easily calculated by comparing the state of the injured party before and after the event.

The negligence model is unsatisfactory in the nursing home context because it does not focus upon the wrongs actually committed and their resultant harm. The typical nursing home negligence action selects out a particular event, such as a fall, in which the nursing home is charged with negligence and from which duty, breach, causation and damages must be proven. This type of action ignores the pattern of behavior of the defendant and the accumulation of practices, one of which may not have alone caused the particular damage, but taken together result in abuse. The failure of negligence actions to remedy the plight of the nursing home resident can be better understood by individually examining the elements of negligence in the context of the nursing home plaintiff.

Since, in relying upon a negligence action, the plaintiff must usually focus upon a particular event, the standard of care must relate to that event. Nursing homes have been generally acknowledged to owe a duty of reasonable care to avoid foreseeable injury, which must include recognition of a resident's age and mental and physical condition as it is known or reasonably should be known by the facility. The definition of what this standard consists of has posed more of a problem. As stated, many courts adopt a medical malpractice model for nursing home negligence suits. This requires expert testimony to establish standards and a look to the local standard of care in other nursing homes, which itself may be abysmally low, to determine the specifics of the standard. While state and federal certification and licensing regulations, when sufficiently specific, have on occasion been used to establish a standard of care, courts have often refused to use the statutes as defining reasonable care.

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Examples of such "ideal" negligence cases can usually be found in tort case books. One such case is Vaughan v. Menlove, 3 Bing. (N.C.) 467, 132 Eng. Rptr. 490 (1837), appearing in W. Prosser, J. Wade, V. Schwartz, Torts: Cases and Materials 149 (1988). In Vaughan, the plaintiff negligently built a hayrick which caught on fire and damaged his neighbor's property.


See Butler, supra note 45, at 643.


'The Nursing Homes Patient's Bill of Rights does not set the standard to which nursing homes are held accountable in negligence damages actions. Such a holding would ignore the purpose of the negligence per se doctrine and the malpractice law of this state. It would permit the trier of fact to set its own standard of care for health providers and speculate virtually without limits on
One reason for this apparent reluctance on the part of courts lies in the underlying theory of a negligence action. The standard of care is theoretically an objective standard favoring neither party. Thus, unless a regulation specifically addresses the circumstance at hand, the court is not really justified in interpreting what may be a vague statute in favor of the plaintiff just because he may be in an inferior economic or social position.

Causation has also proven to be a problem for the nursing home resident/ plaintiff. Given an elderly, frail resident with multiple medical problems and diminished mental capacity, it may be difficult to place the blame for any worsening of the residents' condition on any particular act of the nursing home, especially considering the natural history of most diseases of the elderly. In addition, the resident's impaired condition predisposes her to accidents which could easily be explained without necessarily involving negligence on the part of the nursing home. Unfortunately, nursing home residents, whose mental states are often impaired, seldom make reliable witnesses.

Damages in those negligence actions which have been successful have been small. This reflects our system for measuring damage in negligence actions. Nursing home residents have little capacity for future earnings and very short life expectancy. Their pre-existing conditions make it difficult to determine just how much they have been injured.

Negligence law typically excludes punitive damages. A defendant's conduct is assumed to be accidental in nature, regardless of whether the result was assured by some conscious policy decision. A nursing home's transfer policy, which may purposely reflect its own economic interest and result in transfer trauma to the resident, may be addressed no differently using negligence than a simple fall. The further the situation deviates from the ideal negligence model, the more inadequately negligence serves as a remedy.


Friedman v. Division of Health, 537 S.W.2d 547, 548-49 (Mo. 1976).

See Butler, supra note 45, at 642. Damages have generally ranged between $2,000 and $40,000.

Transfer trauma is the deterioration noted in a resident's physical and mental status following transfer from surroundings in which he has become accustomed to a new environment either in another facility or in a different section of the same facility. Transfer trauma can result in the resident's death and almost always at least results in severe depression or regressive behavior. See O'Bannion v. Town Court Nursing Center: Patients Rights to Participate in Nursing Home Decertification, 7 AM. J.L. & MED. 469, 481-82 (1981). Provisions limiting the involuntary transfer of residents have been included in the federal nursing home Bill of Rights. 42 C.F.R. § 4051121 (k)4.
B. Contract

The main limitation of actions for breach of contract has been the question of damages. Contract damages follow the traditional rule of Hadley v. Baxendale.\(^3\) This rule limits the damages available for breach of contract to those damages within the reasonable contemplation of the parties at the time of the formation of the contract.\(^4\) As Calamari\(^5\) points out, this rule was based upon protection for developing commercial enterprises and dovetails very well with the Holmesian idea of efficient breach. Its failure in the non-commercial setting, such as in the nursing home-resident relationship, to make the aggrieved party whole has limited its usefulness. The separate question of construing the terms of the nursing home contract will be taken up in a later section.

C. State Regulation

In recent years a number of states have passed statutes regulating nursing homes and incorporating into these regulations a so-called Nursing Home Resident’s Bill of Rights which guarantees to the resident protection against certain violations by the nursing home. Currently, at least twenty states have enacted statutes which create a private right of action for the nursing home resident to enforce the regulations.\(^6\) Perhaps the most far reaching of these are the New York and West Virginia statutes which allow for private rights of action and permit recovery of both compensatory and punitive damages to the resident.

While these laws are all laudable in their efforts to reform nursing home abuse, the problem lies in the remedy available to the resident. There is great variability in the types of remedies offered by these statutes. Under the North Carolina statute, the private relief afforded the resident is limited to injunctive relief.\(^67\) The Missouri statute, while set-

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\(^3\) 156 Eng. Rptr. 145 (1854).
\(^4\) Id. at 151.
\(^67\) "The patient shall have the right to institute a civil action for injunctive relief to enforce the provisions of this part." N.C. Gen. Stats. § 131E-123 (1981).
ting forth detailed regulations for nursing homes, permits civil actions for enforcement only when the attorney general has failed to act.  

Nursing home residents are not typical plaintiffs. Dependent as they are on the nursing home, they can ill afford either defeat or Pyrrhic victory. Given the difficulties with proof and damages in traditional tort and contract remedies, there is little incentive for a resident to sue.  

On the other hand, a nursing home resident may have very justified fears of retaliation on the part of the nursing home. Even without retaliation, residents whose nursing home loses its license for violations of state regulations may find themselves in a worse situation than before. Given the limited bedspace available, a resident may find herself with nowhere to go.

In order to meet the needs of nursing home residents, a remedy, if successful, must compensate residents for the harm done and insure that they are placed in a financially secure position to find other acceptable accommodations. Another sad fact of life in the nursing home legal picture is the reluctance of attorneys to take on nursing home patients in the face of current damage constraints. The availability of punitive damages would do much to encourage this area of litigation.

Leaving the solution of nursing home abuse to the state legislatures also raises political problems. Nursing home residents as a group lack political power. They tend not to vote and they lack political organization. In contrast, nursing home political action committees contribute heavily to candidates and have been successful in many states in diluting or entirely blocking nursing home Bill of Rights statutes.

D. Federal Regulation

In 1974, Congress approved the Nursing Home Bill of Rights as part of the conditions of participation for nursing homes accepting medicare and medicaid funds. In 1976, these regulations were extended to include

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68 It should be noted, however, that in Stiffelman v. Abrams, 655 S.W.2d 522 (Mo. 1983), the Missouri Supreme Court held that the statute did establish the standard of care in a negligence action. A similar conclusion was reached by Wisconsin Supreme Court in finding that the statute defined the standard of care. Kuiaowski v. Arbor View Health Care Center, 407 N.W.2d 249 (Wisc. 1987).
69 See Butler, supra note 45, at 622. Despite the well documented extensive level of abuse present in nursing homes, suits brought by residents have been very few. From 1950 to 1978, only 35 personal injury cases were filed by nursing home residents against their nursing homes.
70 Cathrael Kazin, Nowhere To Go and Choose To Stay: Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals, 137 U. PENN L. REV. 903, 919 (1989).
72 42 C.F.R. § 405.1121 (1990). The section is divided into subsections dealing with the financial, administrative and medical management of the nursing home. The subsection of particular interest is (k) Patients' Rights. This section has served as a model for a number of state resident rights statutes and states
intermediate care facilities as well as skilled nursing facilities. Each participating nursing home is required to have written policies which guarantee to each resident certain rights in the areas of privacy, freedom from restraint, and individual autonomy. More recently, these regulations were expanded and made more specific in an attempt to better safeguard the rights of the residents.\textsuperscript{73}

These patients rights policies and procedures ensure that, at least, each patient admitted to the facility: 1) Is fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities; 2) Is fully informed prior to or at the time of admission and during stay, of services available in the facility and of related charges including any charges for services not covered under any titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate; 3) Is fully informed by a physician of his medical condition unless medically contraindicated (as documented by a physician in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; 4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment of his stay (except as prohibited by titles XVIII or XIX of the Social Security Act), and is given notice to ensure orderly transfer or discharge, and such actions are documented in his medical record; 5) Is encouraged and assisted throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written declaration of this responsibility to the facility for any period of time in conformance with state law; 7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or others; 8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract; 9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record); 12) May meet with, and participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record); 13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); 14) If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room unless medically contraindicated (as documented by the attending physician in the medical record).

\textsuperscript{73} In February, 1989, the Health Care Financing Administration published the final revisions of the nursing home regulations passed in the 1987 Omnibus Budget Reconciliation Act. These regulations contained significant expansions of
This expansion reflects a dissatisfaction on the part of Congress with the effectiveness of the enforcement of the regulations by the Department of Health and Human Services. The federal regulations are enforced through the state health departments under an agreement with the federal government. Penalties for violations can range from delicensure and loss of certification to participate in medicare or medicaid to civil fines and admissions restrictions. The individual resident has no power to initiate any of the sanction proceedings.

The effectiveness of these regulations depends on the level of enforcement by the state, which may vary considerably. Nursing home residents have attempted to enforce these regulations by securing private rights of action under the federal regulations. Unfortunately, their efforts have met with little success.

In *Blum v. Yaretsky*, medicaid residents in a nursing home brought a class action suit challenging the home's decision to discharge them. The plaintiffs claimed that the decisions were dictated by federal regulations and therefore qualified as state action. Since the discharges were carried out without proper notice, the plaintiff's claimed their due process rights under the fourteenth amendment had been violated. Justice Rehnquist, writing for the majority held, however, that the decisions were made by private nursing homes based upon their independent medical judgments. Their actions were not encompassed, therefore, by the state action doctrine.

In *Fuzie v. Manor Care, Inc.*, a medicaid patient sued a nursing home for violation of the federal nursing home regulations involving invol-

residents' rights in the following areas: maintaining confidentiality of personal and clinical records; guaranteeing facility access and visitation rights issuing a notice of rights at the time of admission; implementing admission policy requirements; assuring proper use of physical restraints and psychoactive drugs; protecting resident funds from being managed by a facility; ensuring transfer and discharge rights, and issuing notices required of a facility; providing 24 hour licensed nursing services, and services of a registered nurse at least eight hours a day, seven days a week, subject to waiver; furnishing comprehensive assessments and being subject to civil monetary penalties for falsification of assessment; requiring minimum training of nurses' aides, competency evaluation programs, and regular inservice education; prohibiting admission to SNFs and NFs of individuals with mental illnesses and mental retardation, except when they need SNF and NF services and have been pre-screened by a state authority of mental illness or retardation; providing or obtaining routine and emergency dental services; employing a full-time social worker if a facility has more than 120 beds; and meeting disclosure requirements. 54 Fed. Reg. 5316 (1989).

*Special Committee on Aging. U.S. Senate, Hearing on Nursing Home Survey And Certification: Assuring Quality of Care, 97th Cong., 2d Sess. (July 15, 1982).*

As Butler, *supra* note 51, at 650-51, has pointed out, the delicensure procedure is cumbersome and rarely used, and fines are available only in certain delineated situations.

*Id.* at 651.


untary transfer. Applying the Cort test,\textsuperscript{79} the court held that the federal regulations did not create a private right of action and the plaintiff therefore could not maintain a claim based upon the regulations themselves.\textsuperscript{80}

The federal district court in Robertson v. Wood distinguished Fuzie despite an almost identical fact pattern, holding that the federal regulations did create a private cause of action for the resident. This decision, however, has not been followed. In Wagner v. Sheltz\textsuperscript{81} and again in Chalfin v. Beverly Enterprises,\textsuperscript{82} federal district courts have affirmed the holding in Fuzie that no private right of action is created.

\textbf{E. Other Theories of Liability}

The liability of nursing homes to their residents has been found under a variety of theories. Although numbers have been limited, residents have successfully pursued claims based on battery, assault, conversion, false imprisonment,\textsuperscript{83} and violation of state unfair trade laws.\textsuperscript{84} The intentional tort remedies have usually been reserved for the most egregious abuses or have been limited in scope. Theories based on unfair trade laws have been successful in a number of cases\textsuperscript{85} but, in general, remedies are limited by the damages available and the inconsistencies between the various state statutes.\textsuperscript{86} In addition, some consumer protection laws specifically exclude claims for death or personal injury.\textsuperscript{87}

\textsuperscript{79} Cort v. Ash, 422 U.S. 66 (1975). In Cort, the Supreme Court elucidated the test to determine whether a plaintiff has a private right of action under a federal law. The Cort test is composed of four questions: Was the act intended especially to benefit the plaintiff? Does any legislative pronouncement explicitly or implicitly suggest the intent to create or deny a private cause of action? Is it consistent with the underlying purpose of the legislative scheme to imply a cause of action? Is the cause of action one traditionally relegated to state law? \textit{Id.} at 78.

\textsuperscript{80} 464 F.Supp 983 (E.D. Ill. 1979). In Fuzie, the court did however determine that the plaintiff could maintain a claim for breach of contract based upon the federal regulations as an intended third party beneficiary of the contract between the state and the nursing home. This portion of the holding will be discussed in a later section.

\textsuperscript{81} 471 F. Supp. 903 (Conn. 1979).

\textsuperscript{82} 741 F. Supp. 1162 (E.D. Penn. 1989).

\textsuperscript{83} The use of the tort of false imprisonment in the nursing home context was explored in Cathrael Kazin \textit{Nowhere to Go and Choose to Stay: Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals}, 137 U. PA. L. REV. 903 (1989). While this might indeed be a viable alternative in certain cases, the need to prove a specific fact pattern limits the utility of the tort.

\textsuperscript{84} These cases have been based on consumer protection laws found in every state. While most of these laws are directed against specific activities, most also contain general language prohibiting deceptive practices. It is this language which most often serves as a basis for nursing home residents' suits. Diane Horvath & Patricia Nemore, \textit{Nursing Home Abuses as Unfair Trade Practices}, 20 CLEARINGHOUSE REV. 801, 802 (Nov. 1986).

\textsuperscript{85} \textit{Id.} at 804-05.

\textsuperscript{86} A majority of states exempt regulated practices which would likely include a nursing home's regulations. Statutes in twenty-six states limit private litigants to injunctive relief while the damage amounts allowed, even under the more liberal laws, range between $25 and $2000.

\textsuperscript{87} See, e.g., Ohio Consumer Sales Practices Act, OHIO REV. CODE ANN. § 1345.12(C) (Baldwin 1991).
In order to make bad faith breach of contract a workable vehicle for the nursing home resident/plaintiff, an attempt must be made to better define the elements of the tort; a task which has sometimes alluded the courts which have addressed it. As we have stated, this action is a form of corporate intentional tort which combines the most advantageous (for the plaintiff) aspects of contract and tort theories. There must, however, be limits set on its application to distinguish it from a simple breach of contract and a true act of negligence so that every breach of contract is not converted into a tort action or every accident into a breach of contract. Combining the standards of Jurika and Louderback\(^\text{88}\) with those of Owen\(^\text{89}\) and John,\(^\text{90}\) the applicability of the tort would seem to depend on three factors: the nature of the contract, the nature of the relationship between the parties, and the conduct of the defendant. More specifically, the plaintiff would have to prove that: 1) the contract was one made for reasons other than commercial gain;\(^\text{91}\) 2) there is an inequality between the parties such that the weaker party is forced to rely upon the good faith of the stronger party in order to enjoy the benefits of the contract; and 3) the conduct of the stronger party is such that it reflects the adoption of a policy which systematically fails to meet the justified expectations of the weaker party.

The first two elements would serve to distinguish between those contracts subject to the tort of bad faith breach from those subject to an ordinary contract action. The first element singles out the subject matter of the contracts covered. The second element incorporates both the notion of "special relationship" and the idea of quasi-public service and expands the traditional focus on inequality of bargaining power in the formation stage to include inequality in the performance stage.

The third element serves both to distinguish the tort from negligence and to justify punitive damages. It requires the demonstration of some pattern of behavior, either as a result of corporate inadvertence (not realizing what they should do) or evaluation (realizing but acting anyway). In addition, intentional actions would also be included. This element, however, would also take into account that isolated acts of negligence can occur even within a nursing home environment without indicating abuse. Not every act that results in some harm is a bad faith breach of contract. However, focusing on aggregate behavior rather than

\(^{88}\) See supra note 36.
\(^{89}\) Owen, supra note 47.
\(^{90}\) John, supra note 48.

\(^{91}\) This does not necessarily exclude commercial contracts. In Wallis v. Superior Court, 207 Cal. Rptr. 123 (1984), the court upheld a bad faith breach of contract action based on the employer-employee relationship. While the purpose of working is certainly financial gain, other factors enter into the relationship to make it more than a means of commercial gain.
single incidents would relax the demands inherent in a negligence action to prove that all damages stem from a single negligent incident. Thus, cumulative damage from a pattern of behavior could be considered along with justification for the punishment of that behavior.

VI. TERMS OF THE CONTRACT

A. The Nursing Home Contract

The first problem to arise using these elements would be; What constitutes the justified expectation of the weaker party? As the action is based upon breach of contract, the simple answer would be the terms of the contract. Nursing home contracts rarely include express terms guaranteeing quality care or patients' rights. They are, however, generous with exculpatory clauses, waivers of liability for the nursing home, and limitations on resident rights. Reliance, therefore, on the express terms of the nursing home contract will often be futile.

c Some plaintiffs have advanced the argument that the contracts have included an implied promise to provide reasonable care. While courts have accepted this reasoning, they have found the promise to do no more than set the same standard of care which would be applied in a tort case.

In contrast, however, some courts have taken an expansive view of even vaguely written terms of a nursing home contract holding that contracts entered into by persons “in their declining years” should be liberally construed in favor of the elderly. Thus, even vague terms may serve as the basis of a cause of action.

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92 Lutler, supra note 51, at 642.
93 Donna Myers Ambrogi, Legal Issues in Nursing Home Admissions, 18 LAW MED. & HEALTH CARE 254, 257 (Fall 1990). As Ambrogi points out, nursing homes will often incorporate unconscionable, if not illegal terms, into their contracts relying on the residents' ignorance or helplessness. Such terms include waivers of liability for negligence, extra charges for services already covered in the basic fee, requirements for co-signers, solicitations of contributions, restrictions on visitation and requirements that residents commit to a specific length of stay before converting to Medicaid, to name but a few.
94 Brown v. University Nursing Homes, 496 S.W.2d 503 (Tenn. App. 1972). It should be noted that Brown involved a negligence situation where a resident fell as a result of a faulty restraining table. The plaintiff here was suing both in negligence and breach of contract and proposing that under a contract theory the nursing home had some absolute liability to the plaintiff. While the court properly rejected this argument, care must be taken not to over read this case.
95 Hutchins v. Bethel Methodist Home, 370 F. Supp 954 (S.D.N.Y. 1974). In this case, a primarily residential home transferred a patient to another, higher level care facility (with the resident paying the difference in rate). The resident claimed that the clause in her contract in which the nursing home agreed to pay “all necessary medical services” required the home to absorb the additional cost. The court agreed.
96 Id. at 963.
In addition to the dearth of express guarantees to the resident, nursing home contracts usually contain merger clauses to exclude any outside material from the contract. These clauses, especially when included in consumer contracts, have frequently been found to have no effect except where it can be demonstrated that they have truly been agreed to\(^9\) (a condition particularly unlikely in a nursing home contract). If a home is a participant in medicare or medicaid and has complied with the federal regulations requiring written policies to implement the federal nursing home Bill of Rights, it is very possible that these written policies could be introduced as having been incorporated as terms of the contract under the parol evidence rule.\(^98\)

B. Advertisement

Nursing homes in the United States are big business. In 1980 there were 26,000 nursing homes in this country which housed 1.3 million people.\(^99\) The number is assuredly larger now. What was once a business run by sole proprietorships is now dominated by large corporate chains. With this change in the complexion of the marketplace has come increasing competition and the need for marketing strategies including advertising. Recently one major nursing home chain has resorted to television advertisements.\(^100\) This new trend may provide fertile ground for nursing home plaintiffs to expand on the lack of express terms in their contracts.

Sellers have long been held to promises made in promotional literature.\(^101\) An argument can certainly be made that the contract incorporates the promises made in a brochure designed to induce reliance and that these promises can be taken as express warranties. Such promises often encompass both the quality and quantity of care offered.\(^102\) In addition,

\(^9\) Restatement (Second) of Contracts § 216, Comment e (1979).

\(^98\) Even under the more restrictive Willistonian rule, a set of written policies would likely be viewed as consistent additional terms which should be included.

\(^99\) Lawrence R. Leonard, The Ties That Bind: Life Care Contracts and Nursing Homes, 8 AM. J. L. & MED. 153 (Summer 1982).

\(^100\) Manor Care Nursing Home, Inc., one of the largest of the nursing home chains, began airing television commercials in January 1991 in the Cleveland area to test audience response to the advertising of nursing home care. The ads are directed at assuaging the guilt associated with placing a family member in a nursing home. Elisa Williams, Manor Care Ads Irk Shareholders, THE WASHINGTON TIMES, Sept. 6, 1990, at C1.


\(^102\) The following were selected from a sampling of promotional literature from nursing homes in the Cleveland area:

"Open door policy regarding counseling personal concerns, financial or otherwise." "Everything smells clean with an aroma of fresh brewed coffee and homemade apple pies in the oven." "Daily - Three nutritious meals, snacks and/or nourishment planned by our registered dietician. 24 hour - Personal attentive care and grooming by our trained Nursing Assistants. 24 hour Professional and licensed nurses providing guarded and watchful care of your needs and comfort. Clean changes of bedding and linens bi-weekly and as needed daily. Daily housekeeping laundry." Brochure, Mount Royal Villa Care Center, North Royalton, Ohio.
many nursing homes advertise themselves as being medicare and/or medicaid certified. This could be seen as implying that they meet the federal regulations for approval, thus incorporating the nursing home bill of rights into the contract.

Combining promotional literature with the rules that ambiguous language is to be interpreted against the drafter and that an interpretation in favor of the public good should be favored could result in an effective weapon in a bad faith breach of contract suit.

C. State Statutes

As has been mentioned, many states have adopted nursing home resident's Bill of Rights statutes. These statutes, however, often afford limited or no private rights of action. Some commentators have suggested that the state's nursing home regulations could be considered as incorporated into the contract under the rule that the laws of the state are considered part of every contract. An excellent analysis of this theory has been done by Regan. He first notes the contractual nature of the

"[M]eets or exceeds all applicable legal regulatory, professional, and programmatic requirements." "Each resident's individuality and dignity are cherished and maintained in a context of the highest standards of professional care." Brochure, Pleasant Lake Villa, Parma, Ohio.

"We provide the emotional and physiological support to preserve and maintain the personal dignity of each and every resident." "24 hour nursing care." "Nutritional and delicious meals for regular or special diets." "Daily housekeeping and linens." "Flexible visiting hours." Our certified activities director plans a variety of social, religious, physical and intellectual programs." Brochure, Aristocrat Berea, Berea, Ohio.

"Day, evening and weekend activities." "Resident bathing is made comfortable and secure by using the latest techniques and bathing equipment." "[A] warm home like setting." "Licensed nurses are on duty 24 hours a day." "[G]ood food in the cheerful dining room." "Comprehensive therapy programs include physical therapy, occupational therapy, and recreational therapy." Brochure, Alpha Health Care Center, Middleburg Heights, Ohio.

"We provide a total healthcare program tailored to the individual needs of our residents." "The facility provides a full range of rehabilitative services . . . provided under the direction of a licensed therapist." "The facility maintains a varied recreation program." "There are no special visiting hours so family and friends may drop in any time." Brochure, Southwest Health Care Center, Middleburg Heights, Ohio.

"[S]ee Butler, supra note 54, at 643; see also MaryAnne Meyers, New Hope for Quality Care for the Aged in Oregon's Long Term Care Facilities, 18 WILLAMETTE L. REV. 135, 149 (1982).

106 Id. at § 207. This relates back to an idea developed earlier that providing nursing home services is a quasi-public function.

nursing home-resident relationship, even in the absence of a written contract which would contain an implied warranty of adequate care and treatment. He than analogizes to the landlord-tenant relationship in which the implied warranty of habitability has been held to incorporate the local housing and building codes. Such an analysis results in a contract whose measure would be the nursing home’s compliance with all state and possibly federal regulations, including the Nursing Home Residents’ Bill of Rights.\footnote{108}

There is little case law directly on this point. One case that does mention it suggests by implication that the state’s regulations are implicitly incorporated. In \textit{Truesdell v. Proctor},\footnote{109} the plaintiff argued that the state nursing home regulations were included in the contract by virtue of the rule that state laws are an implicit part of every contract. The court appeared to recognize the reasoning but correctly held against the plaintiff because the claim had been raised for the first time in the appeal and had never been presented to the trial court.

Recognition of the incorporation of state and federal statutes in every nursing home contract would provide a resident, regardless of the wording of her contract, a basis for a bad faith breach of contract action, thus allowing the individual resident maximum benefit from the statutes passed to protect her.

\textbf{D. Federal Statutes}

As stated, the same rationale as described above can be applied to the federal regulations and would be especially useful in states which have no nursing home Bill of Rights. A second line of argument based upon

\footnote{108 The rationale behind the adoption of the implied warranty of habitability theory is remarkably similar to that given for bad faith breach of contract. In \textit{Hilder v. St. Peter}, 478 A.2d. 202 (Vt. 1984), the court stated that “[c]onfronted with a recognized shortage of safe decent housing today’s tenant is in an inferior bargaining position compared to that of the landlord. Tenants vying for the limited housing are ‘virtually powerless to compel the performance of essential services.’” (cites omitted) \textit{Id.} at 207. In determining the standard for breach of the implied warranty, the court looked to the provisions of the housing code as a beginning, but beyond this looked to see whether the claimed defect had “an impact on the safety or health of the tenant.” \textit{Id.} at 209.

The court saw fit to extend the general damages to include damages for discomfort and annoyance based upon the nature of the contract and the frequency with which these types of injuries occur in this context. \textit{Id.} The court thus imparted the foreseeability of this type of injury onto the landlord.

The court further authorized the awarding of punitive damages where the breach was carried out “by conduct manifesting . . . a reckless or wanton disregard of [the plaintiff’s] rights.” \textit{Id.} at 210. This language closely parallels that found in \textit{Comunale} and in Owen’s explication of intent in bad faith breach.

It is also noteworthy that most jurisdictions, including the court cited above, have held that the implied warranty of habitability cannot be waived. Analogizing to the nursing home contract, this would render most of the exculpatory clauses in such contracts ineffective.

\footnote{109 443 So.2d 107 (Fla. App 1983).}
third party standing has been developed in suits based on the federal regulations. This same argument could be equally applied to state regulations which prohibit a private right of action.

In Fuzie v. Manor Care, Inc.,\textsuperscript{10} the district court, although denying the resident a private right of action under the federal statutes,\textsuperscript{11} held that the resident, as an intended beneficiary of the contract between the state and the nursing home, could sue the home as a third party beneficiary for breach of contract.\textsuperscript{12} In the medicaid program, the state distributes federal funds to nursing homes in exchange for their agreement to provide care according to the federal conditions of participation. The resident is the intended beneficiary of this agreement and can thus maintain an action.

A similar result was found in Euresti v. Steiner\textsuperscript{13} where a group of indigents sued a hospital for failure to provide low cost health care, as required under their participation in the federal Hill-Burton program. Thus, even if the theory of the direct incorporation of the federal regulations into the nursing home resident contract fails, a resident can sue for breach of contract as a third party beneficiary. The question then, however, is can she sue for the tort of bad faith breach of contract as a third party beneficiary?

VII. THIRD PARTIES AND BAD FAITH BREACH

For the answer to this question we must turn once again to insurance law. The court in Murphy v. Allstate Ins. Co.\textsuperscript{14} implied that in the proper situation a bad faith breach of contract action could be maintained by an appropriate third party. The facts of that case involved an injured party who sued for breach of the insurance company's good faith duty to settle within the limits of the policy. The court held that the injured party could not maintain such a suit because the covenant of good faith extended only to third parties who were intended to benefit from the contract.

\textsuperscript{10} 461 F. Supp. 689 (N.D. Ohio 1977).
\textsuperscript{11} Id. at 696.
\textsuperscript{12} Id. at 697. The court stated:
\begin{quote}
It is apparent from the language of this regulation that it is intended to inure to the benefit of Medicaid patients receiving services in long term care facilities participating in Title XIX through the Ohio state plan. Ohio law has long recognized that 'a third person for whose benefit a promise has been made by another may maintain an action thereon at law in his own name'. The State of Ohio having elected to participate under Title XIX and to receive federal funds, is obligated to provide medicaid service to qualified recipients in a manner consistent with federal law. Defendant Manor Care's obligations under state and federal law and regulations are contractual. Insofar as the provisions of the federal regulations ... reflect a duty owed to Ohio Medicaid patients by the state and the participating providers of their care ... such recipients may maintain an action under a provider's agreement in accordance with the law of Ohio. (cites omitted) Id.
\end{quote}
\textsuperscript{13} 458 F.2d 1115 (Colo. 1972).
\textsuperscript{14} 533 P.2d 172 (Cal. 1976).
In *Northwestern Mutual Ins. Co. v. Farmers Ins. Group,* the action was brought by an excess liability insurer to recover money it was required to pay out on a wrongful death action. The plaintiff alleged that its losses were due to the primary insurer's bad faith refusal to settle within the limits of the policy. The accident involved a permissive user of an automobile insured under an omnibus clause of the insured's policy. In finding for the plaintiff, the court held that "the right of a third party beneficiary to enforce the contract extends to implied covenants.'

The right of a third party to bring a bad faith breach of contract action would seem to depend upon whether that party was an intended beneficiary of the contract. There can be little doubt that the resident is the intended beneficiary of the federal nursing home regulations. Thus, it would seem that a third party beneficiary action for bad faith breach of contract is an option for the nursing home resident.

**VIII. DAMAGES**

**A. Consequential Damages**

To understand the theoretical rationale of consequential damages in bad faith breach of contract suits, it is easiest to approach the issue from the contract perspective. A standard measure of contract damages is a realization by the injured party of his expectation interest. Expectation interest is defined by the Restatement as "his interest in having the benefit of his bargain by being put in as good a position as he would have been in had the contract been performed." This standard is relatively easy to apply in commercial contracts where profits and losses tend to be liquid. However, the nursing home resident benefits in lifestyle. Her losses are physical and mental rather than pecuniary. The only method our system has of placing a value on physical and mental injuries is that used in tort cases to determine consequential damages. Bad faith breach as a composite of tort and contract merely uses the tort valuation system to determine the amount of traditional contract damages for non-traditional contracts.

The first element of the tort as outlined would address this issue of consequential damages. It would seem logical that a contract not made for commercial gain would have a noncommercial expectation interest. This interest also could not logically be realized using a commercial standard. The end remedy, however, placing the injured party in the position he would have been in had the contractual promise been kept, is derived from pure contract theory.

As previously mentioned, even expectation interest in contract remedies is traditionally governed by the rule that recovery is limited to those

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116 Id. at 421.
117 *Restatement (Second) of Contracts* § 344 (1979).
damages which were within the contemplation of the parties at the time of the formation of the contract.\textsuperscript{118} The justification for ascribing to the nursing home the foreseeability of the type of damage that can result is found in the second element of the tort. Because the resident is forced into the position of relying upon the supposed superior judgment of the home for the bulk of her daily decisions, it would seem fair to ascribe to that superior judgment a knowledge of the consequences that could befall the resident as a result of the nursing home's decisions.

B. Punitive Damages

Typically, punitive damages are unavailable in either contract or negligence actions. A breach of contract is traditionally seen as a morally neutral act. In an economic world, overall efficiency is best served if a party is free to commit an economically favorable breach as long as he is willing to make the injured party whole.\textsuperscript{119} Breach in this context may actually be a socially desirable action.

Negligence, although it claims to be based on fault, also adopts a morally neutral standpoint. Intent is irrelevant. Accidents are seen as inevitable events. The focus in negligence is on the meeting of an objective standard of reasonable care and an allocation of losses. Those who fail to meet the standard must absorb the loss.

To justify punitive damages, there must be some act which elicits moral approbation.\textsuperscript{120} In bad faith breach, that moral approbation finds its source in the second element of the tort: a violation of the special relationship based on the trust the weaker party must place in the stronger to act in her best interest. This trust is the source of the quasi-public nature which characterizes the contracts to which bad faith breach has been applied. But as John\textsuperscript{121} points out, a rationale to justify punitive damages is not enough. There must be some standard to guide courts in the awarding of these damages. This is provided by the third element of the tort. The defendant's actions must be scrutinized to identify a pattern of conduct which he knew or should have known would systematically frustrate the plaintiff's enjoyment of the benefits due her. Punitive damages would only be allowed in those cases where the plaintiff was able to prove the systematic conduct of the defendant in depriving her of the benefit of her bargain. The amount of punitive damages would be determined by the seriousness of the objectionable behavior. This serves the plaintiff on the one hand by taking the focus off any single incident in isolation and allows her a remedy for a series of events no one of which can be proven to have proximately caused her injury. On the other hand, it protects the defendant from having a simple act of negligence converted into an action for punitive damages.

\textsuperscript{118} Hadley v. Baxendale, 156 Eng. Rptr. 145 (1854).

\textsuperscript{119} Gilmore, \textit{supra} note 52, at 14-16.

\textsuperscript{120} W. Keeton, D. Dobbs, D. Owen, Prosser and Keeton on Torts 9 (5th ed. 1984).

\textsuperscript{121} John, \textit{supra} note 47, at 2036.
IX. Statute of Limitations

Whether or not a nursing home resident can take advantage of the longer statute of limitations generally available for contract actions when bringing a bad faith breach of contract suit very much depends on the jurisdiction in which she resides. Since a bad faith breach of contract arises from both tort and contract, which statute of limitations applies? In some states such as Ohio, only the tort form of the action is recognized and thus the tort statute of limitations applies. In other states such as New York, the action is recognized as arising out of contract and the contract statute of limitations applies. In California, where the majority of bad faith breach of contract actions have been decided, the courts appear divided.

In Frazier v. Metropolitan Life Ins. Co., the court held that the plaintiff may elect between a contract theory or a tort theory. If the contract theory is elected then she may use the longer statute of limitations but is barred from claiming punitive damages (the court did, however, award damages for emotional distress under the contract theory). In Umann v. Excess Ins. Co., however, the first district court of appeals found that the action arose both in contract and tort and expressly rejected the election theory presented in Frazier. The Umann court stated that, regardless of theory, the plaintiff had to prove the same set of facts, the defendant had available the same defenses, and the jury received the same instructions. It would not be logical, the court reasoned, to allow punitive damages if the action is brought within two years but deny them if it is brought within four years.

Two months later the second district court of appeals, in Prudential Ins. Co. v. Sup. Ct. L.A. County, expressly rejected the holding in Umann and returned to the Frazier standard of election of theory. It is noteworthy that both cases were denied review within a month of one another. The law in California is thus unclear.

X. Conclusion

The number of suits brought by nursing home residents has been few, and the awards the residents have received have been small. Despite extensive federal and state regulation over the past fifteen years, nursing

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125 Id. at 891-892.
126 236 Cal. Rptr. 89 (1987), rev. denied and ordered not to be officially published (July 1987).
127 Id. at 95-96.
NURSING HOME CONTRACTS

home abuse continues. This results in a large number of insured individuals who have been unable or unwilling to obtain redress for their injuries. A significant part of the problem is the cause of action traditionally available to the residents - negligence. Negligence simply does not adequately address the type of institutionalized systematic abuse found in nursing homes.

The tort of bad faith breach of contract has been successfully applied to correct corporate abuse in the insurance industry since 1958. The criteria for application of the tort, as described by Louderback and Jurika, seem to fit the nursing home-resident contractual relationship very well.

As there has been much confusion among the various jurisdictions as to the standard for bad faith breach, an attempt has been made herein to set out elements for the tort and demonstrate how they would apply to the nursing home contract.

In addition to allowing greater damages, the bad faith breach of contract action has the advantage for the nursing home plaintiff of pinpointing the type of conduct which characteristically results in nursing home abuse, specifically corporate oppression.

Although it is yet untried, bad faith breach of contract should prove an effective and powerful weapon for the nursing home resident.

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130 See supra note 36.